Guidelines for Psychological Practice With Girls and Women

American Psychological Association

During recent decades, women and girls of diverse ethnicities, social classes, sexual orientations, and life experiences have encountered dramatic and complex changes in education, health, work, reproductive and caregiving roles, and personal relationships. Although many of these changes have resulted in increased equality, opportunity, and quality of life, girls and women are also at risk for a variety of health concerns and life stresses (*National Healthcare Disparities Report*, 2005). Stressors in the lives of women and girls include interpersonal victimization and violence, unrealistic media images of girls and women, discrimination and oppression, devaluation, limited economic resources, role overload, relationship disruptions, and work inequities. Violence against girls and women is often predicated in sexism, racism, classism, and homophobia (Glick & Fiske, 1997; Koss, Heise, & Russo, 1994; West, 2002). Salient mental health statistics reveal that women are two times more likely than men to be depressed, and girls are seven times more likely than boys to be depressed (Lewinsohn, Rhode, Seeley, & Baldwin, 2001). Women who are subject to group and individual discrimination are even more likely to experience depression (Klonis, Endo, Crosby, & Worell, 1997). Girls and women are also roughly nine times more likely to have eating disorders than boys and men (Stice & Bearman, 2001; Stice, Burton, & Shaw, 2004). Compared with men, women are two to three times more likely to experience many types of anxiety disorders (U.S. Department of Health and Human Services, Office on Women's Health, 2001). The abuse and violence in U.S. society (e.g., abuse, battering, rape) may contribute to the development of dysfunctional behaviors, such as eating disorders, depression, anxiety, and suicidal behavior, whereas discrimination against women and girls of color can result in lowered self-expectations, anxiety, depression, and negative attitudes toward self (Keith, Jackson, & Gary, 2003). In general, the physical and mental health concerns of women and girls are related to complex and diverse economic, biological, developmental, psychological, and sociocultural environments. The concerns, behaviors, values, attitudes, and feelings of women and girls also arise from myriad interactions among their multiple identities related to age, race, ethnicity, class, sexual orientation, marital, partnership and parental status, gender identity, ability, culture, immigration, geography, and other life experiences (Sparks & Park, 2000; Stewart & McDermott, 2004).

Although many psychologists and members of the general public may believe that women's issues in psychology were dealt with and resolved in the 1970s and 1980s, the changing and increasingly complex life experiences of girls and women and the intersection of their gender roles with ethnicity, sexual orientation, ability, socioeconomic status (SES), and so forth demonstrate compelling evidence and need for professional guidance for helping psychologists (a) avoid harm in psychological practice with girls and

These guidelines were approved as APA policy by the APA Council of Representatives on February 16, 2007. They were developed by an interdivisional task force of APA Divisions 17 (Society of Counseling Psychology) and 35 (Society for the Psychology of Women). The task force co-chairs were Roberta L. Nutt, Joy K. Rice, and Carolyn Z. Enns, who were appointed in 2000 by Nadya Fouad, then President-Elect of Division 17, and Janice Yoder, President-Elect of Division 35. Task force members and consultants at various stages of development included Julie Ancis, Martha Bergen, Kathleen Bieschke, Michele Boyer, Laura Boykin, Mary Brabeck, Sara Bridges, Redonna Chandler, Madonna Constantine, Carmen Cruz, Donna Davenport, Amanda Dickson, Ruth Fassinger, Laura Forrest, Linda Forrest, Lisa Frey, Deborah Gerrity, Glenn Good, Barbara Gormley, Michael Gottlieb, Kris Hancock, Nancy Downing Hansen, Michele Harway, Danica Hays, Misty Hook, Kathy Hotelling, Rachel Latta, Karen Lese, Don-David Lusterman, Jim Mahalik, Connie Matthews, Dinah Meyer, Debra Mollen, Cassie Nichols, Laura Palmer, Adrienne Paulson, Randy Pipes, Beverly Pringle, Jill Rader, Faye Reimers, Pam Remer, Rory Remer, Christina Rodriguez, Holly Savoy, Anne Scott, Susan Seem, Elizabeth Skowron, Stacey Smoot, Dawn Szymanski, Virginia Theo-Steelman, Ellen Tunnell, Melba Vasquez, Heather Weiner, Ashley Williams, Libby Nutt Williams, Kacey Wilson, Judy Worell, and Karen Wyche. Twenty doctoral students from eight programs were included in this process.

The development of these guidelines depended on the earlier foundation of such historical precedents as APA's (1978) "Guidelines for Therapy With Women: Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice," APA's (1979) Division 17 "Principles Concerning the Counseling and Psychotherapy of Women," APA Division 35's First National Conference on Education and Training in Feminist Practice in 1993 and its resulting book (Worell & Johnson, 1997), APA's 1998 Division 17 Section for the Advancement of Women Michigan conference on the integration of feminism and multiculturalism, and the ongoing work of APA's Committee on Women in Psychology. Participants were determined to produce guidelines that honored the complexity of the lives of girls and women in their multicultural contexts.

The comments and suggestions garnered from various APA boards and committees, APA divisions, and state and territorial psychological associations added immensely to the richness and utility of the document. The members of the groups may also be considered as consultants and contributors. The authors are particularly indebted to Sarah Jordan for keeping oversight of the complex APA review process in the final stages.

This document is scheduled to expire as APA policy in eight years (2015). After this date, users are encouraged to contact the Practice Directorate, American Psychological Association, to confirm that this document remains in effect or is under revision.

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women; (b) improve research, teaching, consultation, and psychotherapeutic and counseling training and practice; and (c) develop and enhance treatment efforts, research, prevention, teaching, and other areas of practice that will benefit women and girls. In addition, although blatant forms of sexism and racism have decreased over time (J. D. Campbell, Schellenberg, & Senn, 1997), researchers have noted the continuing presence of more subtle forms of sexist and racist bias (e.g., ambivalent, symbolic, or unintentional racism/sexism; Glick & Fiske, 1997; Swim & Cohen, 1997). Given that the majority of those seeking mental health services continue to be female (e.g., Rhodes, Goering, To, & Williams, 2002), special attention to the unique treatment needs of girls and women of diverse backgrounds is warranted (Trimble, Stevenson, Worell, & the American Psychological Association [APA] Commission on Ethnic Minority Recruitment, Retention, and Training Task Force Textbook Initiative Work Group, 2003). The majority of those seeking treatment remain women and girls, and the demographics of the U.S. population are rapidly changing, resulting in more diversity among the women and girls needing psychological services. Improved treatment not only reduces potential harm, but will also likely benefit women and girls, particularly through the greater awareness, education, and prevention fostered by guidelines for psychological practice with girls and women.

Purpose and Scope

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

The "Criteria for Practice Guideline Development and Evaluation" (APA, 2002a) defines the term *guidelines* as

> statements that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by enforcement mechanism. Thus, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. (p. 1048)

Guidelines may be superseded by federal or state laws. The APA (2002a) also distinguishes between treatment and practice guidelines, noting that treatment guidelines "provide specific recommendations about clinical interventions" (p. 1048). In contrast, "practice guidelines consist of recommendations to professionals concerning their conduct and the issues to be considered in particular areas of practice" (p. 1048).

The following practice guidelines have been written to be compatible with the "Ethical Principles of Psychologists and Code of Conduct" (APA, 2002b); the "Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients" (APA, 2000b); the "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2003); and the "Guidelines for Psychological Practice With Older Adults" (APA, 2004a). These guidelines do not refer to practice with transgender individuals. These guidelines are also consistent with the products of the APA Presidential Task Force on Violence and the Family (APA, 1996) and the Task Force on Women, Poverty, and Public Assistance (APA, 1998), as well as with other relevant APA documents, such as the *Resolution on Substance Abuse by Pregnant Women* (APA, 1991), the *Resolution on Cultural and Gender Awareness in International Psychology* (APA, 2004b), the *Resolution on Women and Poverty* (APA, 2000d), the *Resolution on Poverty and Socioeconomic Status* (APA, 2000c), recommendations of the APA's Intimate Partner Abuse and Relationship Violence Working Group (APA, 2002c), and the *Resolution on Male Violence Against Women* (APA, 2005). We strongly encourage institutions, agencies, departments, and/or individuals to discuss ways these guidelines may be applied to their own specific settings and relevant activities. As noted in APA's "Criteria for Practice Guideline Development and Evaluation" (APA, 2002a), practice guidelines "may not be applicable to every professional and clinical situation" (p. 1048). Consistent with APA criteria, these guidelines are not definitive and are designed to respect the decision-making judgment of individual professional psychologists. In addition, these guidelines will need to be periodically reviewed and updated at least every 10 years (8 years is recommended), beginning from the year of acceptance by the APA Council of Representatives, to take into account changes in practice, research, and the effects of changing contemporary social forces and context.

It should be noted that many of the guidelines and recommended practices addressed in this document apply to individuals of both genders with diverse social memberships. For example, many of the guidelines encourage psychologists to understand the consequences of gender-role socialization and its interactions with other social identities, such as race, ethnicity, sexual orientation, and ability, because both females and males experience constraints related to their gender and the gender-role socialization process (see Pittman, 1985; Pleck, 1995), and these processes influence both males' and females' mental and physical health (Addis & Mahalik, 2003; Courtenay, 2000; Murphy, 2003). Hence, the recommendation to integrate an understanding of gender-role socialization into the practice of psychology should not be limited to working with girls and women. Although many of these guidelines are poten-

tially applicable to both genders, this document focuses on the experiences of girls and women for two reasons. First, females in the United States, on average, have less economic, political, and social power than males and, therefore, have experiences that are more likely to contribute to issues of powerlessness. Women of color, on average, suffer from at least two sources of discrimination—gender and race/ethnicity—and therefore may feel even more powerless (Bryant et al., 2005; Moore & Madison-Colmore, 2005; C. B. Williams, 2005). The average pay gap between men and women has been persistent and significant since statistics about gender and pay have been collected. In addition, a pay gap exists between White women and women of color, which has widened during the past 20 years (Costello & Stone, 2001). The impact of such experiences on the mental health and well-being of girls and women as well as the manner in which such experiences affect psychological practice with diverse members of these populations and the obstacles and discrimination with which they may be faced need to be considered. Furthermore, compared with the research that is currently available about boys and men, a much more extensive scientific literature examines the gender-role socialization and gendered experiences of girls and women in connection to issues of practice. As research proceeds on boys and men, however, future practice guidelines should expand the scope of these practice guidelines to encompass gender-sensitive concerns over the lifespan for both females and males across all identity categories. The project focusing on males began in the spring of 2005, and that writing group has been invited to borrow freely from this document.

Need

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

Bias in Diagnosis and Treatment

In recent times, gender bias has been observed to be more covert but is still a detectable and powerful force in psychological practice. Particular areas of concern include the presence of gender bias—as well as bias in other social constructs, such as ethnicity, age, race, disability, and social class—within diagnostic criteria and labeling (Caplan & Cosgrove, 2004; De Barona & Dutton, 1997; Hartung & Widiger, 1998; Marecek, 2001; Ratey & Johnson, 1997; Ross, Frances, & Widiger, 1997). Women of color and lesbians may be especially vulnerable to misdiagnosis and other forms of bias (APA, 2000b; Hall & Greene, 2003). For example, among women and girls, gender-role socialization, economic status, ethnicity, sexual orientation, and disability status, as well as biased criteria and perceptions, may contribute to inappropriate use and overuse of certain diagnoses, such as histrionic and borderline personality disorders, depression, dissociative disorders, somatization disorder, premenstrual dysphoric syndrome, and agoraphobia (Becker & Lamb, 1994; Bekker, 1996; T. L. Campbell, Byrne, & Baron, 1992; Chrisler & Johnston-Robledo, 2002; Cosgrove, 2004; Garb, 1997; Hartung & Widiger, 1998; Klonoff, Landrine, & Campbell, 2000; Landrine & Klonoff, 1997; Lerman, 1996; Sperberg & Stabb, 1998). Many symptoms associated with the aforementioned disorders have been conceptualized as exaggerations or stereotyping of traditional female gender roles and behaviors (as defined by mainstream culture; e.g., overreacting emotionally, attempting to sexually attract men and to preserve romantic relationships at all costs, and placating others by internalizing, denying, or inefficiently expressing anger). Misdiagnosis can also occur when a client's problem behaviors are inconsistent with societal expectations, such as when an Asian woman, assumed by stereotype to be meek, reacts to discrimination with anger. In another example, Crosby and Sprock (2004) found that when clinicians rated a case of a woman with antisocial symptoms, they were more likely to exhibit biases that were consistent with relying on prototypes (i.e., stereotypes regarding diagnostic categories) rather than actual diagnostic criteria. There is ample evidence that poverty and economic inequality are strong predictors of depression in women (APA, 2004b; Belle & Doucet, 2003; C. Brown, Abe-Kim, & Barrio, 2003). African American women are more likely to be diagnosed with schizophrenia than White women (Marecek, 2001). Issues of gender identity have been viewed as pathology rather than an alternate form of gender and sexual expression (American Psychiatric Association, 2000).

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

to be related to fewer teacher referrals, yet attention problems are associated with lower self-esteem and more frequent peer rejection for girls than for boys (Biederman et al., 1999; Gaub & Carlson, 1997; Gershon, 2002; Quinn, 2005).

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

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

Trauma and Other Stressors

One important diagnostic issue is found in posttraumatic stress disorder (PTSD; American Psychiatric Association, 2000). Despite the greater prevalence and chronicity of PTSD among females (Tjaden & Thoennes, 2000a), the construct is based on data from male combat veteran experiences, resulting in measurement problems that can affect both research and practice (Cloitre, Koenen, Gratz, & Jakupcak, 2002; Wolfe & Kimerling, 1997). For example, girls and women may be diagnosed with other Axis I and Axis II disorders when they experience trauma symptoms that do not fit the traditional PTSD profile (Cloitre et al., 2002). Further, women and girls may be misdiagnosed with more stigmatizing and chronic disorders (e.g., borderline personality disorder or schizophrenia) than men with posttraumatic conditions (Fish, 2004). Women of color may experience additional trauma from multiple experiences with discrimination and oppression. This trauma may lead to further misdiagnosis that does not take context into account. The experience of African American women with intergenerational trauma and the ongoing effects of a history of slavery have generally not been considered in the diagnosis of trauma (H. Vasquez & Magraw, 2005). In addition, men and women may experience trauma differently and may respond more effectively to different treatment approaches because of the types of traumas they are likely to encounter, potential differences in neurobiological stress pathways, whether the stressor is chronic or a single-event stressor, and cultural and gender socialization experiences that influence self-concept, expectations, and meaning systems (APA, 2005; Cloitre et al., 2002; Kimerling, Ouimette, & Wolfe, 2002; Krause, DeRosa, & Roth, 2002; Root, 1992, 2001). The *Resolution on Male Violence Against Women* (APA, 2005) noted that more than 20% of women are physically assaulted by a partner, and approximately 12% experience sexual assault at sometime in their lives. The effects of these traumatizing events are compounded by ethnicity/race, social class, physical ability, and sexual orientation because the likelihood of assault increases for marginalized groups (Bryant-Davis, 2005; Harway & O'Neil, 1999; Neville & Heppner, 1999).

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

Not only are 69% of women exposed to a traumatic stressor in their lifetime (H. S. Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), but women are more than twice as likely than men to develop chronic PTSD symptoms following exposure to a traumatic stressor (Kimerling et al., 2002; M. B. Stein, Walker, & Forde, 2000; Sutherland, Bybee, & Sullivan, 1998). Rape and domestic violence seem to account for a higher prevalence of trauma in girls and women of all ethnic groups, and survivors have high rates of PTSD (see review by Wolfe & Kimerling, 1997). In the 1998 National Violence Against Women Survey (Tjaden & Thoennes, 1998), 25% of women and 8% of men reported being raped or physically assaulted by a spouse, partner, or date in their lifetime; men perpetrated approximately 90% of this violence. Girls are also raped.

Child sexual abuse happens two to two-and-one-half times more often to girls than boys (Boney-McCoy & Finkelhor, 1995). Such abuse not only results in immediate psychological symptoms (e.g., Polusny & Follette, 1995), but also results in lifetime risk for self-destructive or suicidal behavior, anxiety and panic attacks, eating disorders, substance abuse, somatization disorder, and sexual adjustment disorders (Finkelhor, 1990). Rates of childhood sexual abuse are similar for Black, White, Hispanic, and Native American women (Arroyo, Simpson, & Aragon, 1997; Robin, Chester, Rasmussen, Jaranson, & Goldman, 1997). Although sexual assault traumas are experienced by women of diverse social identities across the lifespan, the specific issues and challenges of girls and women vary. For example, the presence of stereotyped images of Black women can exacerbate the psychological aftereffects of rape, can contribute to the marginalization of their concerns, and may increase the likelihood of holding victims responsible for their own assault (Donovan & Williams, 2002; Varelas & Foley, 1998).

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

> We suggest that those involved in partner violence have special treatment needs and that those who treat them must do so with sensitivity and from a base of knowledge that comes from specialized training. Psychologists who do not have the requisite training potentially endanger their clients, and likely commit an ethical violation. Those who are teaching psychologists-to-be but who do not teach them about partner violence are abrogating their responsibility and risk perpetuating the conditions which foster this problem. (APA, 2002c, p. 5)

Treatment and Prognosis

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

Practitioners also may not perceive the specific external stresses and contexts of the lives of women and girls and instead may emphasize endogenous and/or intrapsychic factors inappropriately and/or detrimentally, including not taking into account issues of discrimination and oppression based on social groupings (Boston Women's Health Book Collective, 2005; Bullock, 2004; Davis, Matthews, & Twamley, 1999; Marecek & Hare-Mustin, 1998; Porter, 2002). Furthermore, some members of the medical and psychological communities have noted that women's physical illnesses contain psychological components that are not expected in men (Laurence & Weinhouse, 2001; Webster, 2002) and that gender bias is manifested in advertisements for psychotropic medications and in the high use of psychotropic medications among women (Hansen & Osborne, 1995; Nikelly, 1995). Inattention to contextual factors may contribute to the lack of recognition of problems of women and girls, such as battering and other forms of victimization (Harway & Hansen, 2004; Porter, 2002). Inattention to contextual factors also contributes to lack of recognition of the physical and mental health consequences of battering and other forms of violence. An example is the lack of recognition of traumatic brain injury, despite knowledge of the high proportion of injuries to the face, head, and neck during battering. This inattention may also contribute to the underdiagnosis of or double standards about problems such as alcohol abuse (L. H. Collins, 2002; Greenfield, 2002) and the effects of discrimination on stress and performance. For instance, research has found that high school girls expect more educational and career barriers than high school boys and that perceived barriers (e.g., discrimination) are especially likely if girls are also members of an ethnic minority group (McWhirter, 1997). Psychologists may also lack awareness regarding the particular strengths and resources of women and girls that help them deal with stressful issues. For example, many women and girls of color in the United States live in extended families that create larger communities that provide additional support for their growth and development (Reid, 2002).

Culture, Ethnicity, and Other Diversities

Another area of gender bias in psychological practice concerns inattention to the ways in which culture and ethnicity influence problems such as depression and schizophrenia in women and girls (C. Brown et al., 2003; Sparks, 2002). Research has demonstrated that therapist insensitivity to racial stereotypes, the interaction of race and gender, cultural values and mores, and social and economic conditions have an impact on women and girls who live in poverty and women and girls of color (Adams, 1995; APA, 2004b; C. Brown et al., 2003; Gil, 1996; Greene, 1996; Klonoff, Landrine, & Scott, 1995; LaFromboise, Berman, & Sohi, 1994; Ridley, Li, & Hill, 1998; Shum, 1996; Sparks, 2002).

Lesbian relationships and partnerships may also be pathologized through the description of lesbian relationships by terms such as *merged*, *fused*, or *enmeshed* (Morton, 1998; Pardie & Herb, 1997). Social stressors and discrimination from membership in marginalized groups can lead to a variety of internal and external problems.

Sexual Misconduct/Abuse by Psychologists

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

Women With Disabilities

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

Beyond increased risk for abuse and neglect, persons with disabilities traditionally have experienced systematic institutional victimization from all aspects of society, including, but not limited to, the medical profession, the educational system, and the workforce. This victimization of women with disabilities, particularly women of color with disabilities, is especially prevalent. However, disability, gender, and/or culture do not reside solely in a vacuum, and individuals from each social group face struggles within society. Women of color with disabilities experience simultaneous oppression within society by belonging to three or more marginalized groups (e.g., gender, race/ethnicity, disability, sexual orientation, SES). Persons of color with disabilities are more likely to have lower educational levels, higher unemployment, and lower incomes (Block, Balcazar, & Keys, 2002). Moreover, these individuals are faced with having to choose which marginalized identity is most salient in each time frame, which can in itself lead to internal conflicts.

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

Contemporary Social Forces

Gender-related and multicultural issues relevant to practice will change as the broader sociocultural context changes. Good practice requires that psychologists remain abreast of new developments in contemporary social forces and their interaction with gender and other social identities. Many contemporary issues could be cited here; however, four particularly salient and recent examples include (a) the increasing prevalence of global terrorism, violence, and war in which women are particularly victimized by vulnerability to rape, assault, and poverty; (b) the effects of the media in popular culture, which portrays an image of woman as thin, White, sexualized, and victimized; (c) biopsychosocial realities and changes relevant to women's reproductive experiences; and (d) the phenomenon of increasing lifespan with an aging population that consists mostly of women.

Terrorism and War

A contemporary issue that directly affects the welfare and physical and mental health of girls and women of all ethnic/racial groups is terrorism and war. Violence against women and girls is recognized as a global problem (APA, 2004b; World Health Organization, 2000). Women and girls suffer the consequences of violence in war through rape, abuse, torture, and the loss of economic security. Violence against women continues as the threat of terrorism and war across the world continues. Literature that addresses psychological responses to the effects of terrorism and other traumatic incidents suggests that individuals, both adults and children, who directly experience traumatic incidents that involve perceived threat or actual experience of harm to physical integrity often report symptoms of either acute stress disorder or PTSD, which may be exacerbated if they have suffered earlier trauma in the form of ongoing oppression or discrimination based on their ethnicity, SES, sexual orientation, ability, and so forth (Brady, Guy, Poelstra, & Brokaw, 1999; Pine & Cohen, 2002). Mood disorders, adjustment disorders, phobias, and other conditions may also be psychological sequelae for parents and children (Koplewicz et al., 2002; Schuster et al., 2001).

Media

In discussing the influence of contemporary forces, mention must be made of the increasingly powerful presence of the media in modern life. For example, although the 9/11 terrorist attacks on the United States were confined to the Northeast, many Americans vicariously experienced and observed the horrific events through continuous media exposure. Media coverage of the 2001 terrorist attacks generally emphasized men as victims and experts, rendering women and girls nearly invisible and relegating them to stereotypical support and victim roles. There was brief mention made of some African Americans' sense that the 2001 terrorist attacks were isolated incidents, differing significantly from ongoing community violence and the localized terrorism experienced by African Americans in many urban settings (Jenkins, 2002). Media coverage of school shootings has often neglected to emphasize or mention that the perpetrators of the broadcast violence are usually men and boys, with some evidence that misogyny may be one causative factor. The Web sites of the APA and the National Association of School Psychologists, among others, provided abundant materials to help psychologists and the public deal with the traumatization of children that might result from watching the repeated news broadcasts related to the planes hitting the World Trade Center buildings.

In general, the media has become an enormously powerful influence in providing access to information, creating exposure to violence, and conveying cultural stereotypes regarding gender, race, ethnicity, and sexual orientation. The media plays a major role in shaping contemporary values and attitudes. As an increasingly important social influence in U.S. society, television often presents idealized images of women that are stereotyped and distorted by emphasizing youth, extreme thinness, and sexuality (Fouts & Burggraf, 2000; Irving, 2001) as well as presenting negative racial, ethnic, and economic stereotypes (Greene, 1994). There is a large incidence of eating disorders among girls and young women in Western society (K. K. Miller & Mizes, 2000; Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002). Research on the effects of media images and body image disturbance has found that in some young girls and women, increased media attention to the appearance of females on television and in advertising leads to an increased preoccupation with weight, shape, and appearance (Blaine & McElroy, 2002; Botta, 2003; Geier, Schwartz, & Brownell, 2003; Lauzen & Dozier, 2005; Monro & Huon, 2005; Posavac, Posavac, & Posavac, 1998; Posavac, Posavac, & Weigel, 2001; Simonton, 1995; Thornton & Maurice, 1997), which varies widely by ethnic groups with the most impact on White and Asian women and less on African American women. Media images of poor women represent another area of research of importance for practitioners. Women and their children are the largest group of poor individuals in this country, and gender and ethnic stereotypes about poor women can influence both the clinician and the client. Bullock, Wyche, and Williams (2001) found that, although print media is sympathetic to poor women, the structural causes of poverty are not discussed. Hence, women, and particularly women of color, may be blamed for their poverty status. The limitations of the media coverage of poor women, as well as a wide variety of constantly changing sociocultural context factors and their interaction with gender, have the potential to affect practice.

Biopsychosocial Aspects of Reproduction

Although reproduction has always been relevant to the lives of girls and women, recent social developments have contributed to significant changes in the complexity and biopsychosocial meanings of reproduction. As the social roles and pressures experienced by girls and women have expanded, the timing of events related to menarche and childbearing have changed. Reproductive technologies and reproductive medical interventions have become more available and sophisticated, and attitudes toward reproductive choice have also changed. From the onset of menstruation, young girls and women are faced with the biological realities of reproduction (Chrisler & Johnston-Robledo, 2000). Menarche is associated with a variety of physiological, psychological, and social meanings and changes, including changes in appearance beliefs, body image, self-esteem, and peer relationships as well gains and losses in social power, as, for instance, in ethnic groups in which menarche is seen as a marker of adulthood (Crawford & Unger, 2004). The diverse social identities of girls are also related to perceptions of menarche. Although White girls have shown higher depression scores after menarche, no menarche-associated differences have been found in African American and Hispanic girls (Hayward, Hotlib, Schraedley, & Litt, 1999). Although a relationship between the timing of menarche and psychological distress is not consistently found (Stice & Whitenton, 2002), early menarche has been associated with elevated depressive symptoms, eating problems, and substance use and abuse (Stice, Presnell, & Bearman, 2001). As girls mature and gain more body fat at puberty, girls' bodies are less likely to conform to an increasingly thin cultural body ideal. Perceived pressure to be thin and the internalization of a thin ideal have been associated with body dissatisfaction or negative body image (Durkin & Paxton, 2002) and depressive and eating disordered symptoms, particularly for White and Asian girls (Stice & Bearman, 2001). Hence, the biological event of menarche may influence attitudes toward the body. However, those girls who were socialized to think of menarche as a natural event and/or a positive affirmation of womanhood, which is more likely in African American culture, have reported positive experiences (Bishop, 1999). There is also evidence that college women perceive menstruating women as being stronger, more maternal, and more trustworthy (Forbes, Adams-Curtis, White, & Holmgren, 2003).

Similarly, issues associated with reproduction and childbirth can evoke a range of feelings from joy to fear in women and girls. Today, women have greater freedom of choice regarding whether to become a parent and how they want to manage pregnancy and childbirth (Martin & Colbert, 1997) than they did decades ago. Most women con-

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

Sexually transmitted diseases are a growing societal concern, particularly among girls and adolescents (Gutierrez, Oh, & Gillmore, 2000). Women are more vulnerable to STDs than men (Gutierrez et al., 2000; Ickovics, Thayaparan, & Ethier, 2001), and women are more likely to be infected from a single sexual encounter with STDs that produce few detectable symptoms (Jadack, 2001). Women and girls suffer the most severe consequences of STDs, including infertility (Alexander, LaRosa, & Bader, 2001; Jadack, 2001).

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

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

Many women and couples who wish to conceive children are unable to do so (M. Brown & Davey, 2002; Henning & Strauss, 2002). Such women and couples must confront fertility issues and experience loss, grief, and mourning due to reproductive challenges (Anderson, Sharpe, Rattray, & Irvine, 2003; Georgiades & Grieger, 2003; Gerrity, 2001a, 2001b; Kirkman, 2003). Changes in attitudes and practices toward adoption are also relevant. Also, although early literature on adoption focused on negative experiences in adoptive children (Wegar, 2000) and ignored the common practice in some ethnic groups (e.g., African American) of extended family adoption, more recent research is focusing on the full *adoption triad* (i.e., adoptees, birth parents, and adoptive parents) and on both positive and negative aspects of the experience (Lee, 2003; Zamostny, O'Brien, Baden, & Wiley, 2003).

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

Older Women

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

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

On average, women experience more years of good health than men (Altman, 1997); however, they are also more likely to live with chronic illnesses, such as chronic fatigue syndrome, fibromyalgia, arthritis, thyroid conditions, migraine headaches, anemia, and urinary incontinence (Misra, 2001; Schmaling, 2000). These factors have an impact on the psychological identity and lifestyle of women (Altmaier et al., 2003; Stark-Wroblewski & Chwalisz, 2003). Older women can be especially at risk for depression and alcohol problems because they are more likely than men to outlive their spouses and to face other losses that can lead to loneliness and depression (APA, 2004a; Bedford & Blieszner, 2000; Canetto, 2001; Gatz & Fiske, 2003). This effect is less likely for women, such as African American women or others from communal cultures, who have depended on extended family systems for their lifespan (Armstrong, 2001; Bedford & Blieszner, 2000; Reid, 2002; Trotman, 2002). Women are also at greater risk for alcohol-related health problems as they age, such as harmful medication interactions, injury, liver and cardiovascular disease, cognitive changes, and sleep and memory problems (Gambert & Katsoyannis, 1995). As women age, outlive their spouses, and experience increasing dependency and mental and physical health issues, their primary caregivers also tend to be women, many of whom try to balance caring for both their children and their parents or parents-in-law while in full-time employment (Davenport, 1999; Etaugh & Bridges, 2001; Gatz & Fiske, 2003). Numerous studies have indicated that caregivers experience significant emotional, physical, and financial stresses (Canetto, 2001; Etaugh & Bridges, 2001; Huyck, 1999; King, 1993). These issues have caused such concern among psychologists that APA has endorsed and published a separate set of guidelines for older adults (APA, 2004a).

Here we have provided a foundation to establish a public need for these "Guidelines for Psychological Practice With Girls and Women" for all social groups of girls and women, and we have provided evidence of the variable and too often inappropriate treatment of girls and women. Issues that need to be addressed include bias in diagnosis and treatment, differences in environmental stressors and trauma, and the multiple diversity intersections of ethnicity, age, sexual orientation, SES, and disability.

History and Development of the Guidelines

In response to early concerns about women's issues, rights, and discrimination, the APA Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice was charged with studying sexism in psychotherapy and with recommending corrective actions (APA, 1975). The 1975 task force was directed to "be concerned with psychotherapeutic practices as they affect women" (APA, 1975, p. 1169). In response, the task force developed "Guidelines for Therapy With Women" (APA, 1978) for use in training and in continuing professional practice, and this document was published in the December 1978 issue of the *American Psychologist*. These guidelines considered issues of gender bias and sex role stereotypes, sex-discriminatory practices in society, and therapist awareness of these forces and encouraged the elimination of bias in psychological theory and practice. Building on this initial work, various divisions of APA continued to develop and refine recommendations for psychological practice with women.

In 1976, the Division 17 (Counseling Psychology) Ad Hoc Committee on Women initiated plans for developing principles for counseling women and held planning and working conferences in 1977 and 1978. These efforts culminated in "Principles Concerning the Counseling and Psychotherapy of Women" (APA, 1979), which articulated 13 principles for counseling women. The principles were approved as an official policy statement for Division 17 and were also endorsed by Division 12 (Clinical Psychology), Division 16 (School Psychology), Division 29 (Psychotherapy), Division 35 (Psychology of Women), and the APA Board of Educational Affairs. The principles were expanded eight years later to include literature support, rationale, and implementation recommendations and were entitled "The Division 17 Principles Concerning the Counseling/Psychotherapy of Women: Rationale and Implementation" (Fitzgerald & Nutt, 1986). These principles have been used in many doctoral training programs and served as a general resource document for APA (Farmer, 2002).

Almost from the inception of the Division 17 principles, the task forces and divisions recognized and anticipated the need for continuing revision of the document and greater exposition of each principle to guide psychologists

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

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

The Division 17 Section for the Advancement of Women held a 1998 conference in Michigan on the integration of feminism and multiculturalism. The work groups in the conference focused on topics similar to those of the prior Division 35 conference (therapy, assessment, research, ethics, teaching, and supervision) and similarly reinforced the momentum to develop a new set of more timely and relevant guidelines for psychological practice with diverse groups of women, including girls. This conference resulted in a series of 12 articles published in the *Journal of Multicultural Counseling & Development* from 2004 to 2006. Volume 32 published in 2004 contained a special section with a lead article on centralizing feminism and multiculturalism in counseling (Fassinger, 2004) followed by integrative articles on theory (Reynolds & Constantine, 2004), supervision (Steward & Phelps, 2004), consultation (Horne & Mathews, 2004), practice (E. N. Williams & Barber, 2004; Whalen et al., 2004), teaching and pedagogy (Enns, Sinacore, Ancis, & Phillips, 2004; Smith-Adcock, Ropers-Huilman, & Choate, 2004), and mentoring (Benishek, Bieschke, Park, & Slattery, 2004). Later articles addressed career development (Cook, Heppner, & O'Brien, 2005), consultation and advocacy (Hoffman, Phillips, & Noumair, 2006), and further issues in supervision (M. L. Nelson et al., 2006).

During this period, APA's Committee on Women in Psychology (established by the Council of Representatives in 1973) was actively working on its mission to collect information and documentation concerning the status of women, to recommend and implement guidelines, and to facilitate ongoing communications with other agencies and institutions regarding the status of women. The current three priority issues for the Committee on Women in Psychology relate to translating women's health research into practice and policy, women and work, and women as participants in psychological research. Some specific goals include (a) promoting the health and well-being of women, (b) identifying and eliminating discriminatory practices against women, (c) collaborating with others as needed to achieve the empowerment of underrepresented groups, and (d) promoting the generation and communication of knowledge about women's lives. The promulgation of guidelines for psychological practice with girls and women is consistent with the mission, projects and activities of the Committee on Women in Psychology.

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

Process

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

Members of Division 17, Division 35, and other divisions met at the APA convention in San Francisco (2001), the midwinter meeting and multicultural summit (Santa Barbara, 2001), the Houston Counseling Psychology National Conference (2001), a weekend conference retreat in Dallas (2002), the APA convention in Chicago (2002), and two chair meetings in Madison, Wisconsin (2002 and 2004). Most of the original brainstorming and promulgation of language for guideline statements and rationale occurred at the 2002 weekend retreat for approximately 30 participants. Participants began the first session by sharing their dreams for this project and its outcomes. The dominant dream reported was a determination by participants to avoid prior clashes they had witnessed between gender and multicultural perspectives and to produce a truly integrated document that honored both gender and culture. This project was funded by Division 17, Division 35, the APA Board of Directors, Division 43, the Association for

Women in Psychology, and a Committee on Division/APA Relations grant.

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

Definitions

Sex and Gender

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

Gender Bias

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

Social Identities

Social identities encompass personal and group definitions that are embedded in a variety of social groups and statuses. These identities are associated with but are not limited to gender, race, ability level, culture, ethnicity, geographic location, intellectual ability, sexual orientation, gender identity, class, age, body size, religious affiliation, acculturation status, SES, and other sociodemographic variables. The complex interactions of these group identities and statuses are reflected in multidimensional concepts of identity and gender that are influenced by visibility or the degree to which they are easily discernable to others, situational salience or relevance, and experiences of oppression or privilege (Deaux & Stewart, 2001; Stewart & McDermott, 2004; Worell & Remer, 2003).

Oppression and Privilege

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

Diversity

This document uses the definition of *diversity* developed by participants in the 1993 National Conference on Education and Training in Feminist Practice (Greene & Sanchez-Hucles, 1997). These conference participants noted that a diverse psychology of women reflects all women's and girls' experiences, is based on data from a wide range of sources, reflects openness to and a valuing of difference, and cultivates many perspectives and experiences. This approach to diversity also recognizes the ineffectiveness of conceptualizing aspects of gendered experiences in isolation (e.g., culture, race, gender, sexual orientation, ability) and emphasizes the complex interaction of social identities, oppressions, and privileges. Although diversity is often reflected in experiences associated with class, race, gender, ability level, ethnicity, and sexual orientation, our conceptualization of diversity also allows for "other dimensions of

persons or groups that are salient to their understanding of the world and of themselves" (Greene & Sanchez-Hucles, 1997, p. 185).

Psychological Practice

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

Guidelines for Psychological Practice With Girls and Women

The 11 guidelines in the "Guidelines for Psychological Practice With Girls and Women" are organized into three sections: (a) diversity, social context, and power; (b) professional responsibility; and (c) practice applications. The first section presents a framework concerning social identity and gender-role socialization issues that explicates the foundation for the following, more applied sections on professional responsibility and actual practice applications. The supporting references in the literature review emphasize studies from approximately the past 15 years plus classic studies that provide empirical and clinical support and examples for the guidelines. The literature review, however, is not intended to be exhaustive. Recommendations in this section are consistent with broad ethical principles (endorsed by APA, 2002b) of beneficence and nonmaleficence, fidelity and responsibility, integrity, and respect for the rights and dignity of others.

Diversity, Social Context, and Power

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

Rationale

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

Each girl and woman is also socialized within a unique cultural milieu and set of visible and invisible social group memberships (Ballou, Matsumoto, & Wagner, 2002; Sparks & Park, 2000; Stewart & McDermott, 2004; Suyemoto & Kim, 2005) that may include, but are not limited to, gender, race/ethnicity, class, age, sexual orientation, SES, spiritual orientation, nationality, physical or cognitive ability, and body size. The multiple group memberships of girls and women intersect and influence each other and are enacted within the family and cultural institutions (schools, religion), through peer influences, and within media (Deaux & Stewart, 2001; Erkut, Fields, Sing, & Marx, 1996; Greene & Boyd-Franklin, 1996). For example, most women of color in the United States live within an ethnic minority family, which is typically located in the context of an ethnic minority community, which is embedded within the dominant White society (Reid, 2002). The unique developmental and life experiences of girls and women related to their reproductive capacities contribute to the complexities of multiple group memberships for girls and women. Events such as menarche, pregnancy and childbirth, voluntary childlessness and abortion, fertility issues, postpartum responses, and menopause are associated with a variety of cultural, psychological, physiological, and social meanings and changes.

Application

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

Psychologists also strive to recognize that all girls and women are socialized into multiple social group memberships and that within their group memberships, girls and women have both shared and unique identities and developmental pathways. Psychologists endeavor to understand the life issues and special challenges related to the development of girls and women, the diverse beliefs and values of girls and women with whom they work, and how these factors may have an impact on each girl's and woman's experience. Psychologists also strive to recognize the biopsychosocial effects of unique developmental experiences, such as reproduction, on women's lives, and they work to support healthy transitions, prevent problems, and remediate difficulties.

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

Rationale

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

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

Application

To understand girls and women more fully, psychologists are encouraged to identify the social group memberships of girls and women, the extent to which they accept or deny these memberships, their experience of oppression and/or privilege within the context of these memberships, and their abilities to resist confining or oppressive messages. In addition, psychologists strive to understand and appreciate differences in various aspects of identity formation (e.g., sexual and social identity development) in the complexities of the stages through which these various identities may emerge (Cross & Vandiver, 2001; Helms, 1993, 1995; Helms & Cook, 1999; McIntyre, 2000).

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

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

Rationale

Bias and discrimination are embedded in and driven by organizational, institutional, and social structures. These dynamics legitimize and foster inequities, influence personal relationships, and affect the perception and treatment of a person's mental and behavioral problems. Discrimination has been shown to contribute more to women's perceptions of their psychiatric and physical symptoms than any other environmental stressor (Klonoff et al., 2000; Moradi & Subich, 2002). Women who perceive that they are subject to group and individual discrimination are more likely to experience depression (Klonis, Endo, Crosby, & Worell, 1997). Violence against women is often predicated in sexism, racism, classism, and homophobia (Glick & Fiske, 1997; Koss, Heise, & Russo, 1994). The extent to which bias and discrimination can impact the physical and mental health of women and girls is illustrated by the fact that these dynamics have been documented in the following diverse contexts.

Health systems. Because of the structure of the health care system, women and girls often receive unequal treatment in health insurance, in health research, and in health care and specific interventions (Landrine & Klonoff, 2001). Women are often neglected in health care research

(Rothbart, 1999), because there are stereotypes about their ability to handle health care information (Chrisler, 2001), and they are given too much care in some areas (e.g., cesarean section surgeries; Livingston, 1999) and too little care in others (e.g., coronary heart disease; Gan et al., 2000). Women of color are especially likely to receive inadequate health care (Landrine & Klonoff, 2001). Women tend to live longer than men and are more subject to problems with financial resources, racial or ethnic bias, and bias against individuals with specific disability statuses associated with aging (APA, 2004a; Federal Interagency Forum on Aging-Related Statistics, 2000). In mental health systems, ignorance about the specific therapeutic needs of women and girls may lead to inadequate care. Gender bias in the diagnosis of mental disorders may result in pathologizing the normal development of women (e.g., menstruation, childbirth, menopause, aging; Caplan, 1995; Landrine & Klonoff, 2001) and overlooking depression in some girls who tend to internalize personal problems in a way that is consistent with gender stereotypes (Fergusson et al., 2002; Hayward & Sanborn, 2002). Other conditions (e.g., conduct disorders) may be underdiagnosed because of gender differences in the manifestation of aggressive behavior (Delligatti, Akin-Little, & Little, 2003). Gender differences in responses to psychopharmacological treatments have received insufficient attention (Ackerman, 1999). Feminist psychologists have offered alternative approaches for working with girls and women in psychotherapy, have attempted to address bias in mental health treatment (e.g., Ballou & Brown, 2002; L. S. Brown, 1994; Worell & Remer, 2003), and have begun to demonstrate empirically the successful use of feminist therapeutic strategies (Worell, 1996, 2001; Worell & Johnson, 2001).

Education. Although girls and women have benefited by many positive developments in educational systems (e.g., access to educational opportunities), documented differences in the treatment of male and female children in educational settings suggest that problems persist. These problems include exclusion, marginalization, and the devaluation of girls and women in the classroom, curriculum, leadership opportunities, and extracurricular activities. The shortage of women in positions of power and influence at all levels in the educational system and educational information about successful women have been cited as barriers to the success of girls and women in academic pursuits, particularly those who also are members of ethnic minority groups (Fassinger, 2002; Trimble, Stevenson, Worell, & the APA Commission on Ethnic Minority Recruitment, Retention, and Training Task Force Textbook Initiative Work Group, 2003). The encouragement and mentoring of boys over girls, discriminatory testing and counseling practices, and the harassment and bullying of girls and women have also been reported (American Association of University Women Educational Foundation, 2001; L. M. Brown, 2003). Because educational disadvantages provide a foundation for a lifetime of underachievement, these educational issues are particularly important.

Workplace. Women face particular stressors associated with discrimination in the workplace (Fassinger, 2002; Yoder, 2007). Women as a group continue (a) to earn less than men; (b) to be disproportionately represented in jobs that underutilize their capabilities and talents and offer neither status nor opportunity for advancement; (c) to face discriminatory practices in hiring, evaluation, resource allocation, and promotion; (d) to confront the lack of supportive infrastructures with regard to child care facilities, availability of part-time status and adequate remuneration, and availability of sufficient paid maternity and paternity leave; (e) to experience devaluation, exclusion, and harassment; and (f) to shoulder most of the burden of managing the home and family (Dempsey, 2000; Fassinger, 2002). Work-related problems may be exacerbated by other diversity factors, such as class, sexual orientation, and disability, and by discrimination based on expectations of male-defined behavior and attitudes in the workplace (Costello & Stone, 2001; Croteau, Anderson, DiStefano, & Kampa-Kokesch, 2000; Yoder, 2002). For example, women with disabilities make half the income of men with disabilities (Holcomb & Giesen, 1995). These problems result in less job satisfaction and have a negative impact on mental health.

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

Legal system. In the legal system, discriminatory experiences for women are two-pronged: (a) barriers to career advancement in the system and (b) limitations on access to legal rights (Guinier, Fine, & Balin, 1997). The shortage of women in the justice system and the government decreases women's opportunities to design and influence legislation that may protect them and children from violence and ensure their basic human rights (Fassinger, 2002). Women make up only 13% of the U.S. Senate and 14% of the U.S. House of Representatives. Women often receive less than their equal financial share in divorces (Gorlick, 1995), and lesbian mothers are often in danger of losing their children in legal challenges (Falk, 1993). In the justice system, girls are more likely to experience severe sanctions for lesser offenses or status offenses than boys (Harway & Liss, 1999), and girls from marginalized ethnic groups are more likely to be identified as delinquent than boys or White girls (MacDonald & Chesney-Lind, 2001).

Families and couples. In family and couple relationships, women continue to assume disproportionate responsibility for child care, elder care, household management, and partner/spouse relationships (Kulik, 2002; Sanderson & Thompson, 2002; Steil, 2001). Although it has been well documented that multiple roles and relationships

may lead to increased overall mental health for women (Perrone & Worthington, 2001), stress and overload may occur (Barnett & Hyde, 2001). Power inequities within couple and family relationships, as well as within the larger social context, may create conditions under which sexual abuse, rape, sexual harassment, bullying, and other forms of relationship violence (APA, 2005; Koss et al., 1994; Leigh & Huff, 2006) become acceptable and may contribute to self-blame and personal dysfunction or decreased mental health (Harway & O'Neil, 1999; Nutt, 1999). Cultural differences exert considerable variation on duties and acceptable styles of relating and dividing household labor (John & Shelton, 1997). Physical abuse in older couples has also become a growing concern (APA, 2004a; Wilber & McNeilly, 2001).

Research methods and language. The use of biased research methods and noninclusive language (e.g., the use of *mankind* to represent all people) can negatively affect girls and women (APA, 2001; Gilbert & Scher, 1999). Sexist, racist, classist, homophobic or heterosexist, ageist, ableist, and ethnocentric language conveys disregard and disrespect and can have a negative impact on the identity and self-worth of girls and women. An example of bias in research is the multitude of studies that have searched for negative effects on children of mothers working outside the home (Rice, 1994). Overreliance on what are considered objective and value-free empirical methods may result in the removal of persons from situations and power structures such that results may be unrepresentative or unrealistic (Kimmel & Crawford, 2001; Morrow, 2000).

Application

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

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

Professional Responsibility

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

Rationale

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

Psychological measures designed to assess intellectual ability, scholastic achievement, and personality functioning may underestimate the full capabilities of girls and women, particularly women and girls of color and women with disabilities (Olkin, 1999; Sadker & Sadker, 1994; Smedley,

Stith, & Nelson, 2003). Authors and researchers (some identified later) have also identified subtle, but problematic gender biases in theories of psychotherapy. These include (a) overvaluing individualism and autonomy and undervaluing relational qualities, (b) overvaluing rationality instead of viewing mental health from a holistic perspective, (c) paying inadequate attention to context and external influences on girls' and women's lives, (d) basing definitions of positive mental health on behaviors that are most consistent with masculine stereotypes or life experiences, and (e) portraying mothering in problematic ways. Approaches to mental health that have been identified as noninclusive or as containing subtle biases include humanistic (e.g., Lerman, 1992), psychodynamic and object relations (e.g., Okun, 1992), cognitive–behavioral (e.g., Kantrowitz & Ballou, 1992), and couples and family therapies (e.g., Philpot, Brooks, Lusterman, & Nutt, 1997; Rice, 2003). Practitioners may, of course, still use these theoretical frameworks after careful examination and removal of any parts that contain bias (Greene, 1997b; Worell & Remer, 2003).

Issues related to access to treatment and practice services may also disproportionately affect women. These issues include (a) lack of consumer or provider knowledge about psychological services, (b) stigma, (c) high insurance copayments and deductibles, (d) inadequate insurance limits, (e) inability to obtain time off from work, (f) primary family responsibilities, and (g) the unavailability of child and elder care for which women are disproportionately responsible (National Institute of Mental Health, 2000). Major barriers to the utilization of mental health and substance abuse services for women include the financial burden of seeking help (K. S. Collins, Rowland, Salganicoff, & Chiat, 1994), the reality that women are more likely than men to receive mental health care from general practitioners (Alvidrez & Azocar, 1999), and lack of health insurance coverage, which may not be available to low-income women, older women, and single-parent mothers working part-time or in entry-level jobs (Greenley & Mullen, 1990). Other research has demonstrated a direct correlation between the structure of an insurance plan and the type of care received. Women with HMO coverage are much more likely to receive medications and are less likely to receive psychotherapy than are women covered under fee-for-service insurance plans (Glied, 1998). Studies have also shown that women receive more prescriptions than men for all types of medications and particularly for anxiolytics and antidepressants (Hohmann, 1989; Marsh, 1995). This statistic is of particular concern because most drug-treatment regimens have been developed with male participants. These circumstances led APA Division 35 (Psychology of Women) to approve a series of position statements that begins as follows:

> Training in prescription privileges needs to include both mainstream and specialized focus on treatment of Women and Girls of all ethnic groups, and Men of Color. . . . U.S. research needs to be expanded to include women in areas other than reproductive health. . . . Research funds should be especially targeted toward the effects of medication on women. (Division 35, 1996)

Women also may respond to and metabolize medication differently from men (Ackerman, 1999). Additionally, some women of color have different needs and may metabolize medications differently from their European American counterparts (Comas-Díaz & Jacobsen, 1995; Jacobsen & Comas-Díaz, 1999; Ruiz, 2000). Other data suggest that women and men of color with mental health problems are more likely to receive psychopharmacological treatment than psychotherapy (Homma-True, Greene, Lopez, & Trimble, 1993). In addition, because of significant reductions in spending for outpatient psychotherapy, total spending on mental health care for women with depression has fallen to half its prior amount (APA, 2002d).

Application

Psychologists strive to be knowledgeable about the theoretical and empirical support for the assessment, treatment, research, consultation, teaching, and supervision practices they use with girls and women. Psychologists are encouraged to be aware of assumptions in theory, research, and practice that are noninclusive and to use theories and practices that pay equal attention to relational and autonomous qualities. Psychologists endeavor to understand the biopsychological factors that influence the response of women and girls to psychological treatment and medication. They are urged to show caution when using methods that have not been developed with the specific needs of diverse groups of girls and women in mind. In considering and deciding which treatments and practices to use, psychologists are also urged to consider the many biopsychosocial factors that contribute to substantial within-gender differences (Gilbert & Scher, 1999; Hyde & Kling, 2001). In the area of testing and diagnosis, psychologists are encouraged to be knowledgeable about validity, reliability, standardization processes, and norming information and to use multiple methods of assessment, especially when research support is limited (Pope & Vasquez, 2005).

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

Psychologists are also urged to be knowledgeable about and work to help eliminate barriers to psychological treatment for girls and women and to ensure full access to psychological services. Psychologists are encouraged to help their female clients gain access to quality mental health services and equitable insurance coverage that will enable them to have continuing, appropriate treatment. They strive to promote access to recovery-focused, evidence-based treatment for both their female and male cli-

ents. This treatment should be gender and culturally sensitive and tailored to the needs and circumstances of the individual. Such tailoring may include the recognition that for some women and girls, recovery-focused treatment may not be entirely appropriate (e.g., in cases of chronic disability where the client may be powerless to change the circumstances, although work on coping skills may still be helpful). In another example, in working with women with postpartum depression, a psychologist can promote the benefits of early screening and intervention and the use of a biopsychosocial model of treatment that addresses the physical and mental health needs of the female client, her child, and her family. In treating women who present with physical problems (e.g., adjustment to breast cancer), a psychologist can affirm a woman's personal strength and resiliency in coping with pain, anxiety, and change in body image and can also refer her to appropriate survivor groups for additional help and support. It must be noted that although the term *evidence based* encompasses a broad definition of *evidence,* for some groups of women and girls, little research has been conducted or published.

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

Rationale

The practice of psychologists is likely to be influenced by their culture, values, biases, socialization, and experiences of privilege and oppression or disempowerment. Limited self-knowledge may contribute to subtle belief systems that can be potentially harmful to girls and women with diverse social identities. For example, studies have revealed that psychotherapists may engage in subtle forms of differential treatment of male and female clients (e.g., Friedlander, Wildman, Heatherington, & Skowron, 1994; Werner-Wilson et al., 1997) and thereby may be at risk for reinforcing views about gender, sexual orientation, culture, and family life that may be detrimental to girls and women. Similar results have been reported for evidence of personal bias related to culture and/or sexual orientation in other APA practice guidelines (APA, 2000b, 2003).

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

Application

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

Psychologists, who are products of their socialization and culture, are encouraged to be aware of their attitudes toward and expectations for women and girls from a variety of backgrounds and to be mindful of the ways in which their values and attitudes about salient social issues may influence their practice with girls and women (APA, 2000c, 2004b; T. L. Robinson & Howard-Hamilton, 2000). Psychologists are urged to engage in ongoing examination of values, attitudes, and stereotypes toward girls and women to ensure that their attitudes support optimal practice (APA, 2000b, 2003). The benefits of such awareness and self-exploration include a greater sensitivity to the worldviews of others, attentiveness to possible power differentials, and an enhanced level of professional responsiveness and responsibility, which will positively affect the psychologist's work with clients, supervisees, and other consumers of their services.

Practice Applications

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

Rationale

The practice of psychologists is enhanced by knowledge about the challenges, strengths, social contexts, and identities of girls and women as well as about interventions that are associated with positive outcomes. In the case of psychotherapy, positive outcomes are consistently associated with the therapeutic alliance and common curative psychotherapy factors (e.g., Lambert & Bergin, 1994; Wampold, 2001), such as client expectations and openness, therapist sensitivity and expertise in implementing interventions, length of treatment, and the similarity of the client's and psychologist's worldviews (e.g., Fischer, Jome, & Atkinson, 1998; Kopta, Lueger, Saunders, & Howard, 1999). If evidence-based interventions are not used, there is the danger of not being helpful or even causing harm (Werner-Wilson et al., 1997; Woolley, 2000).

Specific interventions have been found to be associated with positive outcomes for specific types of concerns relevant to women and girls. The following examples are illustrative and not all inclusive. Therapies that teach female clients to modify negative internalized self-attitudes and expectations about body size have been found to be effective in the treatment of eating disorders, such as bulimia (Thompson-Brenner, Glass, & Westen, 2003; Williamson & Netemeyer, 2000). Psychotherapy approaches that focus on interpersonal issues and challenge ruminative and distorted thinking are related to positive outcomes in the treatment of depression (Mazure, Keita, & Blehar, 2002) as well as eating disorders (e.g., Wilfley, Dounchis, & Welch, 2000; Wilson et al., 2002). For survivors of domestic abuse and sexual abuse/assault, positive outcomes are associated with therapies that help women cope with trauma-related memories, reduce negative self-talk, and change their distorted sense of responsibility for trauma (Foa & Street, 2001; Kubany, Hill, & Owens, 2003; Resick, 2001). With women diagnosed with PTSD, approaches that help restore women's sense of control and efficacy are related to positive outcomes (Blake & Sonnenberg, 1998; Foa & Meadows, 1997) and may include specific training for developing assertive communication and self-advocacy skills (Kubany et al., 2003). For women facing major health challenges, interventions such as stress management techniques, relaxation training, psychoeducation, guided imagery, meditation, contemplative techniques, and cognitive–behavioral methods have been identified as helping women increase their knowledge and control of symptoms, helping them adjust to life changes, and facilitating coping with physical and psychological pain (Altmaier et al., 2003; Salmon et al., 2004).

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

Application

Psychologists are therefore encouraged to (a) implement interventions that encourage the development of protective factors, such as healthy relationships and body image, (b) reframe girls' and women's concerns from a coping and ecological perspective, and (c) emphasize a strength and empowerment perspective in psychotherapy treatment, research, advocacy, teaching, consultation, and supervision. Psychologists are further encouraged to participate in ongoing educational activities and to incorporate into their practice information about (a) psychotherapy climate and process issues (e.g., Jordan, 1997); (b) interventions that have been demonstrated to be effective for high-prevalence issues of girls and women (e.g., anxiety and depression); and (c) strategies that empower girls and women (e.g., Worell, 2001; Worell & Remer, 2003). In addition, further training may be warranted in abuse- and trauma-related theory and treatment (e.g., APA, 2005; Courtois, 1999; Foa & Rothbaum, 1998) and in interventions and models that are helpful for countering the negative impacts on girls and women of culture and the media, which manifest themselves as body objectification, body image, and eating problems (e.g., R. I. Stein et al., 2001; Worell & Johnson, 2001). Especially important is education regarding the cultural appropriateness of various models and interventions as they interact with a client's multiple identities (e.g., APA, 2003, 2004b; Greene & Croom, 2000; Sparks, 2002). These issues are also important within individual, family, and group modalities (Chin, 2001; Philpot et al., 1997).

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

Rationale

Symptoms of depression, disturbed body image and eating disorders, and dependency in girls and women can emerge in a context of powerlessness (Enns, 2004; Mazure et al., 2002). Fear of rape and other forms of violence and coercion may limit girls' and women's full participation in society and can contribute to passivity and learned helplessness (APA, 2005; Gutek & Done, 2001; Koss, 1993). These issues may be compounded by the impact of their intersection with social class, race/ethnicity, sexual orientation, physical illness, and physical ability (Harway & O'Neil, 1999; Koss et al., 1994; Neville & Heppner, 1999). Gender roles related to the giving and receiving of caregiving and social support are relevant to empowerment (Harway & Nutt, 2006). The experience of giving and receiving social support is often a major emotional resource for women and is strongly related to women's life satisfaction (Diener & Fujita, 1995). Under some conditions, however, gender roles of girls and women (e.g., caregiving) can also contribute to the depletion of emotional resources and to a lack of self-development, independence, and personal choice (Farran, Miller, Kaufman, Donner, & Fogg, 1999).

Within psychotherapy, research has indicated that the active participation of clients in therapy is associated with improved outcomes regarding empowerment (Moradi, Fischer, Hill, Jome, & Blum, 2000; Rader, 2003). Cooperative mutuality and connection facilitate psychotherapy, supervision, teaching, and consultation (J. B. Miller & Stiver, 1997; Porter & Vasquez, 1997). In addition, studies have suggested that counselors and therapists who prioritize issues of power with their clients are more likely to engage

in behaviors that promote empowerment of clients (Worell, 2001). Empowerment goals are also associated with client self-ratings of improvement over time (Chandler, Worell, Johnson, Blount, & Lusk, 1999). Empowerment flourishes in an environment of safety, and this condition is protected by appropriate boundaries.

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

Application

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

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

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

Rationale

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

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

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

Application

Psychologists, therefore, strive to make unbiased, appropriate assessments and diagnoses by considering multiple relevant aspects of the experiences of girls and women. These may include but are not limited to the following: developmental experiences, physical and psychological health, violence and other traumatic events, life history (including experiences of privilege and discrimination), social and kinship support systems, educational and work experiences, geographical and national affiliation influences, various multiple group memberships, and other relevant aspects related to the cultural context as it uniquely interacts with gender (APA, 2004b; De Barona & Dutton, 1997; Worell & Remer, 2003).

Psychologists are also encouraged to work toward developing mutual, collaborative assessments of problems, goals, and plans with their female clients by integrating the psychologist's expertise with a client's knowledge of her own experience (Ballou & West, 2000; L. S. Brown, 1994) as is consistent with other APA guidelines (APA, 2000b, 2003). Psychologists are encouraged to explore information about the strengths of girls and women, their coping capacities, and their past accomplishments in the assessment process and to help their female clients reframe perceived personal deficits as experiences that occur in a complex social context (Enns, 2000; Wyche & Rice, 1997). Assessment tools, such as social, cultural, and gender-role identity analyses, may be especially useful for facilitating assessment of the experiences of girls and women (e.g., L. S. Brown, 1994; Worell & Remer, 2003). Psychologists are also urged to show caution when using assessment procedures and tests developed in the United States in countries in which cultural differences and norms have not been considered (APA, 2004b).

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

Rationale

As discussed in Guideline 3, sociocultural variables, oppressive environments, and power differentials may precipitate and maintain problematic issues for women and girls, limit their access to resources, or contribute to blaming girls and women for their problems (Martinez, Davis, & Dahl, 1999). Social statuses of women and girls, such as gender, ethnicity, disability, age, sexual orientation, and culture, may influence their development, behavior, and symptom presentation. As an example, it is normative in some cultural contexts for women to be physically coerced within marriage. Psychologists' perceptions of the social roles and identities of women and girls, as well as psychologists' personal biases, values, and social identities, may also have an impact on their understanding and ratings of the adjustment, traits, symptoms, and assumptions about future behavior of girls and women (Becker & Lamb, 1994; Porter, 1995). A psychologist with a traditional gender-role orientation, for example, might perceive exaggerations of the traditional female gender role as markers of a personality disorder rather than considering the full range of sociopolitical factors that may contribute to a client's problems.

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

Application

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

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

Rationale

The APA ethics code (APA, 2002b) principle of fidelity and responsibility states that "Psychologists consult with,

refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work" (p. 3). Gaining information about the availability of community resources has also been identified as a culturally and sociopolitically relevant factor in a client's history (see, e.g., Guideline 16 from the *Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients* [APA, 2000b]; the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* [APA, 2003]; and Guideline 18 from *Guidelines for Psychological Practice With Older Adults* [APA, 2004a]). Complex psychological problems with multiple causes are likely to be best addressed by collaborative approaches that draw on personal, interpersonal, educational, and community resources. Community-based, culturally competent, collaborative systems of care can complement or enhance therapeutic, educational, and research efforts. These resources include women's self-help groups; women's centers, shelters, and safe houses; psychoeducational experiences for girls and women; work/training experiences; and public assistance resources.

Application

Psychologists strive to become knowledgeable about community resources and to consult others with expertise about community resources that can help girls and women. Psychologists are encouraged to help meet consumers' needs by creating and maintaining current resource lists of local financial, legal, parenting, aging, reproductive health, religious and/or spiritual, professional, and social service providers or organizations that are sensitive to the needs and experiences of girls and women, as well as to the needs of boys and men, in all of their intersecting identities. Many community colleges have on-site resources to help women (e.g., re-entry centers to provide educational and employment resources for women). Psychologists may also assist in identifying and evaluating self-help books and electronic information and support structures (e.g., discussion boards and Web pages) as potential self-help resources for girls and women. In addition, psychologists are encouraged to be aware of their own limits and the expertise of other psychologists in their community and to refer their female clients, students, or supervisees to other professionals and other community resources when appropriate.

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

Rationale

As directed by the APA ethics code (APA, 2002b), psychologists "recognize that fairness and justice entitle all persons to have access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists" (p. 1062). In addition,

> psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. (APA, 2002b, p. 1063)

Psychologists "seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons" (APA, 2002b, p. 1062).

Other codes of ethics in the psychological arena include a commitment to social change and justice within health and mental health, political, religious, economic, legal, and educational institutions (Brabeck & Brown, 1997; Brabeck & Ting, 2000; Feminist Therapy Institute, 2000). Similarly, multicultural guidelines (APA, 2003) encourage psychologists "to use organizational change processes to support culturally informed organizational (policy) development and practices" (p. 392). The multicultural guidelines also identify the value of "psychologists acting as change agents and policy planners" (APA, 2003, p. 394) who strive to promote organizational and societal change. Improving the status and welfare of girls and women and promoting an egalitarian society can be facilitated through a multitude of prevention, education, and social policy activities (Chin & Russo, 1997). Examples of organized efforts to influence public policy have included APA task forces on male violence against women (Goodman, Koss, Fitzgerald, Russo, & Keita, 1993; Koss, 1993), violence within the family (APA, 1996), and women and poverty (APA, 1998; Rice, 2001; Rice, Wyche, & Lott, 1997).

Application

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

In the area of public policy, psychologists are encouraged to apply psychological research findings to major social issues, such as family leave, work–family interface,

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

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

REFERENCES

Abrams, L. S. (2003). Contextual variations in young women's gender identity negotiations. *Psychology of Women Quarterly, 27,* 64–74.

Ackerman, R. J. (1999). An interactional approach to pharmacopsychologists and psychologists: Gender concerns. *Journal of Clinical Psychology in Medical Settings, 6,* 39–47.

Adams, D. L. (Ed.). (1995). *Health issues for women of color: A cultural diversity perspective.* Thousand Oaks, CA: Sage.

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58,* 5–14.

Alexander, L. L., LaRosa, J. H., & Bader, H. (2001). *New dimensions in women's health* (2nd ed.). Boston: Jones & Bartlett.

Altmaier, E. M., Fraley, S. S., Homaifar, B. Y., Maloney, R., Rasheed, S., & Rippentrop, A. E. (2003). Health counseling: Assessment and intervention. In M. Kopala & M. E. Eitel (Eds.), *Handbook of counseling women* (pp. 323–344). Thousand Oaks, CA: Sage.

Altman, L. K. (1997, June 22). Is the longer life the healthier life? *New York Times,* p. WH 158.

Alvidrez, J., & Azocar, F. (1999). Distressed women's clinic patients: Preferences for mental health treatments and perceived obstacles. *General Hospital Psychiatry, 21,* 340–347.

American Association of University Women Educational Foundation. (2001). *Hostile hallways: Bullying, teasing, and sexual harassment in school.* Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychological Association. (1975). Report of the Task Force on Sex Bias and Sex-Role Stereotyping in Psychotherapeutic Practice. *American Psychologist, 30,* 1169–1175.

American Psychological Association. (1978). Guidelines for therapy with women: Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice. *American Psychologist, 33,* 1122–1123.

American Psychological Association. (1979). Principles concerning the counseling and psychotherapy of women. *Counseling Psychologist, 8,* 21.

American Psychological Association. (1991). *Resolution on substance abuse by pregnant women.* Washington, DC: Author.

American Psychological Association. (1996). *Violence and the family: Report of the American Psychological Association Presidential Task Force on Violence and the Family.* Washington, DC: Author.

American Psychological Association. (2000a). *The behavioral health care needs of rural women.* Washington, DC: Author.

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

American Psychological Association. (2000c). *Resolution on poverty and socioeconomic status.* Washington, DC: Author.

American Psychological Association. (2000d). *Resolution on women and poverty.* Washington, DC: Author.

American Psychological Association. (2001). *Publication manual of the American Psychological Association* (4th ed.). Washington, DC: Author.

American Psychological Association. (2002a). Criteria for practice guideline development and evaluation. *American Psychologist, 57,* 1048–1051.

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

American Psychological Association. (2002c). *Intimate partner abuse and relationship violence.* Retrieved December 13, 2003, from http://www.apa.org/pi/iparv.pdf

American Psychological Association. (2002d). *Summit on women and depression.* Washington, DC: Author.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologists, 58,* 377–402.

American Psychological Association. (2004a). Guidelines for psychological practice with older adults. *American Psychologist, 59,* 236–260.

American Psychological Association. (2004b). *Resolution on culture and gender awareness in international psychology.* Washington, DC: Author.

American Psychological Association. (2005). *Resolution on male violence against women.* Washington, DC: Author.

American Psychological Association Task Force on Women, Poverty, and Public Assistance. (1998). *Making welfare to work really work.* Washington, DC: Author.

Ancis, J. R., & Ladany, N. (2001). A multicultural framework for counselor supervision. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process, and practice* (3rd ed., pp. 63–90). Philadelphia: Brunner-Routledge.

Anderson, K. M., Sharpe, M., Rattray, A., & Irvine, D. S. (2003). Distress and concerns in couples referred to a specialist infertility clinic. *Journal of Psychosomatic Research, 54,* 353–355.

Angold, A., Erkanli, A., Silberg, J., Eaves, L., & Costello, E. J. (2002). Depression scale scores in 8–17-year-olds: Effects of age and gender. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 43,* 1052–1063.

Apter, T. (1996). Path of development in midlife women. *Feminism and Psychology, 6,* 557–562.

Armstrong, M. J. (2001). Ethnic minority women as they age. In J. D. Garner & S. O. Mercer (Eds.), *Women as they age* (2nd ed., pp. 97–111). New York: Haworth.

Arroyo, J. A., Simpson, T. L., & Aragon, A. S. (1997). Childhood sexual abuse among Hispanic and non-Hispanic White college women. *Journal of Behavioral Sciences, 19,* 57–68.

Avis, N. E. (2003). Depression during the menopausal transition. *Psychology of Women Quarterly, 27,* 91–100.

Bachanas, P. J., Morris, M. K., Lewis-Gess, J., Sarett-Cuasay, E. J., Sirl, K., Ries, J. K., & Sawyer, M. K. (2002). Predictors of risky sexual behavior in African American adolescent girls: Implications for prevention intervention. *Journal of Pediatric Psychology, 27,* 519–530.

Ballou, M., & Brown, L. S. (Eds.). (2002). *Rethinking mental health and disorder: Feminist perspectives.* New York: Guilford.

Ballou, M., Matsumoto, A., & Wagner, M. (2002). Toward a feminist ecological theory of human nature: Theory building in response to real-world dynamics. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 99–141). New York: Guilford.

Ballou, M., & West, C. (2000). Feminist therapy approaches. In M. Biaggio & M. Hersen (Eds.), *Issues in the psychology of women* (pp. 273–297). New York: Kluwer Academic/Plenum.

Banks, M. E., & Kaschak, E. (2003). *Women with visible and invisible*

disabilities: Multiple intersections, multiple issues, multiple therapies. New York: Haworth.
Banks, M. E., & Marshall, C. (2004). Beyond the "triple whammy": Social class as a factor in discrimination against persons with disabilities. In J. L. Chin (Ed.), *The psychology of prejudice and discrimination: Combating prejudice in all forms of discrimination: Vol. 4. Disability, religion, physique, and other traits* (pp. 95–110). Westport, CT: Praeger.
Barer, B. M. (2001). The "grands and greats" of very old Black grandmothers. *Journal of Aging Studies, 15,* 1–11.
Barnett, R. C., & Hyde, J. S. (2001). Women, men, work, and family: An expansionist theory. *American Psychologist, 56,* 781–796.
Barrett, C. J., Berg, P. I., Eaton, E. M., & Pomeroy, E. L. (1974). Implications of women's liberation and the future of psychotherapy. *Psychotherapy: Theory, Research and Practice, 11,* 11–15.
Basow, S. A., & Rubin, L. A. (1999). Gender influences on adolescent development. In N. G. Johnson, M. C. Roberts, & J. Worell (Eds.), *Beyond appearance: A new look at adolescent girls* (pp. 25–52). Washington, DC: American Psychological Association.
Beck, C. T. (2002). Theoretical perspectives of postpartum depression and their treatment implications. *American Journal of Maternal/Child Nursing, 27,* 282–287.
Becker, D., & Lamb, S. (1994). Sex bias in the diagnosis of borderline personality disorder and post traumatic stress disorder. *Professional Psychology: Research and Practice, 25,* 56–61.
Bedford, V. H., & Blieszner, R. (2000). Older adults and their families. In D. H. Demo, K. R. Allen, & M. A. Fine (Eds.), *Handbook of family diversity* (pp. 216–232). New York: Oxford University Press.
Bekker, M. H. J. (1996). Agoraphobia and gender: A review. *Clinical Psychology Review, 16,* 129–146.
Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly, 27,* 101–113.
Bem, S. L. (1993). *The lenses of gender: Transforming the debate on sexual inequality.* New Haven, CT: Yale University Press.
Benishek, L. A., Bieschke, K. J., Park, J., & Slattery, S. M. (2004). A multicultural feminist model of mentoring. *Journal of Multicultural Counseling & Development, 32,* 428–442.
Beyene, Y. (1992). Menopause: A biocultural event. In A. J. Dan & L. L. Lewis (Eds.), *Menstrual health in women's lives* (pp. 169–177). Chicago: University of Illinois Press.
Biederman, J., Faraone, S. V., Mick, E., Williamson, S., Wilens, T. E., Spencer, T. J., et al. (1999). Clinical correlates of ADHD in females: Findings from a large group of girls ascertained from pediatric and psychiatric referral sources. *Journal of the American Academy of Child & Adolescent Psychiatry, 38,* 966–975.
Bishop, T. A. (1999). *A qualitative study of young adult women's recollections of menarche*. Unpublished doctoral dissertation, California School of Professional Psychology, Berkeley/Alameda.
Blaine, B., & McElroy, J. (2002). Selling stereotypes: Weight loss infomercials, sexism, and weightism. *Sex Roles, 46,* 351–357.
Blake, D. D., & Sonnenberg, R. T. (1998). Outcome research on behavioral and cognitive behavioral treatments for trauma survivors. In V. M. Follette, J. Ruzek, & F. Abueg (Eds.), *Trauma in context* (pp. 15–47). New York: Guilford.
Block, P., Balcazar, F., & Keys, C. B. (2002). Race, poverty and disability: Three strikes and you're out! Or are you? *Social Policy, 33,* 34–38.
Bondas, T., & Eriksson, K. (2001). Women's lived experiences of pregnancy: A tapestry of joy and suffering. *Qualitative Health Research, 11,* 824–840.
Boney-McCoy, S., & Finkelhor, D. (1995). Psychosocial sequelae of violent victimization in a national youth sample. *Journal of Consulting and Clinical Psychology, 63,* 726–736.
Boston Women's Health Book Collective. (2005). *Our bodies, ourselves: A new edition for a new era.* Magnolia, MA: Peter Smith.
Botta, R. A. (2003). For your health? The relationship between magazine reading and adolescents' body image and eating disturbance. *Sex Roles, 48,* 389–399.
Brabeck, M., & Brown, L. (1997). Feminist theory and psychological practice. In J. Worell & N. G. Johnson (Eds.), *Shaping the future of feminist psychology: Education, research, and practice* (pp. 15–71). Washington, DC: American Psychological Association.
Brabeck, M. M., & Ting, K. (2000). Introduction. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp. 3–15). Washington, DC: American Psychological Association.
Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice, 30,* 386–393.
Brown, C., Abe-Kim, J. S., & Barrio, C. (2003). Depression in ethnically diverse women: Implications for treatment in primary care settings. *Professional Psychology: Research and Practice, 34,* 10–19.
Brown, J. D., Steele, J. R., & Walsh-Childers, K. (Eds.). (2002). *Sexual teens, sexual media: Investigating media's influence on adolescent sexuality.* Mahwah, NJ: Erlbaum.
Brown, L. M. (2003). *Girlfighting: Betrayal and rejection among girls.* New York: New York University Press.
Brown, L. S. (1994). *Subversive dialogues: Theory in feminist therapy.* New York: Basic Books.
Brown, M., & Davey, D. B. (2002). Involuntary childlessness: Psychological assessment, counseling and psychotherapy. *Issues in Mental Health Nursing, 24,* 587–589.
Bryant, R. M., Coker, A. D., Durodoye, B. A., McCollum, V. J., Pack-Brown, S. P., Constantine, M. G., & Bryant, B. J. (2005). Having our say: African American women, diversity, and counseling. *Journal of Counseling and Development, 83,* 313–319.
Bryant-Davis, T. (2005). *Thriving in the wake of trauma: A multicultural guide.* Westport, CT: Praeger.
Bullock, H. E. (2004). Diagnosis of low-income women. In P. J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. 115–120). Northvale, NJ: Jason Aronson.
Bullock, H. E., Wyche, K., & Williams, W. (2001). Media images of the poor. *Journal of Social Issues, 56,* 229–247.
Calasanti, T. M., & Slevin, K. F. (2001). *Gender, social inequalities, and aging.* Walnut Creek, CA: Alta-Mira Press.
Calvert, S. L. (1999). *Children's journeys through the information age.* New York: McGraw-Hill.
Campbell, J. D., Schellenberg, E. G., & Senn, C. Y. (1997). Evaluating measures of contemporary sexism. *Psychology of Women Quarterly, 21,* 89–102.
Campbell, T. L., Byrne, B. M., & Baron, P. (1992). Gender differences in the expression of depression symptoms in early adolescents. *Journal of Early Adolescence, 12,* 326–338.
Canetto, S. S. (2001). Older adult women: Issues, resources, and challenges. In R. K. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 183–197). New York: Wiley.
Caplan, P. J. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide who's normal.* Reading, MA: Addison-Wesley.
Caplan, P. J., & Cosgrove, L. (Eds.). (2004). *Bias in psychiatric diagnosis.* Northvale, NJ: Jason Aronson.
Chandler, R., Worell, J., Johnson, D., Blount, A., & Lusk, M. (1999, August). *Measuring long-term outcomes of feminist counseling and psychotherapy.* Paper presented at the annual meeting of the American Psychological Association, Boston.
Chesler, P. (1972). *Women and madness.* Garden City, NY: Doubleday.
Chin, J. L. (Ed.). (2001). *Relationships among Asian American women.* Washington, DC: American Psychological Association.
Chin, J. L., & Russo, N. F. (1997). Feminist curriculum development: Principles and resources. In J. Worell & N. G. Johnson (Eds.), *Shaping the future of feminist psychology: Education, research, and practice* (pp. 93–120). Washington, DC: American Psychological Association.
Chrisler, J. C. (2001). Gendered bodies and physical health. In R. K. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 289–301). New York: Wiley.
Chrisler, J. C., & Johnston-Robledo, I. (2000). Motherhood and reproductive issues. In M. Biaggio & M. Hersen (Eds.), *Issues in the psychology of women* (pp. 199–226). New York: Kluwer Academic/Plenum.
Chrisler, J. C., & Johnston-Robledo, I. (2002). Raging hormones? Feminist perspectives on premenstrual syndrome and postpartum depression. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 174–197). New York: Guilford.
Cloitre, M., Koenen, K. C., Gratz, K. L., & Jakupcak, M. (2002). Differ-

ential diagnosis of PTSD in women. In R. Kimerling, P. Ouimette, & J. Wolfe (Eds.), *Gender and PTSD* (pp. 117–149). New York: Guilford Press.

Collins, K. A., Bennett, A. T., & Hanzlick, R. (2000). Elder abuse and neglect. *Archives of Internal Medicine, 160,* 1567–1568.

Collins, K. S., Rowland, D., Salganicoff, A., & Chiat, E. (1994). *Assessing and improving women's health.* Washington, DC: Women's Research and Education Institute.

Collins, L. H. (2002). Alcohol and drug addiction in women: Phenomenology and prevention. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 198–230). New York: Guilford.

Collins, N. L., Dunkel-Schetter, C., Lobel, M., & Scrimshaw, S. C. (1993). Social support in pregnancy: Psychosocial correlates of birth outcomes and postpartum depression. *Journal of Personality and Social Psychology, 65,* 1243–1258.

Comas-Díaz, L., & Jacobsen, F. M. (1995). Psychopharmacology for women of color: An empowering perspective. *Women and Therapy, 16,* 85–112.

Comas-Díaz, L., & Jansen, M. A. (1995). Global conflict and violence against women. *Peace and Conflict, 1,* 315–331.

Cook, E. P., Heppner, M. J., & O'Brien, K. M. (2005). Multicultural and gender influences in women's career development: An ecological perspective. *Journal of Multicultural Counseling & Development, 33,* 165–179.

Cosgrove, L. (2004). Gender bias and sex distribution of mental disorders in the *DSM–IV–TR.* In P. J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. 127–140). Northvale, NJ: Jason Aronson.

Costello, C. B., & Stone, A. J. (Eds.). (2001). *The American woman: 2001–2002.* New York: Norton.

Courtenay, W. H. (2000). Engendering health: A social constructionist examination of men's health beliefs and behaviors. *Psychology of Men & Masculinity, 1,* 4–15.

Courtois, C. A. (1999). *Recollections of sexual abuse: Treatment principles and guidelines.* New York: Norton.

Cowan, P. A., & Cowan, C. P. (1998). New families: Modern couples as new pioneers. In M. A. Mason, A. Skolnik, & S. Sugarman (Eds.), *The evolving American family: New policies for new families* (pp. 196–219). London: Oxford University Press.

Cozzarelli, C. (1993). Personality and self-efficacy as predictors of coping with abortion. *Journal of Personality and Social Psychology, 65,* 1224–1236.

Crawford, M., & Unger, R. (2004). *Women and gender: A feminist psychology* (4th ed.). New York: McGraw-Hill.

Crosby, J. P., & Sprock, J. (2004). Effect of patient sex, clinician sex, and sex role on the diagnosis of antisocial personality disorder: Models of underpathologizing and overpathologizing biases. *Journal of Clinical Psychology, 60,* 583–604.

Cross, W. E., Jr., & Vandiver, B. J. (2001). Nigrescence theory and measurement: Introducing the Cross Racial Identity Scale (CRIS). In J. G. Ponterotto, J. M. Casas, L. M. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 371–393). Thousand Oaks, CA: Sage.

Croteau, J. M., Anderson, M. Z., DiStefano, T. M., & Kampa-Kokesch, S. (2000). Lesbian, gay, and bisexual vocational psychology: Reviewing foundations and planning construction. In R. M. Perez, K. A. Debord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 383–486). Washington, DC: American Psychological Association.

Dankoski, M. E., Penn, C. D., Carlson, T. D., & Hecker, L. L. (1998). What's in a name? A study of family therapists' use and acceptance of the feminist perspective. *American Journal of Family Therapy, 26,* 95–104.

Danzinger, P. R., & Welfel, E. R. (2000). Age, gender and health bias in counselors: An empirical analysis. *Journal of Mental Health Counseling, 22,* 135–149.

Davenport, D. (1999). Dynamics and treatment of middle-generation women. In M. Duffy (Ed.), *Handbook of counseling and psychotherapy with older adults* (pp. 267–280). New York: Wiley.

Davies, P. G., Spencer, S. J., & Steele, C. M. (2005). Clearing the air: Identity safety moderates the effects of stereotype threat on women's leadership aspirations. *Journal of Personality and Social Psychology, 88,* 276–287.

Davis, M. C., Matthews, K. A., & Twamley, E. W. (1999). Is life more difficult on Mars or Venus? A meta-analytic review of sex differences in major and minor life events. *Annals of Behavioral Medicine, 21,* 83–97.

Deaux, K., & Stewart, A. J. (2001). Framing gendered identities. In R. K. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 84–97). New York: Wiley.

De Barona, M. S., & Dutton, M. A. (1997). Feminist perspectives on assessment. In J. Worell & N. G. Johnson (Eds.), *Shaping the future of feminist psychology: Education, research, and practice* (pp. 37–56). Washington, DC: American Psychological Association.

Delligatti, N., Akin-Little, A., & Little, S. G. (2003). Conduct disorder in girls: Diagnostic and intervention issues. *Psychology in the Schools, 40,* 183–192.

Dempsey, K. C. (2000). Men's and women's power relationship in the persisting inequitable division of housework. *Journal of Family Studies, 6,* 7–24.

Denmark, F. L. (1999). Enhancing the development of adolescent girls. In N. G. Johnson, M. C. Roberts, & J. Worell (Eds.), *Beyond appearance: A new look at adolescent girls* (pp. 377–404). Washington, DC: American Psychological Association.

Diener, E., & Fujita, F. (1995). Resources, personal strivings, and subjective well-being: A nomothetic and ideographic approach. *Journal of Personality and Social Psychology, 68,* 926–935.

Division 35. (1996). *Division 35 position statements on prescribing authority.* Retrieved November 18, 2006, from http://apa.org/divisions/div35/drug.pdf

Donovan, R., & Williams, M. (2002). Living at the intersection: The effects of racism and sexism on Black rape survivors. In C. M. West (Ed.), *Violence in the lives of Black women: Battered, Black, and blue* (pp. 95–105). New York: Haworth.

Dovidio, J. F., Gaertner, S. E., Kawakami, K., & Hodson, G. (2002). Why can't we just get along? Interpersonal biases and interracial trust. *Cultural Diversity and Ethnic Minority Psychology, 8,* 88–102.

Downing, N. E., & Roush. K. L. (1985). From passive-acceptance to active commitment: A model of feminist identity development for women. *Counseling Psychologist, 13,* 695–709.

DuBois, D. L., Burk-Braxton, C., Swenson, L. P., Tevendale, H. D., & Hardesty, J. L. (2002). Race and gender influences on adjustment in early adolescence: Investigation of an integrative model. *Child Development, 73,* 1573–1592.

Durkin, S. J., & Paxton, S. J. (2002). Predictors of vulnerability to reduced body image satisfaction and psychological well being in response to exposure to idealized female media images in adolescent girls. *Journal of Psychosomatic Research, 53,* 995–1005.

Enns, C. Z. (2000). Gender issues in counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed., pp. 601–638). New York: Wiley.

Enns, C. Z. (2004). *Feminist theories and feminist psychotherapies: Origins, themes, and diversity* (2nd ed.). Binghamton, NY: Haworth.

Enns, C. Z., Sinacore, A. L., Ancis, J. R., & Phillips, J. (2004). Toward integrating feminist and multicultural pedagogies. *Journal of Multicultural Counseling & Development, 32,* 414–427.

Erkut, S., Fields, J. P., Sing, R., & Marx, F. (1996). Diversity in girls' experiences: Feeling good about who you are. In B. R. Leadbeater & N. Way (Eds.), *Urban girls: Resisting stereotypes, creating identities* (pp. 53–64). New York: New York University Press.

Espín, O. M. (1993). Issues of identity in the psychology of Latina lesbians. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (pp. 348–363). New York: Columbia University Press.

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

Etaugh, C. (1993). Women in the middle and later years. In F. L. Denmark & M. A. Paludi (Eds.), *Psychology of women: A handbook of issues and theories* (pp. 213–246). Westport, CT: Greenwood.

Etaugh, C., & Bridges, J. S. (2001). Midlife transitions. In J. Worell (Ed.), *Encyclopedia of women and aging* (pp. 756–769). San Diego: Academic Press.

Etaugh, C., & Folger, D. (1998). Perceptions of parents whose work and

parenting behaviors deviate from role expectations. *Sex Roles, 39,* 215–223.
Falk, P. (1993). Lesbian mothers: Psychosocial assumptions in family law. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences. Between men–between women: Lesbian and gay studies* (pp. 420–436). New York: Columbia University Press.
Farley, M. (2004). *Prostitution, trafficking, and traumatic stress.* New York: Haworth.
Farmer, H. S. (2002). Focus on Division 17's Committee on Women/ Section for the Advancement of Women: Achievements and challenges. *Counseling Psychologist, 30,* 417–440.
Farran, C. J., Miller, B. H., Kaufman, J. E., Donner, E., & Fogg, L. (1999). Finding meaning through caregiving: Development of an instrument for family caregivers of persons with Alzheimers' disease. *Journal of Clinical Psychology, 55,* 1107–1125.
Fassinger, R. E. (2002). Hitting the ceiling: Gendered barriers to occupational entry, advancement and achievement. In L. Diamant & J. Lee (Eds.), *The psychology of sex, gender, and jobs: Issues and solutions* (pp. 21–46). Westport, CT: Greenwood.
Fassinger, R. E. (2004). Special section: Centralizing feminism and multiculturalism in counseling. *Journal of Multicultural Counseling & Development, 32,* 344–345.
Federal Interagency Forum on Aging-Related Statistics. (2000). *Older Americans 2000: Key indicators of well-being.* Washington, DC: U.S. Government Printing Office.
Feminist Therapy Institute. (2000). *Feminist therapy code of ethics (revised from 1999).* San Francisco: Author.
Fergusson, D. M., Swain-Campbell, N. R., & Horwood, L. J. (2002). Does sexual violence contribute to elevated rates of anxiety and depression in females? *Psychological Medicine, 32,* 991–996.
Fine, M., & Weis, L. (1998). *The unknown city: Lives of poor and working-class young adults.* Boston: Beacon.
Finkelhor, D. (1990). Early and longterm effects of childhood sexual abuse: An update. *Professional Psychology: Research and Practice, 21,* 325–330.
Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998). Reconceptualizing multicultural counseling: Universal healing conditions in a culturally specific context. *Counseling Psychologist, 26,* 525–588.
Fish, V. (2004). Some gender biases in diagnosing traumatized women. In P. J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. 213–220). Northvale, NJ: Jason Aronson.
Fitzgerald, L. F., & Nutt, R. (1986). The Division 17 principles concerning the counseling/psychotherapy of women: Rationale and implementation. *Counseling Psychologist, 14,* 180–216.
Foa, E. B., & Meadows, E. A. (1997). Psychosocial treatments for posttraumatic stress disorder: A critical review. *Annual Review of Psychology, 48,* 449–480.
Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive–behavioral therapy for PTSD.* New York: Guilford.
Foa, E. B., & Street, G. P. (2001). Women and traumatic events. *Journal of Clinical Psychiatry, 62*(Suppl. 17), 29–34.
Forbes, G. B., Adams-Curtis, L. E., White, K. B., & Holmgren, K. M. (2003). The role of hostile and benevolent sexism in women's and men's perceptions of the menstruating woman. *Psychology of Women Quarterly, 27,* 58–63.
Fouts, G., & Burggraf, K. (2000). Television situation comedies: Female weight, male negative comments, and audience reactions. *Sex Roles, 42,* 925–932.
Fowers, B. J., Applegate, B., Tredinnick, M., & Slusher, J. (1996). His and her individualisms? Sex bias and individualism in psychologists' responses to case vignettes. *Journal of Psychology, 130,* 159–174.
Friedan, B. (1993). *The fountain of age.* New York: Simon & Schuster.
Friedlander, M. L., Wildman, J., Heatherington, L., & Skowron, E. A. (1994). What we do and don't know about the process of family therapy. *Journal of Family Psychology, 8,* 390–416.
Gambert, S. R., & Katsoyannis, K. K. (1995). Alcohol-related medical disorders of older heavy drinkers. In T. Beresford & E. Gomberg (Eds.), *Alcohol and aging* (pp. 70–81). New York: Oxford University Press.
Gan, S. C., Beaver, S. K., Houck, P. M., MacLehose, R. F., Lawson, H. W., & Chan, L. (2000). Treatment of acute myocardial infarction and 30-day mortality among women and men. *New England Journal of Medicine, 343,* 8–15.
Gannon, L. R. (1999). *Women and aging: Transcending the myths.* New York: Routledge.
Garb, H. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice, 42,* 99–120.
Gatz, M., & Fiske, A. (2003). Aging women and depression. *Professional Psychology: Research and Practice, 34,* 3–9.
Gaub, M., & Carlson, C. L. (1997). Gender differences in ADHD: A meta-analysis and critical review. *Journal of the American Academy of Child & Adolescent Psychiatry, 36,* 1036–1045.
Gay, C., & Tate, K. (1998). Doubly bound: The impact of gender and race on the politics of Black women. *Political Psychology, 19,* 169–184.
Geier, A. B., Schwartz, M. B., & Brownell, K. D. (2003). "Before and after" diet advertisements escalate weight stigma. *Eating & Weight Disorders, 8,* 282–288.
Georgiades, I., & Grieger, I. (2003). Counseling women for grief and loss: Theoretical and clinical considerations. In M. Kopala & M. A. Keitel (Eds.), *Handbook of counseling women* (pp. 220–242). Thousand Oaks, CA: Sage.
Gerrity, D. A. (2001a). A biopsychosocial theory of infertility. *Family Journal: Counseling & Therapy for Couples & Families, 9,* 151–158.
Gerrity, D. A. (2001b). Five medical treatment stages of infertility: Implications for counselors. *Family Journal: Counseling & Therapy for Couples & Families, 9,* 140–150.
Gershon, J. (2002). A meta-analytic review of gender differences in ADHD. *Journal of Attention Disorders, 5,* 143–154.
Gil, R. M. (1996). Hispanic women and mental health. *Annals of the New York Academy of Sciences, 789,* 147–160.
Gilbert, L. A. (1999). Reproducing gender in counseling and psychotherapy: Understanding the problem and changing the practice. *Applied & Preventive Psychology, 8*(2), 119–127.
Gilbert, L. A., & Scher, M. (1999). *Gender and sex in counseling and psychotherapy.* Needham Heights, MA: Allyn & Bacon.
Gilkes, C. T. (2001). *If it wasn't for the women.* Maryville, NY: Orbis.
Gillespie, R. (2003). Childfree and feminine: Understanding the gender identity of voluntarily childless women. *Gender & Society, 17,* 122–136.
Gilligan, C. (1982). *In a different voice.* Cambridge, MA: Harvard University Press.
Glick, P., & Fiske, S. T. (1997). Hostile and benevolent sexism: Measuring ambivalent sexist attitudes toward women. *Psychology of Women Quarterly, 21,* 119–136.
Glied, S. (1998). The treatment of women with mental health disorders under HMO and fee-for-insurance. *Women and Health, 26,* 1–16.
Golden, C. (2000). The intersexed and the transgendered: Rethinking sex/gender. In J. C. Chrisler, C. Golden, & P. D. Rozee (Eds.), *Lectures on the psychology of women* (2nd ed., pp. 81–95). Boston: McGraw-Hill.
Goodman, L. A., Koss, M. P., Fitzgerald, L. F., Russo, N. F., & Keita, G. P. (1993). Male violence against women: Current research and future directions. *American Psychologist, 48,* 1054–1058.
Gorlick, C. A. (1995). Divorce: Options available, constraints forced, pathways taken. In N. Mandell & A. Duffy (Eds.), *Canadian families: Diversity, conflict and change* (pp. 211–234). Toronto: Harcourt Brace Canada.
Greene, B. (1994). Lesbian women of color: Triple jeopardy. In L. Comas-Díaz & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 389–427). New York: Guilford.
Greene, B. (1996). African-American women: Considering diverse identities and societal barriers in psychotherapy. *Women and Mental Health: Annals of the New York Academy of Sciences, 789,* 191–209.
Greene, B. (1997a). Lesbian woman of color: Triple jeopardy. *Journal of Lesbian Studies, 1,* 109–147.
Greene, B. (1997b). Psychotherapy with African American women: Integrating feminist and psychodynamic models. *Smith College Studies in Social Work, 67,* 299–322.
Greene, B., & Boyd-Franklin, N. (1996). African American lesbian couples: Ethnocultural considerations in psychotherapy. In M. Hill & E. D. Rothblum (Eds.), *Couples therapy: Feminist perspectives* (pp. 49–60). New York: Harrington Park Press.

Greene, B., & Croom, G. L. (2000). *Education, research, and practice in lesbian, gay, bisexual, and transgendered psychology: A resource manual.* Thousand Oaks, CA: Sage.
Greene, B., & Sanchez-Hucles, J. B. (1997). Diversity: Advancing an inclusive feminist psychology. In J. Worell & N. G. Johnson (Eds.), *Shaping the future of feminist psychology: Education, research, and practice* (pp. 173–202). Washington, DC: American Psychological Association.
Greenfield, S. F. (2002). Women and alcohol use disorders. *Harvard Review of Psychiatry, 10*(2), 76–85.
Greenley, J. R., & Mullen, J. (1990). Help-seeking and the use of mental health services. In J. R. Greenley (Ed.), *Research in community and mental health* (Vol. 6, pp. 325–350). Greenwich, CT: JAI Press.
Greer, G. (1992). *The change: Women, aging, and the menopause.* New York: HarperCollins.
Guinier, L., Fine, M., & Balin, J. (1997). *Becoming gentlemen: Women, law school, and institutional change.* Boston: Beacon Press.
Gutek, B. A., & Done, R. S. (2001). Sexual harassment. In R. K. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 358–366). New York: Wiley.
Gutierrez, L., Oh, H. J., & Gillmore, M. R. (2000). Towards an understanding of (em)power(ment) for HIV/AIDS prevention with adolescent women. *Sex Roles, 42,* 581–611.
Hall, R. L., & Greene, B. (2003). Contemporary African American families. In L. B. Silverstein & T. J. Goodrich (Eds.), *Feminist family therapy: Empowerment in social context* (pp. 107–120). Washington, DC: American Psychological Association.
Hansen, F. J., & Osborne, D. (1995). Portrayal of women and elderly patients in psychotropic drug advertisements. *Women and Therapy, 16*(1), 129–141.
Hartung, C. M., & Widiger, T. A. (1998). Gender differences in the diagnosis of mental disorders: Conclusions and controversies of the *DSM–IV*. *Psychological Bulletin, 123,* 260–278.
Harway, M., & Hansen, M. (2004). *Spouse abuse: Treating battered women, batterers and their children* (2nd ed.). Sarasota, FL: Professional Resource Press.
Harway, M., & Liss, M. (1999). Dating violence and teen prostitution: Adolescent girls in the justice system. In N. G. Johnson, M. C. Roberts, & J. Worell (Eds.), *Beyond appearance: A new look at adolescent girls* (pp. 277–300). Washington, DC: American Psychological Association.
Harway, M., & Nutt, R. L. (2006). Women and giving. In J. Worell & C. R. Goodheart (Eds.), *Handbook of girls' and women's psychological health: Gender and well-being across the lifespan* (pp. 200–207). New York: Oxford.
Harway, M., & O'Neil, J. M. (Eds.). (1999). *What causes men's violence against women?* Thousand Oaks, CA: Sage.
Haworth, J. T., Jarman, M., & Lee, S. (1997). Positive subjective states in the daily life of a sample of working women. *Journal of Applied Social Psychology, 27,* 345–370.
Hayward, C., Hotlib, I., Schraedley, P. D., & Litt, I. F. (1999). Ethnic differences in association between pubertal status and symptoms of depression in adolescent girls. *Journal of Adolescent Health, 25,* 143–149.
Hayward, C., & Sanborn, K. (2002). Puberty and the emergence of gender differences in psychopathology. *Journal of Adolescent Health, 30,* 49–58.
Helms, J. E. (Ed.). (1993). *Black and White racial identity: Theory, research and practice.* Westport, CT: Praeger.
Helms, J. E. (1995). An update of Helms' White and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–198). Thousand Oaks, CA: Sage.
Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and practice.* Boston, MA: Allyn & Bacon.
Henning, K., & Strauss, B. (2002). Psychological and psychosomatic aspects of involuntary childlessness: State of research at the end of the 1990s. In B. Strauss (Ed.), *Involuntary childlessness: Psychological assessment, counseling and psychotherapy* (pp. 3–18). Kirkland, WA: Hogrefe & Huber.
Hoffman, M. A., Phillips, E., & Noumair, D. (2006). Toward a feminist and multicultural model of consultation and advocacy. *Journal of Multicultural Counseling & Development, 34,* 116–128.
Hohmann, A. A. (1989). Gender bias in psychotropic drug prescribing in primary care. *Medical Care, 27,* 478–490.
Holcomb, L. P., & Giesen, C. B. (1995). Coping with challenges: College experiences of older women and women with disabilities. In J. C. Chrisler & A. H. Hemstreet (Eds.), *Variations on a theme: Diversity and the psychology of women* (pp. 175–199). Albany: State University of New York Press.
Homma-True, R., Greene, B., Lopez, S. R., & Trimble, J. (1993). Ethnocultural diversity in clinical psychology. *Clinical Psychologist, 46,* 50–63.
Horne, S. G., & Mathews, S. S. (2004). Collaborative consultation: International applications of a multicultural feminist approach. *Journal of Multicultural Counseling & Development, 32,* 366–378.
Horton, A. L., & Johnson, B. L. (1993). Profiles and strategies of women who have ended abuse. *Families in Society, 74,* 481–492.
Huyck, M. H. (1999). Gender roles and gender identity in midlife. In S. L. Willis & J. D. Reid (Eds.), *Life in the middle* (pp. 209–232). San Diego: Academic Press.
Hvas, L. (2001). Positive aspects of menopause: A qualitative study. *Maturitas, 39,* 11–17.
Hyde, J. S., & Kling, K. C. (2001). Women, motivation, and achievement. *Psychology of Women Quarterly, 25,* 364–378.
Ickovics, J. R., Thayaparan, B., & Ethier, K. A. (2001). Women and AIDS: A contextual analysis. In A. Baum, T. A. Revenson, & J. E. Singer (Eds.), *Handbook of health psychology* (pp. 817–840). Mahwah, NJ: Erlbaum.
Irving, L. (2001). Media exposure and disordered eating: Introduction to the special section. *Journal of Social and Clinical Psychology, 20,* 259–271.
Jackson, J. S., Chatters, L. M., & Taylor, R. J. (Eds.). (1993). *Aging in Black America.* Newbury Park, CA: Sage.
Jackson, L. C., & Greene, B. (Eds.). (2000). *Psychotherapy with African American women.* New York: Guilford.
Jacobsen, F. M., & Comas-Díaz, L. (1999). Psychopharmacological treatment of Latinas. *Essential Psychopharmacology, 3,* 29–42.
Jadack, R. A. (2001). Sexually transmitted infections and their consequences. In J. Worell (Ed.), *Encyclopedia of women and gender* (pp. 1033–1041). San Diego: Academic Press.
Jenkins, E. J. (2002). Black women and community violence: Trauma, grief, and coping. *Women and Therapy, 25*(3/4), 29–44.
Jenskins, S. R., Goodness, K., & Buhrmester, D. (2002). Gender differences in early adolescents: Relationship qualities, self-efficacy, and depression symptoms. *Journal of Early Adolescence, 22,* 277–309.
John, D., & Shelton, B. A. (1997). The production of gender among Black and White women and men: The case of household labor. *Sex Roles, 36,* 171–193.
Johnson, M. K., Searight, H. R., Handal, P. J., & Gibbons, J. L. (1993). Survey of clinical psychology graduate students' gender attitudes and knowledge: Toward gender-sensitive psychotherapy training. *Journal of Contemporary Psychotherapy, 23,* 233–249.
Johnson, N. G. (2003). On treating adolescent girls: Focus on strengths and resiliency in psychotherapy. *Journal of Clinical Psychology, 59,* 1193–1203.
Jones, C., & Shorter-Gooden, K. (2003). *Shifting: The double lives of Black women in America.* New York: Harper Collins.
Jordan, J. V. (Ed.). (1997). *Women's growth in diversity: More writings from the Stone Center.* New York: Guilford.
Kantrowitz, R. E., & Ballou, M. (1992). A feminist critique of cognitive–behavioral therapy. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals* (pp. 70–87). New York: Guilford.
Keith, V. M., Jackson, J. S., & Gary, L. E. (2003). (Dis)respected and (dis)regarded: Experiences in racism and psychological distress. In D. R. Brown & V. M. Keith (Eds.), *In and out of our right minds: The mental health of African American women* (pp. 83–98). New York: Columbia University Press.
Kenkel, M. B. (Ed.). (2003). *Rural women: Strategies and resources for meeting their behavioral health needs.* Washington, DC: American Psychological Association.
Kimerling, R., Ouimette, P., & Wolfe, J. (Eds.). (2002). *Gender and PTSD.* New York: Guilford Press.
Kimmel, E. B., & Crawford, M. C. (2001). Methods for studying gender.

In J. Worell (Ed.), *Encyclopedia of women and gender* (pp. 749–758). San Diego, CA: Academic Press.
King, T. (1993). The experience of midlife daughters who are caregivers for their mothers. *Health Care for Women International, 14,* 410–426.
Kinsella, K., & Velkoff, V. A. (2001). *An aging world: 2001* (U.S. Census Bureau Series P. 95/01–1). Washington, DC: U.S. Government Printing Office.
Kirkland, K., Kirkland, K., & Reaves, R. (2004). On the professional use of disciplinary data. *Professional Psychology: Research and Practice, 35,* 179–184.
Kirkman, M. (2003). Infertile women and the narrative work of mourning: Barriers to the revision of autobiographical narratives of motherhood. *Narrative Inquiry, 13,* 243–262.
Klonis, S., Endo, J., Crosby, F. J., & Worell, J. (1997). Feminism as a life raft. *Psychology of Women Quarterly, 21,* 333–346.
Klonoff, E. A., Landrine, H., & Campbell, R. (2000). Sexist discrimination may account for well-known gender differences in psychiatric symptoms. *Psychology of Women Quarterly, 24,* 93–99.
Klonoff, E. A., Landrine, H., & Scott, J. (1995). Double jeopardy: Ethnicity and gender in health research. In H. Landrine (Ed.), *Bringing cultural diversity to feminist psychology: Theory, research, and practice* (pp. 335–360). Washington, DC: American Psychological Association.
Koocher, G. P., & Keith-Spiegel, P. (1998). *Ethics in psychology: Professional standards and cases* (2nd ed.). New York: Oxford University Press.
Koplewicz, H. S., Vogel, J. M., Solanto, M. V., Morrissey, R. F., Alonso, C. M., Abikoff, H., et al. (2002). Child and parent response to the 1993 World Trade Center bombing. *Journal of Traumatic Stress, 15,* 77–85.
Kopta, S. M., Lueger, R. J., Saunders, S. M., & Howard, K. I. (1999). Individual psychotherapy outcome and process research: Challenges leading to greater turmoil or a positive transition? *Annual Review of Psychology, 50,* 441–470.
Koss, M. (1993). Rape: Scope, impact, interventions, and public policy responses. *American Psychologist, 48,* 1062–1069.
Koss, M. P., Bailey, J. A., Yuan, N. P., Herrera, V. M., & Lichter, E. L. (2003). Depression and PTSD in survivors of male violence: Research and training initiatives to facilitate recovery. *Psychology of Women Quarterly, 27,* 130–142.
Koss, M. P., Heise, L., & Russo, N. F. (1994). The global health burden of rape. *Psychology of Women Quarterly, 18,* 509–537.
Krause, E. D., DeRosa, R. R., & Roth, S. (2002). Gender, trauma themes, and PTSD: Narratives of male and female survivors. In R. Kimerling, P. Ouimette, & J. Wolfe (Eds.), *Gender and PTSD* (pp. 349–381). New York: Guilford Press.
Kubany, E. S., Hill, E. E., & Owens, J. A. (2003). Cognitive trauma therapy for battered women with PTSD: Preliminary findings. *Journal of Traumatic Stress, 16,* 81–91.
Kubik, M. Y., Lytle, L. A., Birnbaum, A. S., Murray, D. M., & Perry, C. L. (2003). Prevalence and correlates of depressive symptoms in young adolescents. *American Journal of Health Behavior, 27,* 546–553.
Kulik, L. (2002). The impact of social background on gender-role ideology. *Journal of Family Issues, 23,* 53–73.
Ladany, N., Inman, A. G., Constantine, M. G., & Hofheinz, E. W. (1997). Supervisee multicultural case conceptualization ability and self-reported multicultural competence as functions of supervisee racial identity and supervisor focus. *Journal of Counseling Psychology, 44,* 284–293.
LaFromboise, T. D., Berman, J. S., & Sohi, B. K. (1994). American Indian women. In L. Comas-Díaz & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 30–71). New York: Guilford.
Lamb, D. H., & Catanzaro, S. J. (1998). Sexual and nonsexual boundary violations involving psychologists, clients, supervisees, and students: Implications for professional practice. *Professional Psychology: Research and Practice, 29,* 498–503.
Lamb, S. (2000). *White saris and sweet mangoes: Aging, gender, and body in North India.* Berkeley, CA: University of California Press.
Lamb, S. (2002). Women, abuse, and forgiveness: A special case. In S. Lamb & J. G. Murphy (Eds.), *Before forgiving; Cautionary view of forgiveness in psychotherapy* (pp. 155–171). New York: Oxford.
Lambert, J. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143–189). New York: Wiley.
Landrine, H., & Klonoff, E. A. (1997). *Discrimination against women: Prevalence, consequences, remedies.* Thousand Oaks, CA: Sage.
Landrine, H., & Klonoff, E. A. (2001). Health and health care: How gender makes women sick. In J. Worell (Ed.), *Encyclopedia of women and gender* (pp. 577–594). San Diego, CA: Academic Press.
Laurence, L., & Weinhouse, B. (2001). Outrageous practices: The alarming truth about how medicine treats women. In E. L. Daniel & C. Levine (Eds.), *Taking sides: Clashing views on controversial issues in health and society* (pp. 168–178). New York: McGraw-Hill.
Lauzen, M. M., & Dozier, D. M. (2005). Maintaining the double standard: Portrayals of age and gender in popular films. *Sex Roles, 52,* 437–446.
Lee, R. M. (2003). The transracial adoption paradox: History, research, and counseling implications of cultural socialization. *Counseling Psychologist, 31,* 711–744.
Leigh, W. A., & Huff, D. (2006). *Women of color health data book: Adolescents to seniors* (3rd ed., NIH Publication No. 06–4247). Bethesda, MD: Office of Research on Women's Health, National Institutes of Health.
Lerman, H. (1992). The limits of phenomenology: A feminist critique of the humanistic personality theories. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals* (pp. 8–19). New York: Guilford.
Lerman, H. (1996). *Pigeonholing women's misery: A history and critical analysis of the psychodiagnosis of women in the twentieth century.* New York: Basic Books.
Lesko, A. C., & Corpus, J. H. (2006). Discounting the difficult: How high math-identified women respond to stereotype threat. *Sex Roles, 54,* 113–125.
Letherby, G. (2002). Childless and bereft? Stereotypes and realities in relation to "voluntary" and "involuntary" childlessness and womanhood. *Sociological Inquiry, 72,* 7–20.
Lewinsohn, P. M., Rhode, P., Seeley, J., & Baldwin, C. (2001). Gender differences in suicide attempts from adolescence to young adulthood. *Journal of the American Academy for Child & Adolescent Psychiatry, 40,* 427–434.
Lips, H. M. (2001). *Sex and gender: An introduction* (4th ed.). Mountain View, CA: Mayfield.
Livingston, M. (1999). How to think about women's health. In C. Forden, A. E. Hunter, & B. Birns (Eds.), *Readings in the psychology of women: Dimensions of the female experience* (pp. 244–253). Boston: Allyn & Bacon.
Lopez, S. R., & Guarnaccia, P. J. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology, 51,* 571–598.
MacDonald, J. M., & Chesney-Lind, M. (2001). Gender bias and juvenile justice revisited: A multiyear analysis. *Crime & Delinquency, 47,* 173–195.
Magnus, K., Diener, E., Fujita, F., & Pavot, W. (1993). Extraversion and neuroticism as predictors of objective life events: A longitudinal analysis. *Journal of Personality and Social Psychology, 65,* 1046–1053.
Major, B., Richards, C., Cooper, M. L., Cozzarelli, C., & Zubek, J. (1998). Personal resilience, cognitive appraisals, and coping: An integrative model of adjustment to abortion. *Journal of Personality and Social Psychology, 74,* 735–752.
Marcus-Newhall, A., Thompson, S., & Thomas, C. (2001). Examining a gender stereotype: Menopausal women. *Journal of Applied Social Psychology, 31,* 698–719.
Marecek, J. (2001). Disorderly constructs: Feminist frameworks for clinical psychology. In R. K. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 303–316). New York: Wiley.
Marecek, J. (2002). Unfinished business: Postmodern feminism in personality theory. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 3–28). New York: Guilford.
Marecek, J., & Hare-Mustin, R. T. (1998). A short history of the future: Feminism and clinical psychology. In D. L. Anselmi & A. L. Law (Eds.), *Questions of gender: Perspectives and paradoxes* (pp. 748–758). Boston: McGraw-Hill.
Markson, E. W. (2001). Sagacious, sinful or superfluous? The social

construction of older women. In J. M. Coyle (Ed.), *Handbook on women and aging* (pp. 53–71). Westport, CT: Greenwood.
Marsh, F. (1995). Feminist psychopharmacology: An aspect of feminist psychiatry. In J. A. Hamilton, M. F. Jensvold, E. D. Rothblum, & E. Cole (Eds.), *Psychopharmacology from a feminist perspective* (pp. 73–84). New York: Haworth.
Martens, A., Johns, M., Greenberg, J., & Schimel, J. (2006). Combating stereotype threat: The effect of self-affirmation on women's intellectual performance. *Journal of Experimental Social Psychology, 42,* 236–243.
Martin, C. A., & Colbert, K. K. (Eds.). (1997). *Parenting: A life span perspective.* New York: McGraw-Hill.
Martinez, L. J., Davis, K. C., & Dahl, B. (1999). Feminist ethical challenges in supervision: A trainee perspective. *Women and Therapy, 22*(4), 35–54.
Matlin, W. W. (2001, May). *Wise and wonderful . . . or wrinkled and wretched: How psychologists and the rest of the world view older women.* Paper presented at the Midwestern Psychological Association, Chicago.
Mazure, C. M., Keita, G. P., & Blehar, M. C. (2002). *Summit on women and depression: Proceedings and recommendations.* Washington, DC: American Psychological Association.
McCarn, S. R., & Fassinger, R. E. (1996). Revisioning sexual minority identity formation: A new model of lesbian identity and its implications for counseling and research. *Counseling Psychologist, 24,* 508–534.
McCloskey, L. (1997). The continuum of harm: Girls and women at risk for sexual abuse across the lifespan. In D. Cicchetti & S. L. Toth (Eds.), *Developmental perspectives on trauma: Theory, research, and intervention* (pp. 553–578). Rochester, NY: University of Rochester Press.
McIntosh, P. (1998). White privilege: Unpacking the invisible knapsack. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 147–152). New York: Guilford.
McIntyre, A. (2000). Antiracist pedagogy in the university: The ethical challenges of making Whiteness public. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp. 55–74). Washington, DC: American Psychological Association.
McWhirter, E. H. (1997). Perceived barriers to education and career: Ethnic and gender differences. *Journal of Vocational Behavior, 50,* 124–140.
McWright, L. (2002). African American grandmothers' and grandfathers' influence in the value socialization of grandchildren. In H. P. McAdoo (Ed.), *Black children* (2nd ed., pp. 27–44). Thousand Oaks, CA: Sage.
Miller, J. B., & Stiver, I. P. (1997). *The healing connection.* New York: Guilford.
Miller, K. K., & Mizes, J. S. (Eds.). (2000). *Comparative treatments for eating disorders.* New York: Springer.
Misra, D. (Ed.). (2001). *Women's health databook: A profile of women's health in the United States* (3rd ed.). Washington, DC: Jacobs Institute of Women's Health and the Henry J. Kaiser Family Foundation.
Mitchell, V., & Helson, R. (1990). Women's prime of life. Is it the 50s? *Psychology of Women Quarterly, 14,* 451–470.
Monro, F., & Huon, G. (2005). Media-portrayed idealized images, body shame, and appearance anxiety. *International Journal of Eating Disorders, 38,* 85–90.
Moore, J. L., & Madison-Colmore, O. (2005). Using the H. E. R. S. model in counseling African American women. *Journal of African American Studies, 9*(2), 39–50.
Moradi, B., Fischer, A. R., Hill, M. S., Jome, L. M., & Blum, S. A. (2000). Does "feminist" plus "therapist" equal "feminist therapist"? *Psychology of Women Quarterly, 30,* 6–43.
Moradi, B., & Subich, L. M. (2002). Perceived sexist events and feminist identity development attitudes: Links to women's psychological distress. *Counseling Psychologist, 30,* 44–65.
Moradi, B., Subich, L. M., & Phillips, J. C. (2002). Revisiting feminist identity development theory, research, and practice. *Counseling Psychologist, 30,* 6–43.
Morell, C. (2000). Saying no: Women's experiences with reproductive refusal. *Feminism and Psychology, 10,* 313–322.
Morrow, S. L. (2000). Feminist reconstructions of psychology. In M. Biaggio & M. Hersen (Eds.), *Issues in the psychology of women* (pp. 15–31). New York: Kluwer Academic/Plenum.
Morrow, S. L., & Smith, M. L. (1995). Constructions of survival and coping by women who have survived childhood sexual abuse. *Journal of Counseling Psychology, 42,* 23–33.
Morton, S. B. (1998). Lesbian divorce. *American Journal of Orthopsychiatry, 68,* 410–419.
Murphy, E. M. (2003). Being born female is dangerous for your health. *American Psychologist, 58,* 205–210.
National healthcare disparities report, 2005. (2005). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved June 28, 2007, from http://www.ahrq.gov/qual/nhdr05/nhdr05.htm
National Institute of Mental Health. (2000). *Depression: What every woman should know* (NIH Publication No. 00–4779). Washington, DC: Author.
Nelson, M. L., Gizara, S., Cromback, A., Weitzman, L., Phelps, R. E., Steward, R. J., et al. (2006). A feminist multicultural perspective on supervision. *Journal of Multicultural Counseling & Development, 34,* 105–115.
Nelson, T. D. (Ed.). (2002). *Stereotyping and prejudice against older persons.* Cambridge, MA: MIT Press.
Neville, H. A., & Heppner, M. J. (1999). Contextualizing rape: Reviewing sequelae and proposing a culturally inclusive ecological model of sexual assault recovery. *Applied and Preventive Psychology, 3,* 41–62.
Nikelly, A. G. (1995). Drug advertisements and the medicalization of unipolar depression in women. *Health Care for Women International, 16,* 229–242.
Nolen-Hoeksema, S. (2002). Gender differences in depression. In I. H. Gotlib & C. Hammen (Eds.), *Handbook of depression* (pp. 492–509). New York: Guilford.
Nutt, R. L. (1999). Women's gender-role socialization, gender-role conflict, and abuse: A review of predisposing factors. In M. Harway & J. M. O'Neil (Eds.), *What causes men's violence against women?* (pp. 117–134). Thousand Oaks, CA: Sage.
O'Hara, M. W., & Stuart, S. (1999). Pregnancy and postpartum. In R. G. Robinson & W. R. Yates (Eds.), *Psychiatric treatment of the medically ill* (pp. 253–277). New York: Marcel Dekker.
Okun, B. F. (1992). Object relations and self psychology: Overview and feminist perspective. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals* (pp. 20–45). New York: Guilford.
Olkin, R. (1999). *What psychotherapists should know about disability.* New York: Guilford.
Pardie, L., & Herb, C. R. (1997). Merger and fusion in lesbian relationships: A problem of diagnosing what's wrong in terms of what's right. *Women and Therapy, 20*(3), 51–61.
Park, K. (2002). Stigma management among the voluntarily childless. *Sociological Perspectives, 45,* 21–45.
Perrone, K. M., & Worthington, E. L. (2001). Factors influencing ratings of marital quality by individuals within dual-career marriages: A conceptual model. *Journal of Counseling Psychology, 48,* 3–9.
Philpot, C., Brooks, G. R., Lusterman, D.-D., & Nutt, R. L. (1997). *Bridging separate gender worlds: Why men and women clash and how therapists can bring them together.* Washington, DC: American Psychological Association.
Pine, D. S., & Cohen, J. A. (2002). Trauma in children and adolescents: Risk and treatment of psychiatric sequelae. *Biological Psychiatry, 51,* 519–531.
Pipes, R. B., Holstein, J. E., & Aguirre, M. G. (2005). Examining the personal–professional distinction: Ethics codes and the difficulty of drawing a boundary. *American Psychologist, 60,* 325–334.
Pittman, F. (1985). Gender myths: When does gender become pathology? *Family Therapy Networker, 9,* 25–33.
Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *The new psychology of men* (pp. 11–32). New York: Basic Books.
Polusny, M. A., & Follette, V. M. (1995). Long-term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied and Preventive Psychology, 4,* 143–166.
Pope, K. S. (1994). *Sexual involvement with therapists: Patient assessment, subsequent therapy, forensics.* Washington, DC: American Psychological Association.
Pope, K. S. (2001). Sex between therapist and client. In J. Worell (Ed)., *Encyclopedia of sex and gender* (pp. 955–962). New York: Academic Press.

Pope, K. S., Sonne, J. L., & Holroyd, J. (1993). *Sexual feelings in psychotherapy: Explorations for therapists and therapists-in-training.* Washington, DC: American Psychological Association.

Pope, K. S., & Vasquez, M. J. T. (1998). *Ethics in psychotherapy and counseling: A practical guide* (2nd ed.). San Francisco: Jossey-Bass.

Pope, K. S., & Vasquez, M. J. T. (2005). *How to survive and thrive as a therapist: Information, ideas, and resources for psychologists in practice.* Washington, DC: American Psychological Association.

Pope, K. S., & Vetter, V. A. (1991). Prior therapist–patient sexual involvement among patients seen by psychologists. *Psychotherapy, 28,* 429–438.

Porter, N. (1995). Supervision of psychotherapists: Integrating anti-racist, feminist, and multicultural perspectives. In H. Landrine (Ed.), *Bringing cultural diversity to feminist psychology: Theory, research, and practice* (pp. 163–176). Washington, DC: American Psychological Association.

Porter, N. (2002). Contextual and developmental frameworks in diagnosing children and adolescents. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 262–278). New York: Guilford.

Porter, N., & Vasquez, M. (1997). Covision: Feminist supervision, process, and collaboration. In J. Worell & N. G. Johnson (Eds.), *Shaping the future of feminist psychology: Education, research, and practice* (pp. 155–171). Washington, DC: American Psychological Association.

Posavac, H. D., Posavac, S. S., & Posavac, E. J. (1998). Exposure to media images of female attractiveness and concern with body weight among young women. *Sex Roles, 38,* 187–201.

Posavac, H. D., Posavac, S. S., & Weigel, R. G. (2001). Reducing the impact of media images on women at risk for body image disturbance: Three targeted interventions. *Journal of Social and Clinical Psychology, 20,* 324–331.

Pyle, R. P., McQuivey, R. W., Brassington, G. S., & Steiner, H. (2001). High school student athletes: Associations between intensity of participation and health factors. *Clinical Pediatrics, 42,* 697–701.

Qualls, S. H., Segal, D., Norman, S., Niederehe, G., & Gallagher-Thompson, D. (2002). Psychologists in practice with older adults: Current patterns, sources of training, and need for continuing education. *Professional Psychology: Research and Practice, 33,* 435–442.

Quermit, D. S., & Conner, L. C. (2003). Empowerment psychotherapy with adolescent females of color. *Journal of Clinical Psychology, 59,* 1215–1224.

Quinn, P. O. (2005). Treating adolescent girls and women with ADHD: Gender-specific issues. *Journal of Clinical Psychology, 61,* 579–587.

Rader, J. (2003). *The egalitarian relationship in feminist therapy.* Unpublished doctoral dissertation, University of Texas at Austin.

Ratey, J., & Johnson, C. (1997). *Shadow syndromes.* New York: Random House.

Rawlings, E. I., & Carter, D. K. (1977). Feminist and nonsexist psychotherapy. In E. I. Rawlings & D. K. Carter (Eds.), *Psychotherapy for women* (pp. 49–76). Springfield, IL: Charles C Thomas.

Reid, P. T. (1993). Poor women in psychological research: Shut up and shut out. *Psychology of Women Quarterly, 17,* 133–150.

Reid, P. T. (2002). Multicultural psychology: Bringing together gender and ethnicity. *Cultural Diversity and Ethnic Minority Psychology, 8*(2), 103–114.

Reid, P. T., & Kelly, E. (1994). Research on women of color: From ignorance to awareness. *Psychology of Women Quarterly, 18,* 477–486.

Renzetti, C. M. (1997). Violence in lesbian and gay relationships. In L. O'Toole & J. R. Schiffman (Eds.), *Gender violence: Interdisciplinary perspectives* (pp. 285–393). New York: New York University Press.

Resick, P. A. (2001). Cognitive therapy for post-traumatic stress disorder. *Journal of Cognitive Psychotherapy, 15,* 321–329.

Resnick, H. S., Kilpatrick, D. G., Dansky, B. S., Saunders, B. E., & Best, C. L. (1993). Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology, 61,* 984–991.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., et al. (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association, 278,* 823–832.

Reynolds, A. L., & Constantine, M. G. (2004). Feminism and multiculturalism: Parallels and intersections. *Journal of Multicultural Counseling & Development, 32,* 346–357.

Rhodes, A. E., Goering, P. N., To, T., & Williams, J. I. (2002). Gender and outpatient mental health service use. *Social Science and Medicine, 54,* 1–10.

Rice, J. K. (1994). Reconsidering research on divorce, family life cycle, and the meaning of family. *Psychology of Women Quarterly, 18,* 559–584.

Rice, J. K. (2001). Poverty, welfare, and patriarchy: How macro-level changes in social policy can help low-income women. *Journal of Social Issues, 57,* 355–374.

Rice, J. K. (2003). I can't go back: Divorce as resistance. In L. B. Silverstein & T. J. Goodrich (Eds.), *Feminist family therapy: Empowerment in social context* (pp. 51–63). Washington, DC: American Psychological Association.

Rice, J. K., & Else-Quest, N. (2006). The mixed messages of motherhood. In J. Worell & C. R. Goodheart (Eds.), *Handbook of girls' and women's psychological health: Gender and well-being across the lifespan* (pp. 339–349). New York: Oxford.

Rice, J. K., & Rice, D. G. (1973). Implications of the women's liberation movement for psychotherapy. *American Journal of Psychiatry, 130,* 191–196.

Rice, J. K., Wyche, K., & Lott, B. (1997). *Implementing welfare policy to insure long-term independence and well-being.* Washington, DC: American Psychological Association.

Ridley, C. R., Li, L. C., & Hill, C. L. (1998). Multicultural assessment: Reexamination, reconceptualization, and practical applications. *Counseling Psychologist, 26,* 827–910.

Robin, R. W., Chester, B., Rasmussen, J. K., Jaranson, J. M., & Goldman, D. (1997). Prevalence and characteristics of trauma and posttraumatic stress disorder in a Southwestern American Indian community. *American Journal of Psychiatry, 154,* 1582–1588.

Robinson, G. (2002). Cross-cultural perspectives on menopause. In A. E. Hunter & C. Forden (Eds.), *Readings in the psychology of gender* (pp. 140–149). Boston: Allyn & Bacon.

Robinson, G. E., & Stewart, D. S. (2001). Postpartum disorders. In N. L. Stotland & D. E. Stewart (Eds.), *Psychological aspects of women's health care* (pp. 117–139). Washington, DC: American Psychiatric Press.

Robinson, T. L., & Howard-Hamilton, M. F. (2000). *The convergence of race, ethnicity, and gender: Multiple identities in counseling.* Upper Saddle River, NJ: Merrill.

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

Root, M. (2001). *Love's revolution: Interracial marriage in America.* Philadelphia: Temple University Press.

Ross, R., Frances, A., & Widiger, T. A. (1997). Gender issues in *DSM–IV.* In M. R. Walsh (Ed.), *Women, men, and gender: Ongoing debates* (pp. 348–357). New Haven, CT: Yale.

Rostosky, S. S., & Travis, C. B. (2000). Menopause and sexuality: Ageism and sexism unite. In C. B. Travis & J. W. White (Eds.), *Sexuality, society, and feminism* (pp. 181–209). Washington, DC: American Psychological Association.

Rothbart, B. (1999). Venus and the doctor. In G. Null & B. Seaman (Eds.), *For women only: Your guide to health empowerment* (pp. 1397–1400). New York: Seven Stories Press.

Rozee, P. D., & Koss, M. P. (2001). Rape: A century of resistance. *Psychology of Women Quarterly, 25,* 295–311.

Rudman, L. A., & Glick, P. (2001). Prescriptive gender stereotypes and backlash toward agentic women. *Journal of Social Issues, 57,* 743–762.

Ruiz, P. (Ed.). (2000). *Ethnicity and psychopharmacology.* Washington, DC: American Psychiatric Press.

Russo, N. F. (2000). Understanding emotional responses after abortion. In J. C. Chrisler, C. Golden, & P. D. Rozee (Eds.), *Lectures on the psychology of women* (pp. 113–128). Boston: McGraw-Hill.

Sadker, M., & Sadker, D. (1994). *Failing at fairness: How America's schools cheat girls.* New York: Scribner.

Salmon, P., Sephton, S., Weissbecker, I., Hoover, K., Ulmer, C., & Studts, J. (2004). Mindfulness meditation in clinical practice. *Cognitive and Behavioral Practice, 11,* 434–446.

Sanchez-Hucles, J., & Hudgins, P. (2001). Trauma across diverse settings. In J. Worell (Ed.), *Encyclopedia of women and gender: Sex similarities*

and differences and the impact of society on gender (Vol. 2, pp. 1151–1168). San Diego: Academic Press.
Sanderson, S., & Thompson, V. L. S. (2002). Factors associated with perceived paternal involvement in childrearing. *Sex Roles, 46,* 99–111.
Saris, R. N., & Johnston-Robledo, I. (2000). Poor women are still shut out of mainstream psychology. *Psychology of Women Quarterly, 24,* 233–235.
Schmaling, K. B. (2000). Poorly understood conditions. In M. B. Goldman & M. C. Hatch (Eds.), *Women & health* (pp. 1055–1057). San Diego: Academic Press.
Schuster, M. A., Stein, B. D., Jaycox, L. H., Collins, R. L., Marshall, G. N., Elliot, M. N., et al. (2001). A national survey of stress reactions after the September 11th, 2001 terrorist attacks. *New England Journal of Medicine, 345,* 1507–1512.
Seem, S. R., & Johnson, E. (1998). Gender bias among counseling trainees: A study of case conceptualization. *Counselor Education and Supervision, 37,* 257–268.
Seguin, L., Potvin, L., St.-Denis, M., & Loiselle, J. (1999). Depressive symptoms in the late postpartum among low socioeconomic status women. *Birth, 26,* 157–163.
Seiffge-Krenke, I., & Stemmler, M. (2002). Factors contributing to gender differences in depressive symptoms: A test of three developmental models. *Journal of Youth and Adolescence, 31,* 405–417.
Sered, S. S. (1999). "Woman" as symbol and women as agents: Gendered religious discourses and practices. In M. M. Ferree & J. Lorber (Eds.), *Revisioning gender. The gender lens* (Vol. 5, pp. 193–221). Thousand Oaks, CA: Sage.
Sheehy, G. (1992). *The silent passage.* New York: Random House.
Sherwin, B. B. (2001). Menopause: Myths and realities. In N. Stotland & D. E. Stewart (Eds.), *Psychological aspects of women's health care* (2nd ed., pp. 241–259). Washington, DC: American Psychiatric Press.
Shore, G. (1999). Soldiering on: An exploration into women's perceptions and experiences on menopause. *Feminism & Psychology, 9,* 168–178.
Shum, L. M. (1996). Asian-American women: Cultural and mental health issues. *Women and mental health: Annals of the New York Academy of Sciences, 789,* 181–190.
Simonton, A. (1995). Women for sale. In C. Lott (Ed.), *Women and media* (pp. 143–164). Belmont, CA: Wadsworth.
Sinnott, J. D., & Shifren, K. (2001). Gender and aging: Gender differences and gender roles. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of psychology and aging* (pp. 454–476). San Diego: Academic Press.
Skodol, A. E., & Bender, D. S. (2003). Why are women diagnosed borderline more than men? *Psychiatric Quarterly, 74,* 349–360.
Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academies Press.
Smith-Adcock, S., Ropers-Huilman, B., & Choate, L. H. (2004). Feminist teaching in counselor education: Promoting multicultural understanding. *Journal of Multicultural Counseling & Development, 32,* 402–413.
Sommer, B., Shumaker, B., Avis, N., Meyer, P., Ory, M., Madden, T., et al. (1999). Attitudes toward menopause and aging across ethnic/racial groups. *Psychosomatic Medicine, 61,* 868–875.
Sparks, E. (2002). Depression and schizophrenia in women: The intersection of gender, race/ethnicity, and class. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 279–305). New York: Guilford.
Sparks, E. E., & Park, A. H. (2000). The integration of feminism and multiculturalism: Ethical dilemmas at the border. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp. 203–224). Washington, DC: American Psychological Association.
Spence, S. H., Sheffield, J., & Donovan, C. (2002). Problem-solving orientation and attributional style: Moderators of the impact of negative life events on the development of depressive symptoms in adolescence. *Journal of Clinical Child and Adolescent Psychology, 31,* 219–220.
Sperberg, E. D., & Stabb, S. D. (1998). Depression in women as related to anger and mutuality in relationships. *Psychology of Women Quarterly, 22,* 223–238.
Spraggins, R. E. (2003). *Women and men in the United States: March 2002* (Current Population Reports, P. 20–544). Washington, DC: U.S. Census Bureau.
Stark-Wroblewski, K., & Chwalisz, K. (2003). Adjustment to illness. In M. Kopala & M. A. Keitel (Eds.), *Handbook of counseling women* (pp. 309–322). Thousand Oaks, CA: Sage.
Steil, J. (2001). Marriage: Still "his" and "hers"? In J. Worell (Ed.), *Encyclopedia of women and gender* (pp. 677–686). San Diego: Academic Press.
Stein, M. B., Walker, J. R., & Forde, D. R. (2000). Gender differences in susceptibility to posttraumatic stress disorder. *Behaviour Research and Therapy, 38,* 619–628.
Stein, R. I., Saelens, B. E., Dounchis, J. Z., Lewczyk, C. M., Swenson, A. A., & Wilfley, D. E. (2001). Treatment of eating disorders in women. *Counseling Psychologist, 29,* 695–732.
Stevens, D., Riger, G., & Riley, P. J. (2001). Working hard and hardly working: Domestic labor and marital satisfaction among dual-earner couples. *Journal of Marriage and Family, 63,* 514–526.
Steward, R. J., & Phelps, R. E. (2004). Feminist and multicultural collaboration in counseling supervision: Voices from two African American women. *Journal of Multicultural Counseling & Development, 32,* 358–365.
Stewart, A., & McDermott, C. (2004). Gender in psychology. *Annual Review of Psychology, 55,* 519–544.
Stice, E., & Bearman, S. K. (2001). Body-image and eating disturbances prospectively predict increases in depressive symptoms in adolescent girls: A growth curve analysis. *Developmental Psychology, 37,* 597–607.
Stice, E., Burton, E. M., & Shaw, H. (2004). Prospective relations between bulimic pathology, depression, and substance abuse: Unpacking comorbidity in adolescent girls. *Journal of Consulting and Clinical Psychology, 72,* 62–71.
Stice, E., Presnell, K., & Bearman, S. K. (2001). Relation of early menarche to depression, eating disorders, substance abuse, and comorbid psychopathology among adolescent girls. *Developmental Psychology, 37,* 608–619.
Stice, E., Ragan, J., & Randall, P. (2004). Prospective relations between social support and depression: Differential direction of effects for parent and peer support? *Journal of Abnormal Psychology, 113,* 155–159.
Stice, E., & Whitenton, K. (2002). Risk factors for body dissatisfaction in adolescent girls: A longitudinal investigation. *Developmental Psychology, 38,* 669–678.
Strader, T. N., Collins, D. A., & Roe, T. D. (2000). *Building healthy individuals, families, and communities: Creating lasting connections.* New York: Plenum.
Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect, 24,* 1257–1274.
Surgeon General. (1999). *Mental health: A report of the Surgeon General: Main findings: Mental illnesses are real, disabling conditions affecting all populations regardless of race or ethnicity.* Washington, DC: U.S. Department of Health and Human Services.
Sutherland, C., Bybee, D., & Sullivan, C. (1998). The long-term effects of battering on women's health. *Women's Health, 4,* 41–70.
Suyemoto, K. L., & Kim, G. S. (2005). Journeys through diverse terrains: Multiple identities and social contexts in individual therapy. In M. P. Mirkin, K. L. Suyemoto, & B. F. Okun (Eds.), *Psychotherapy with women: Exploring diverse contexts and identities* (pp. 9–41). New York: Guilford.
Swim, J. K., & Cohen, L. L. (1997). Overt, covert, and subtle sexism. *Psychology of Women Quarterly, 21,* 103–118.
Szymanski, D. M., Chung, Y. B., & Balsam, K. F. (2001). Psychosocial correlates of internalized homophobia in lesbians. *Measurement and Evaluation in Counseling and Development, 34,* 27–38.
Thompson-Brenner, H., Glass, S., & Westen, D. (2003). A multidimensional meta-analysis of psychotherapy for bulimia nervosa. *Clinical Psychology: Science and Practice, 10,* 269–287.
Thornton, B., & Maurice, J. (1997). Physique contrast effect: Adverse impact of idealized body images. *Sex Roles, 37,* 433–439.
Tjaden, P., & Thoennes, N. (1998). *Prevalence, incidence and consequences of violence against women: Findings from the National Violence Against Women Survey* (NCJ Publication No. 172837). Retrieved November 24, 2000, from http://www.ncjrs.org/txtfiles/172837.txt
Tjaden, P., & Thoennes, N. (2000a). *Extent, nature, and consequences of*

intimate partner violence: Findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice.
Tjaden, P., & Thoennes, N. (2000b). *Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey*. Washington, DC: U.S. Department of Justice.
Tolman, D. L., & Brown, L. M. (2001). Adolescent girls' voices: Resonating resistance in body and soul. In R. K. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 133–155). New York: Wiley.
Torpy, J. M. (2002). Partner violence. *Journal of the American Medical Association, 288,* 662.
Trimble, J. E., Stevenson, M. R., Worell, J. P., & the APA Commission on Ethnic Minority Recruitment, Retention, and Training Task Force Textbook Initiative Work Group. (2003). *Toward an inclusive psychology: Infusing the introductory psychology textbook with diversity content.* Washington, DC: American Psychological Association.
Trotman, F. K. (2002). Old, African American, and female: Political, economic, and historical contexts. In F. K. Trotman & C. M. Brody (Eds.), *Psychotherapy and counseling with older women* (pp. 70–86). New York: Springer.
Trotman, F. K., & Brody, C. M. (2002). Cross-cultural perspectives: Grandmothers. In F. K. Trotman & C. M. Brody (Eds.), *Psychotherapy and counseling with older women* (pp. 41–57). New York: Springer.
U.S. Census Bureau. (1996). *Statistical abstracts of the United States, 1996.* Washington, DC: Congressional Information Service.
U.S. Census Bureau. (2000). *Facts for features—Americans With Disabilities Act*. Retrieved September 4, 2006, from http://www.census.gov/Pressrelease/www/releases/archives/facts_for_features_special_editions/006841.html
U.S. Census Bureau. (2001). Poverty in the United States: 2000. In *Current Population Reports* (pp. 60–214). Washington, DC: U.S. Government Printing Office.
U.S. Department of Health and Human Services, Office on Women's Health. (2001). *Women's health issues: An overview*. Washington, DC: National Women's Health Information Center.
Varelas, N., & Foley, L. A. (1998). Blacks' and Whites' perceptions of interracial and intraracial date rape. *Journal of Social Psychology, 138,* 392–400.
Vasquez, H., & Magraw, S. (2005). Building relationships across privilege: Becoming an ally in the therapeutic relationship. In M. P. Mirkin, K. L. Suyemoto, & B. F. Okun (Eds.), *Psychotherapy with women: Exploring diverse contexts and identities* (pp. 64–83). New York: Guilford.
Vasquez, M. J. T. (2001). Leveling the playing field—Toward the emancipation of women. *Psychology of Women Quarterly, 25,* 89–97.
Wade, M. E. (2001). Women and salary negotiation: The costs of self-advocacy. *Psychology of Women Quarterly, 25,* 65–77.
Walker, L. E. A. (2001). Battering in adult relations. In J. Worell (Ed.), *Encyclopedia of women and gender* (pp. 169–188). San Diego: Academic Press.
Wampold, B. E. (2001). *The great psychotherapy debate.* Mahwah, NJ: Erlbaum.
Way, N. (1995). "Can't you see the courage, the strength I have?" Listening to urban adolescent girls speak about their relationships. *Psychology of Women Quarterly, 19,* 107–128.
Webster, D. (2002). Somatoform and pain disorders. In M. Ballou & L. S. Brown (Eds.), *Rethinking mental health and disorder: Feminist perspectives* (pp. 145–173). New York: Guilford.
Wegar, K. (2000). Adoption, family ideology, and social stigma: Bias in community attitudes, adoption research, and practice. *Family Relations: Interdisciplinary Journal of Applied Family Studies, 49,* 363–370.
Weisstein, N. (1968). *Kinder, kirche, kuche as scientific law: Psychology constructs the female.* Boston: New England Free Press.
Werner-Wilson, R., Price, S., Zimmerman, T. S., & Murphy, M. (1997). Client gender as a process variable in marriage and family therapy: Are women clients interrupted more than men clients? *Journal of Family Psychology, 11,* 373–377.
West, C. (2002). *Violence in the lives of Black women: Battered, Black, and blue.* Binghamton, NY: Haworth Press.
West, C., & Zimmerman, D. G. (1987). Doing gender. *Gender and Society, 1,* 125–151.
Whalen, M., Fowler-Lese, K. P., Barber, J. S., Williams, E. N., Judge, A. B., Nilsson, J. E., & Shibazaki, K. (2004). Counseling practice with feminist–multicultural perspectives. *Journal of Multicultural Counseling & Development, 32,* 379–389.
Wiesner, M. (2003). A longitudinal latent variable analysis of reciprocal relations between depressive symptoms and delinquency during adolescence. *Journal of Abnormal Psychology, 112,* 633–645.
Wilber, K. H., & McNeilly, D. P. (2001). Elder abuse and victimization. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (5th ed., pp. 569–591). San Diego: Academic Press.
Wile, J., & Arechigo, M. (1999). Sociocultural aspects of postpartum depression. In L. J. Miller (Ed.), *Postpartum mood disorders* (pp. 83–98). Washington, DC: American Psychiatric Press.
Wilfley, D. E., Dounchis, J. A., & Welch, R. R. (2000). Interpersonal psychotherapy. In K. K. Miller & J. S. Mizes (Eds.), *Comparative treatments for eating disorders* (pp. 128–159). New York: Springer.
Williams, C. B. (2005). Counseling African American women: Multiple identities—Multiple constraints. *Journal of Counseling and Development, 83,* 278–283.
Williams, E. N., & Barber, J. S. (2004). Power and responsibility in therapy: Integrating feminism and multiculturalism. *Journal of Multicultural Counseling & Development, 32,* 390–401.
Williamson, D. A., & Netemeyer, S. B. (2000). Cognitive–behavior therapy. In K. J. Miller & J. S. Mizes (Eds.), *Comparative treatments for eating disorders* (pp. 61–81). New York: Springer.
Wilson, G. T., Fairburn, C. C., Agras, W. S., Walsh, B. T., & Kraemer, H. (2002). Cognitive–behavior therapy for bulimia nervosa: Time course and mechanisms of change. *Journal of Consulting and Clinical Psychology, 67,* 451–459.
Wolfe, J., & Kimerling, R. (1997). Gender issues in the assessment of posttraumatic stress disorder. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 192–238). New York: Guilford.
Woolley, S. (2000). Gender biases and therapists' conceptualizations of couple difficulties. *American Journal of Family Therapy, 28,* 181–192.
Worell, J. (1996). Opening doors to feminist research. *Psychology of Women Quarterly, 20,* 469–485.
Worell, J. (2001). Feminist interventions: Accountability beyond symptom reduction. *Psychology of Women Quarterly, 25,* 335–343.
Worell, J., & Johnson, D. M. (2001). Therapy with women: Feminist frameworks. In R. K. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 317–329). New York: Wiley.
Worell, J., & Johnson, N. G. (Eds.). (1997). *Shaping the future of feminist psychology: Education, research, and practice.* Washington, DC: American Psychological Association.
Worell, J., & Remer, P. (2003). *Feminist perspectives in therapy: Empowering diverse women* (2nd ed.). New York: Wiley.
Worell, J., Stilwell, D., Oakley, D., & Robinson, D. (1999). Educating women about gender: Cognitive, personal, and professional options. *Psychology of Women Quarterly, 23,* 797–812.
World Health Organization. (2000). *World health statistics annual.* Geneva, Switzerland: Author.
Wyche, K. F., & Rice, J. K. (1997). Feminist therapy: From dialogue to tenets. In J. Worell & N. G. Johnson (Eds.), *Shaping the future of feminist psychology: Education, research, and practice* (pp. 57–71). Washington, DC: American Psychological Association.
Yoder, J. D. (2002). Context matters: Understanding tokenism processes and their impact on women's work. *Psychology of Women Quarterly, 26,* 1–8.
Yoder, J. D. (2007). *Women and gender: Making a difference* (3rd ed.). Cornwall-on-Hudson, NY: Sloan.
Zamostny, K. P., O'Brien, K. M., Baden, A. L., & Wiley, M. O. (2003). The practice of adoption: History, trends and social context. *Counseling Psychologist, 31,* 651–678.