DISCUSSION 5 *

Prior to beginning work on this interactive assignment, please review Cases 18, 19, and 20 in *Case Studies in Abnormal Psychology* (Gorenstein & Comer 2015) and any relevant Instructor Guidance.

In practice, clinical and counseling psychologists utilize psychoeducational tools (e.g., bibliotherapy, client handouts, worksheets, etc.) to enhance the client's knowledge about mental health issues, coping strategies, and resources.

For this interactive assignment, you will create a visually interesting client handout based on the case study chosen for the Psychiatric Diagnosis assignment in PSY645 and your Week Six Psychological Treatment Plan in this course. You must attach your client handout document to your initial post in the forum.

The client handout will include the following required elements.

Education: Explain, with as much visual information as possible, the client's cognitive or behavioral symptoms based on your selected theoretical orientation. You may choose to create diagrams, figures, or charts to illustrate the relationship between the client's cognitions, affect, and behavior.

Intervention: Create a self-help exercise (e.g., a dysfunctional thought record, meditation, deep breathing, guided imagery, muscle relaxation, thought stopping, etc.) to assist the client in monitoring or reducing maladaptive cognitions, affect, and/or behavior outside of therapeutic sessions. Include an explanation about how the handout could be useful in reducing the client's symptoms. You may choose to visually represent this exercise with charts, scripts, steps, or other media.

Resources: Assess current trends in psychotherapy, and list complete APA reference entries for five sources that would help the client learn more about his or her presenting problem(s), early warning signs of relapse, and managing symptoms. Please include hyperlinks if such exist for your resources.

CASE 19

You Decide: The Case of Fred

This case is presented in the voices of Fred and his wife, Margaret. Throughout the case, you are asked to consider a number of issues and to arrive at various decisions, including diagnostic and treatment decisions. You can find Fred's probable diagnosis, the DSM-5 criteria, clinical information, and possible treatment directions in Appendix B.

Margaret "My Husband's Brain Stopped Working Properly"

About 8 years ago, my life changed completely. The reason? My husband's brain stopped working properly. We had been married 34 years and Fred was 67 years old. He had worked for the same construction company in New Jersey for 32 years, first as a laborer, then as a security supervisor and union leader. He was a big strong man, a good husband, and a good father to our son, Mark. Together, we had managed to make a decent living with him in construction and me an actress in television commercials—the original Odd Couple, our friends would call us. Life was good. And then Fred's brain went downhill, taking the whole family down with it.

The problems seemed small at first, hardly noticeable really. Sometimes, when telling me about his day at work, Fred would talk about the foreman, Jimmy, driving a "tractor" when he meant "bulldozer," or he'd say that he had made a "revision" instead of "decision." Little stuff. And he'd catch himself. I didn't worry too much about it, but it was odd. It doesn't sound like much, but it wasn't like him. I even thought, "Oh, well, the old boy's slipping," and would laugh to myself. But when he forgot the anniversary of our first date, well. . . I knew something was wrong. I gave him all kinds of hell for that—I accused him of having an affair, I cried, I really let him have it. But I was also scared. I mean, maybe an anniversary like that doesn't mean much to other people, but for us—well, over the years, he'd taken me to Atlantic City for shows and to dinners in expensive restaurants. Once, after Mark was grown, he even got us a hotel room in the Catskills for a weekend. There was always some sort of surprise. So, 8 years ago, in anticipation of a special evening, I got all dressed up. When he got home from work that night and sat down on the sofa, I knew he'd forgotten; and when he saw the disappointment in my eyes, he realized the same thing pretty quickly. In fact, he felt terrible about it, and took me out to a very fancy Italian restaurant after I calmed down. But it was a bad sign. That year turned out to be a rough one.

> Forgetfulness is universal, and increases in forgetfulness are a normal part of aging. How might we distinguish normal forgetting or normal aging from the symptoms of a clinical disorder?

It wasn't as if he suddenly forgot everything, but it seemed like he was forgetting a bunch of things that he'd never forgotten before. I had always been the one with my head in the clouds, forgetting dates and losing car keys. Fred would be the one telling me, "Maggie, you've got to stay more on the ball. If you forget to pay the bills, they're gonna shut off our electricity." Or he'd chew me out about forgetting to make a doctor's appointment for Mark. Of course, I'd joke, "Why don't we switch jobs and you'll see who's got it tougher," but he definitely had a sharper head, no denying that. Now, suddenly, he was losing his wallet and we'd find it later in the study, where he'd sworn he hadn't been in days. Or he would leave half-full glasses

of juice on the floor of the living room, and when I'd chide him about it he'd say, "Oh, I'm sorry," and change the subject. This was Mr. Neat Freak who, in the past, couldn't stand it if a dirty dish sat on the kitchen table more than a half hour after dinner.

What might be the most difficult aspects of observing a spouse, parent, or other close relative gradually lose their memory or other cognitive faculties?

He also had little accidents, spilling food on himself, or knocking over a pile of papers or the jar of pencils from the counter. Then he started asking me to drive him to work all the time. He said that he'd caught himself veering off the road a few times and had just barely avoided an accident. "It's all the stress," he'd tell me. "We've got a new contract coming up and I don't think it's gonna go our way. I've just got too much on my mind."

As the forgetfulness and unusual behavior mounted, it couldn't be ignored any more. Yet somehow I found a way to do just that. I wanted to believe that he was fine. Then, one day, he missed a meeting with an important contractor—just didn't show up. Instead, he went to his office like it was any other day. The company lost the contract and a lot of money, and it also was bad for their image. Actually, by that point in time, I wasn't all that surprised by his error. This strong and organized man, who had taken care of everything for so many years, was by then becoming a different person, and I was now taking care of him. That's when I told him that he must see a doctor. And Fred did something I'd never seen him do: He burst into tears.

Despite his emotional outpouring that evening, Fred managed to put off medical treatment for nearly a year. Eventually, however, the incidents caught up with him—for example, leaving his glasses in the mailbox or mowing only half the lawn—and he went for a neuropsychological exam. The results of a battery of tests revealed some significant problems, and the neuropsychologist, Dr. Schoenfeld, broke the news to us that he was suffering from a neurocognitive disorder. He explained to us that we would be facing a very difficult battle—that Fred would become less and less able to take care of himself. He also told us that very little could be done to stem the progress of Fred's condition. Fred was going to have to rely on the support of his loved ones, particularly me, to see him through this.

Neurocognitive disorders include a group of organic syndromes, marked by major problems in cognitive functioning, such as memory and learning, attention, visual perception, planning and decision making, language ability, or social awareness. Based on your reading of either the DSM-5 or your textbook, what form of neurocognitive disorder might Fred be displaying? Which of his symptoms suggest this diagnosis?

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Fred had already planned to retire, as his position in the company had been scaled down drastically after the contract debacle. The doctor's diagnosis simply made it official in our minds. Within 3 months, he was thrown a retirement party by his coworkers, many of whom he had mentored. By then he was having trouble remembering people's names, but that party meant a lot to him. He knew just how lucky he was to have so many caring friends and colleagues. He was still embarrassed about having lost that contract, but everybody tried their best to show him that they had nothing but gratitude for his years of service. He wasn't walking too well by then, either, so I helped him to a chair, where he sat for most of the party, sometimes crying quietly to himself because he no longer had full control of his emotions. I think that was really his last great experience, the last time he had a really special night out.

At the party, Fred gave a short talk to his coworkers, thanking them for the event. He had been worried about this speech for days. He feared attempting to reminisce or trying to be too specific, because he'd been having so much trouble remembering things. But he didn't want to read a written speech, so he just kept it short. It broke my heart when I heard him say, "This is really a special night. I want to thank you all for this and for helping me out the way you've done the last few months. I'm not the kinda guy who talks a lot and makes big speeches to his friends. And that's what you are—my friends. That's why I've had a great time all these years. That's why I've loved my job, and going to work in the morning. We've had a lot of good times, and I'll miss you, my friends."

In 2012, more than 15 million family members and friends volunteered 17.5 billion hours to care for individuals with dementia, which can lead to a range of psychological problems for caregivers. What kinds of problems would you expect caregivers to develop?

It was more than a retirement speech; it was a farewell speech. But, as painful as that was, the impromptu speech that he gave to me alone just 2 days later hurt even more. He was lucid that day. He was clear and organized and sharp as a tack, just like the old Fred. And he was hurting.

Fred "Preparing for a Trip to Nowhere"

I'm mad, I'm frustrated, I'm everything in between. It sure is embarrassing, Maggie, it sure is. Can you imagine what it's like to have to think for 2 whole minutes before remembering our own grandchild's name? A child I held in my arms when he was born, and said, "This boy is a perfect child." I watched him grow and played ball with him, and I can see his face in front of me as if he was in the room with me, but when I reach for his name, there's nothing there. Blank. How do I convince an 8-year-old child that his grandpa loves him and cares about him when I can't even be bothered to know his name?

I spend my whole life trying to be sharp, but I end up a failure. I'm a 69-year-old man who needs a woman to take care of him like he's 90. What use am I? I provided for my family. I earned money. I did my job to help keep Wellstone Construction running. And now that's all gone. All gone. I can't do any of it anymore. Lying in bed or sitting in a chair all day. My wife and son provide for me. The company takes care of me. I'm a drain. No one will ever again think of trusting me with anything. Anything. "No, it would be too taxing for the poor guy." That's what they'll say, but what they'll mean is, "He'll just screw it up, like he screws everything up."

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> Consider Case 5, Major Depressive Disorder. Did Fred show any symptoms of clinical depression as his disorder unfolded? Did Margaret? Would any of the treatment techniques described in Case 5 be helpful to either of them?

Sometimes, all of a sudden, I don't know what time of day it is, or even what day of the week it is. I don't even know what I had for breakfast this morning. If I want to go over there to pick up that book off that table, I have to ask you if you can help me walk. I can't walk without leaning on someone. Otherwise, I'll fall or have to stop and sit down.

Why should I even want to get up in the morning? Being up isn't all that different from being asleep, only a bit more confusing. Nothing in the world is more infuriating than knowing that you know the thing you can't remember. Knowing that you're not stupid, but that everything you once knew is being stripped away from you, little by little. God knows how long I'll even know who you are, Maggie. How long will it be before it's all just shapes and colors? How long before everyone else is making plans for me. Putting me in a home, putting me out to pasture, putting me to sleep. I feel like I'm preparing for a trip to nowhere.

> If you were to lose your memory and cognitive faculties, bit by bit, how would you feel? What fears and worries do you think you would experience?

I don't even know if I'll mind that so much. When I don't remember anything, it won't be so hard. Probably then I won't feel so stupid. I won't realize how much I am forgetting. That's what gets me—the forgetting. It gets me mad, but it gets me scared, too. I reach for a pen that I thought I was just writing with and I realize that it's not there. I look for it and then I realize that I'm not writing anything. Now I can't find the pen, and I don't even remember why I'm looking for it, and nothing makes any damned sense. It's like this dream that's real upsetting because I don't know what's going on, but I know I should know. Oh, God!

When this all started, you know, I didn't believe it. A man can get used to a lot if he can convince himself that nothing is wrong. Every time I'd forget something, or lose something, or drive off the road, it bothered me for exactly 5 minutes. I'd be scared for 5 minutes and I'd admit to myself for those 5 minutes that there was a serious problem—that these things were happening more and more and that something was very wrong and that I should get this taken care of somehow. But after those 5 minutes, I would laugh it off and decide that everything was fine—everyone forgets things, everyone loses concentration driving, everyone misplaces things—and I'd be fine. I'd come home, and I wouldn't think about it until the next thing happened. Then I'd be upset for another 5 minutes.

> Why would Fred and Margaret have tried to overlook his symptoms, even as they were worsening?

I want you to put me away, Maggie—you know what I mean—let me go, if I ever don't remember who

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you are. I don't want to forget my beautiful wife, and if I don't know who you are anymore, have them just inject me or give me whatever is necessary in order to get this life over with. Don't worry about whether it's the right thing, because it is. I'm afraid that you won't do this, that you'll let me go on when I'm not myself anymore. I don't want you to have to see me and not know that I love you and need you with me. I don't want you to doubt my love for you because of this damned disease. Please, Maggie, don't let that happen. Please promise me.

Margaret "A Long Goodbye"

> Unlike most of the other disorders in this casebook, Fred's problem was organic, progressive, and largely irreversible. What role might psychological treatments play in disorders of this kind?

I heard that speech from Fred several other times during the next 2 years. But of course I couldn't make that promise. Eventually, he became less clear and less interested, and less able, and he stopped saying those things. The last 4 years really have been a long goodbye for us. As the years have passed, Fred has been less and less able to do for himself. He has been increasingly unsteady on his feet. Furthermore, he lost control of his motor functions and is now unable to feed or clothe himself, or to use the bathroom on his own. At first, this was very upsetting to Fred; he was still aware enough to feel that his incapacitation made him ridiculous in some way, and he often lashed out at me in anger—even accusing me at times of trying to drug him so that he couldn't take care of himself. Later, he would tearfully apologize after these outbursts.

About 4 years ago, I bought him a walker to make it easier for him to get around. But a year later, he fell while trying to walk across the hall to take a bath. He broke his hip and couldn't leave his bed for 4 months. Fred became more and more depressed and began spending days staring at the wall or the bed sheets, refusing to talk even when I tried to speak to him. After his hip had healed, he still remained in bed, refusing to try to walk. He even began hearing voices and seeing people who weren't really in the room. Sometimes he would believe that long-gone relatives were in front of him and talking to him. Eventually, it seemed like it was just too taxing for him to try to distinguish the real from the imagined, and Fred began to treat everyone and everything around him with indifference or doubt. He treated real people who were talking to him as though they might be figments of his imagination and just turned away.

> What role might psychotherapists play in helping close relatives cope with the deterioration of a loved one? What therapy approaches described throughout this casebook might be particularly helpful to such relatives?

Our son, Mark, visited regularly, at least once every other weekend, from his New Hampshire home. Even so, Mark was always surprised by the speed of his deterioration. After breaking his hip, Fred, who had always looked so forward to Mark's visits, often failed to get out of bed to greet our son, sometimes sleeping through the entire visit. Mark noticed that his father appeared to get less pleasure from the visits. He tried to prepare himself for the ravages of Fred's condition, but as his father deteriorated more and more, he became very shaken.

During one visit, Fred looked Mark in the eye, then turned to me and asked, "Who is this, Maggie? Who's he? Is that your brother Jimmy? What's he doin' here?" Mark faced his father and said in a quiet voice, "Dad, it's me. Your son, Mark. And I love you." As he said this, however, Fred fell asleep, and Mark left the room feeling dejected. Later, after Mark and I ate lunch, Fred awoke again, and called out. When Mark entered the room and stood over his father's bed, Fred touched his hand to Mark's face and after a minute said, quietly and hoarsely, "Son . . ." And they held hands without saying a word for an hour. I almost couldn't bear it.

Also, about 3 years ago, Fred started having violent nightmares, and he would sometimes wake me with his screaming. During and after some of the nightmares, he seemed like a completely different person, with a crazed passion behind his frightened eyes. He was growing more and more convinced that I was plotting against him. During one of our visits to the neuropsychologist, he complained, "She's stealing things from me. She steals my clothes so that she can make me feel foolish when I can't find them. I was eating a banana, and she wanted the banana. I put it down and turned my back for a minute, and that banana was gone. She's taking my food. This is all her fault. I know it is."

> People with a disorder such as Fred's often become angry, suspicious, and accusatory. What are some of the potential

People with a disorder such as Fred's often become angry, suspicious, and accusatory. What are some of the potential reasons for such reactions and personality changes?

It's now been 8 years of taking care of him. At this point, I have to feed him and help him use the bathroom. I bathe him and I take him to the doctor. Thanks to his retirement package, we're okay financially. Still, I need to spend every penny we have on Fred's care. I can't work myself, since I have to be with him. The worst part is when he looks at me and I know he doesn't know who I am, yells at me as if I'm an enemy, and accuses me of stealing his things. At other times, however, he looks at me and his eyes say, "Thanks, Maggie," and I know he hasn't forgotten—even if he's remembering for only a moment.

Fred's decline seemed to reach a new level beginning around 6 months ago. Since then, he has been completely incontinent and barely able to speak. He has also been unable to leave our bedroom. He hasn't shown any recognition of Mark during his visits, and has barely even acknowledged me. About 3 weeks ago, he developed a cold that would not go away, and last week I took him to the hospital. He's still there, with a respiratory infection, using a ventilator to breathe. He is in such a weakened condition that doctors are not sure that he will live out the week.

I suspect that Mark and I each privately hope that the doctors' prognoses are accurate and Fred will die within the week. Neither of us has dared express this to the other, but I think we will both be relieved when Fred is gone—that is, the bedridden Fred whose true spirit has already left us. When he is gone, we will all finally be delivered from this long ordeal. And Mark and I will be able to remember our beloved Fred again as he once was—strong of mind and body.

After a long ordeal such as Fred's, it is common for close relatives to find themselves almost wishing for or looking forward to the person's death. What factors might explain such feelings and reactions?

Assignment 5

PLEASE USE all attached RESOURCES * along 3 more to make 7 sources

Literature Review

Prior to beginning work on this assignment, read the Ryder, Ban, & Chentsova-Dutton (2011) "Towards a Cultural-Clinical Psychology," American Psychological Association (2014) "Guidelines for Prevention in Psychology," Hage, et al. (2007) "Walking the Talk: Implementing the Prevention Guidelines and Transforming the Profession of Psychology," and Rivera-Mosquera, et al. (2007) "Prevention Activities in Professional Psychology: A Reaction to the Prevention Guidelines" articles.

Clinical and counseling psychology is a dynamic field that is constantly evolving and striving toward better treatment options and modalities. In this literature review, you will explore and integrate psychological research into a literature review, addressing current trends in three major areas of clinical and counseling psychology: assessment, clinical work, and prevention.

In your review, include the following headings, and address the required content.

Assessment
Support this section with information from the Ryder et al. (2011) article "Towards a Cultural-Clinical Psychology" and at least one additional peer-reviewed article from the Ashford University Library.

- Compare the assessments currently in use by clinical and counseling psychologists.
- Explain the trend towards cultural-clinical psychology and the suitability of clinical assessments with diverse clients.

Clinical work
Support this section using a minimum of three peer-reviewed articles from the Ashford University Library. The recommended articles for this week may be useful in generating your response.

- Compare and contrast technical eclecticism, assimilative integration and theoretical integration.
- Provide a historical context and identify the major theorists for each perspective.
- Assess the trends in psychotherapy integration.
- List three pros and cons for each perspective, sharing which perspective most closely aligns with your own.
- Analyze the major trends in psychology and explain the connection between evidenced-based practices and psychotherapy integration.

Prevention
Review the "Guidelines for Prevention in Psychology" (American Psychological Association, 2014), and support this section with information from the Hage, et al. (2007) "Walking the Talk: Implementing the Prevention Guidelines and Transforming the Profession of Psychology," and Rivera-Mosquera, et al. (2007) "Prevention Activities in Professional Psychology: A Reaction to the Prevention Guidelines" articles.

- Describe general prevention strategies implemented by clinical and counseling psychologists at the micro, meso, exo, and macro levels.

The Literature Review

- Must be 7 to 10 double-spaced pages in length (not including title and references pages) and formatted according to APA style as outlined in the Ashford Writing Center (Links to an external site.).
- Must include a separate title page with the following:
  - Title of paper
  - Student's name
  - Course name and number
  - Instructor's name
  - Date submitted
- Must use at least seven peer-reviewed sources in addition to the course text.
- Must document all sources in APA style as outlined in the Ashford Writing Center.
- Must include a separate references page that is formatted according to APA style as outlined in the Ashford Writing Center.

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Towards a Cultural–Clinical Psychology

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Abstract

For decades, clinical psychologists have catalogued cultural group differences in symptom presentation, assessment, and treatment outcomes. We know that 'culture matters' in mental health – but do we know how it matters, or why? Answers may be found in an integration of cultural and clinical psychology. Cultural psychology demands a move beyond description to explanation of group variation. For its part, clinical psychology insists on the importance of individual people, while also extending the range of human variation. Cultural–clinical psychology integrates these approaches, opening up new lines of inquiry. The central assumption of this interdisciplinary field is that culture, mind, and brain constitute one another as a multi-level dynamic system in which no level is primary, and that psychopathology is an emergent property of that system. We illustrate cultural–clinical psychology research using our work on depression in Chinese populations and conclude with a call for greater collaboration among researchers in this field.

Horace Cho[1] is a 57-year-old businessman from Hong Kong who has resided in Vancouver for fifteen years, referred for insomnia, fatigue, loss of appetite, gastrointestinal distress, and depressed mood. Mr. Cho was raised in Hong Kong, completed his MBA in California, and moved to Vancouver to join his wife's family and start a new business. Despite Mr. Cho's excellent English and knowledge of North American practices, his business is in difficulty. He attributes business troubles to the effects of his physical symptoms, rather than seeing these symptoms as resulting from psychosocial stress.

Mr. Cho lives in a majority Chinese suburb and encourages his children to stay close to Chinese traditions; however, his daughters desire greater participation in North American society. He describes his wife as much more traditional than he is, but to his surprise it is she who encourages the children to participate in mainstream society. At the initial interview, Mr. Cho denies depressed mood but agrees that symptoms, business difficulties, and values conflicts in his family are 'upsetting sometimes'.

What is Mr. Cho's 'culture', and is it the same as his wife's? Does he have a mental health problem and, if so, what is it? In what ways does culture shape the experience, expression, and communication of his distress? Where can psychologists look for ways to think about such questions?

Over the past few decades, scholars from several disciplines have examined the interrelation of culture and mental health. Many more have taken on cross-cultural comparisons in mainstream psychology. That 'culture matters' in clinical psychology is nothing new, although it bears frequent repetition in an era of biological reductionism. Rather, our claim is threefold: first, that there is relatively little cultural research in clinical psychology that aspires to explanation, to telling a culturally-framed story about what is observed; second, that the means for achieving this can be found in greater integration of cultural and clinical

psychology, to the benefit of both; and third, that the result is a new field. Cultural–clinical psychology has in some sense been around for a while, pursued by a small number of researchers. Nonetheless, it has not yet coalesced as an established field of study or as an approach to culture and mental health research. This paper aims to promote these ends.

We start by locating ourselves with respect to 'cultural psychology' and 'clinical psychology', and then present some first steps toward a cultural–clinical psychology. Central to this integration is the idea of mutual constitution – that culture, mind, and brain form a single system in which no level can be understood without the others. We then draw on our own research, pertaining to depression in Chinese populations, to provide some empirical examples. We conclude with a brief critique of these studies, considering ways in which they could be improved and interpreted in light of cultural–clinical psychology. Concrete suggestions to improve cultural–clinical psychology research are summarized in the Appendix and referenced throughout.

Cultural–Clinical Psychology: A Brief Introduction

Cultural psychology

In positioning cultural–clinical psychology, we begin by grounding the first term in the 'cultural psychology' perspective (e.g., Markus & Kitayama, 1991; Shweder, 1990). The word 'culture' has long been used in psychology to stand for ethnicity or nationality, and invoked as a black-box explanation: groups differ because of 'culture', but the specific ways in which this happens remain unclear. Cultural psychology represents a move away from cataloguing differences to understanding culture and how it shapes psychological variation (e.g., Betancourt & López, 1993; Cohen, Nisbett, Bowdle, & Schwarz, 1996; Heine and Norenzayan, 2006; Kitayama, Markus, Matsumoto, & Norasakkunkit, 1997). Differentiating between culture and 'cultural group' emphasizes that individual group members can partially adhere to or reject aspects of culture. For example, Mr. Cho and his wife have different views about the acculturation of their children, and not in ways that are obviously predictable from their own degree of traditionalism (Appendix: 1.1).

Is culture best understood as 'in the head' or 'in the world'? These views are held in tension and they sometimes conflict but, as with cognition and behavior in clinical psychology, neither is sufficient alone. People do not simply carry out behaviors. Rather, they perform 'acts of meaning' (Bruner, 1990), intended by the actor and understood by observers as meaningful. These acts are framed by the cultural meaning system and their enactment contributes to shaping this system (Kashima, 2000). Nisbett and Cohen (1996), for example, conducted an important series of studies on the 'Culture of Honor' in the American South, reporting that southerners have more favorable attitudes towards violence in cases where honor is at stake. Moreover, they demonstrated experimentally that southerners whose honor has been challenged are more physiologically reactive and take longer to step out the way of a confederate walking toward them in a narrow corridor. Cultural variation is captured here by both opinions and behaviors, and the behaviors of both participant and confederate are understood as meaningful.

The idea of *cultural scripts* can bridge these perspectives, as they both reflect meaning structures in the head and guide behavioral practices in the world (DiMaggio, 1997). Scripts refer to organized units of knowledge that encode and propagate meanings and practices. They serve as mechanisms that allow for rapid automatic retrieval and use of information acquired from the world while shaping how that information is perceived. Enacted as behavior, scripts are observable to others and become part of the cultural

context, shaping assumptions about what others think and expectancies about how they will behave (Chiu, Gelfand, Yamagishi, Shteynberg, & Wan, 2010). Moreover, people can access multiple cultural scripts, primed by different contextual cues (Hong & Chiu, 2001). If while at home Mr. Cho scolds his children for pursuing a 'Western lifestyle', he is accessing available scripts for cultural preservation while his actions and others' responses contribute to shaping these scripts, and passing them to his children. In work contexts, these same scripts may be primed rarely if at all. Mr. Cho's wife can understand him according to their shared meaning system even as she accesses a different available cultural script – promoting her children's well-being by ensuring they can function in a new society (Appendix: 2.2).

Clinical psychology

In using the term 'clinical' in cultural–clinical psychology, we are thinking primarily of researchers trained as scientists or scientist-practitioners in clinical psychology, health psychology, or experimental psychopathology. Although not all of these researchers are directly engaged with both science and practice, there is an emphasis on moving between theory and research about groups on the one hand, and the experiences and needs of individual sufferers on the other. Clinical psychology is concerned both with describing pathological phenomena and with using psychological principles to intervene with these phenomena therapeutically.

As a health discipline, clinical psychology inevitably discusses 'symptoms' and 'syndromes' – specific pathological experiences and the ways in which they are grouped. Mr. Cho's reported symptoms are insomnia, fatigue, loss of appetite, and gastrointestinal distress, with some evidence of depressed mood. A clinician trained in DSM-IV has over 300 syndromes to consider, but would most likely consider Major Depressive Disorder (MDD). Clinical psychology has long had a certain willingness to critique diagnostic systems accompanied by a preference for evidence-based symptom dimensions (Achenbach & Edelbrock, 1983; Krueger & Markon, 2006). This openness benefits cultural studies of psychopathology, as diagnostic systems are themselves cultural products (Gone & Kirmayer, 2010; Lewis-Fernández & Kleinman, 1994). Moreover, Kleinman (1988) argues that rigid application of a diagnostic system conceals cultural variation. He has shown how The International Pilot Study of Schizophrenia reliably identified patients meeting diagnostic criteria for schizophrenia, but in doing so eliminated a large proportion of psychotic patients at each site – precisely those patients who showed the most variability across the cultural groups (Appendix: 1.2).

Cultural–clinical psychology: what's new?

In an era both of fragmentation and interdisciplinarity in psychology (Cacioppo, 2007) it is easy to argue that two areas can benefit from collaboration on topics of shared concern. We wish to make a stronger claim in this case: a new field emerges at their intersection. For this to be plausible, we must first establish that clinical psychology is altered by consideration of cultural questions. More challenging, we must also establish that cultural psychology is altered by clinical questions, not simply given new content. Research in cultural–clinical psychology should tell us something new about the cultural contexts under study, not just the pathologies. Finally, we must demonstrate that new questions and methods for addressing them emerge from this sub-discipline, or at least that the potential is there (Appendix 2.1).

Clinical psychology encounters cultural psychology. A central issue for clinical psychology – what is disorder? – cannot be fully understood without considering deep cultural influence. The oft-used distinction between illness and disease defines illness as the socially-situated experience of having a particular disorder and disease as the corresponding malfunction in biological or psychological processes (Boorse, 1975; Kleinman, 1977). Wakefield (1992) similarly defines disorder as harmful dysfunction, in which harm indicates that the disorder is problematic in a given cultural context and dysfunction indicates the failure of a biological system evolutionarily adapted for particular ends.

While these approaches ostensibly give equal credit to culture and biology, uncritical acceptance plays into biases of mainstream clinical psychology. Researchers can end up exemplifying Geertz's (1984, p. 269) characterization of the behavioral sciences, in which, "culture is icing, biology, cake...difference is shallow, likeness, deep". We prefer to see disorder as both biological and cultural, in a fundamentally inseparable way. Depressed mood has many biological and cultural constituents worthy of focused study for specific purposes, but there is no depressed mood until these constituents come together and are experienced by someone.

Methodologically, clinical research has much to gain from incorporating the cultural psychology perspective. Integration of findings on the cultural shaping of psychological functioning can allow clinical psychologists to develop a broader and more nuanced view of normal human experience. Cultural psychology is well positioned to help clinical psychology move beyond conceptualizations of mental illnesses as products of solitary minds to thinking of it as contextually embedded in networks of local meanings, norms, institutions, and cultural products (e.g., Adams, Salter, Pickett, Kurtis, & Phillips, 2010). Finally, cultural psychology can inform our understanding of the ways in which people, including both patients and clinicians, incorporate contextual information in detecting, reporting and interpreting symptoms of mental illness (for examples of these cultural psychology ideas, not yet adapted for clinical questions, see Heine, Lehman, Markus, & Kitayama, 1999; Hong, Morris, Chiu, & Benet-Martínez, 2000; Masuda & Nisbett, 2001; Uchida, Norasakkunkit, & Kitayama, 2004. In Mr. Cho's case, the institutional demands of a mental health clinic may have tilted the emphasis toward symptoms and attributions and away from the understandable suffering caused by business and family difficulties (Appendix: 2.3).

The idea of scripts can help us think about specific ways in which mental health is shaped by cultural context. Although by definition abnormality violates expectations of what is normal, people nonetheless have scripts to help them make sense of pathology as best they can. Confusing and frightening experiences, such as emerging psychopathology, have a particularly strong need for scripts (Philippot & Rimé, 1997; Taylor, 1983). The large but finite number of ways to be physically or psychologically distressed is further molded by cultural-historical context, so that specific disorders draw upon a pool of available symptoms (Shorter, 1992). Cultural scripts can then be seen as mapping the sufferer's experience to what is available in this 'symptom pool', focusing on and thereby amplifying those symptoms that best serve explanatory and communicative purposes. Denial of depressed mood and acknowledgement that his problems are upsetting can be seen as serving Mr. Cho's communication goals in a particular health care setting.

Cultural psychology encounters clinical psychology. Beyond providing new content, potential contributions of clinical psychology begin with two of cultural psychology's core concerns: heterogeneity of cultural groups and limited coherence of cultural contexts (Kashima, 2000). These concerns do not necessarily require clinical psychology, but the

study of mental disorder serves as an engine to generate many examples of each. Psychopathological phenomena also shed new light on culture; as with the lesion studies that propelled neuroscience, we learn new things about cultural processes when the normal cultural scripts no longer work. (For a similar idea, not specific to psychopathology, see Beckstead, Cabell, & Valsiner, 2009). North American studies of social phobia patients highlight the central role fear of negative evaluation plays when healthy interpersonal functioning breaks down (see Hofmann & Barlow, 2002). These findings also reveal some of the assumptions of normal social relationships in North America: one is to portray one's true self and have it be positively evaluated by others. Studies of socially anxious patients in other cultural groups can serve the same function, showing for example how fear of causing discomfort to others – perhaps by inappropriately revealing one's true self – is a central concern for many socially anxious people in East Asian contexts (Rector, Kocovski, & Ryder, 2006; Sasaki & Tanno, 2005; Zhang, Yu, Draguns, Zhang, & Tang, 2000).

Methodologically, clinical psychology has a rich tradition of modeling ways in which abnormal behavior is shaped by constraints imparted by physiological and environmental influences, and their interactions. For example, contemporary research on depression spans multiple levels of analysis ranging from genes to hormones, brain anatomy and function, attention, memory, emotional reactivity, personality, and interpersonal functioning (Hammen, 2003; for a thorough review, see chapters in Gotlib & Hammen, 2009). Clinical psychology can also provide tools for theorizing about the ways in which psychological processes become functional or dysfunctional in a cultural context. For example, cultural innovation and propagation depends on specific abilities, such as harnessing novel associations or conveying negative emotions (Chentsova-Dutton & Heath, 2007), that are also associated with predisposition to certain forms of psychopathology.

Cultural–clinical psychology: mutual constitution of culture–mind–brain

The core claim of cultural psychology is not simply that groups differ or 'culture matters', but rather that human culture and human psychology are each grounded in the other: that culture and mind 'make each other up' (Shweder, 1991). Clinical psychology research, in keeping with trends in psychological science and in psychiatry, tends to focus more on the interrelation of mind and brain (Andreasen, 1997; Barrett, 2009; Ilardi & Feldman, 2001). We argue that the best approach for cultural–clinical psychology emerges from the joint concerns of the two fields, leading us to discuss mutual constitution of culture, mind, and brain. This approach follows recent trends in cultural psychiatry (Kirmayer, forthcoming) and cultural psychology (Chiao, 2009; Kitayama & Park, 2010; Kitayama & Uskul, 2011), in which culture, mind, and brain are thought of as multiple levels of a single system, here called the *culture–mind–brain* (Appendix: 3.1).

Culture and mind. The mutual constitution of culture and mind develops through processes that are an integral part of socialization, in that minds develop in cultural contexts that are themselves composed of minds (Cole, 1996; Valsiner, 1989). We cannot understand human minds unless we understand them in cultural context, and we cannot understand human culture unless we understand minds. The goal is to find ways of thinking and studying the psychological and the cultural so that neither is seen as the ultimate source of the other (Markus & Hamedani, 2006; Shweder, 1995).

Mind and brain. It is increasingly untenable to propose models of mental health that have no room for the brain, as shaped by the genome and in turn by evolutionary processes.

While we agree wholeheartedly with Geertz (1973) that, "it is culture all the way down", we also simultaneously make the opposite claim: it is biology all the way up. Both must be true for mutual constitution to have any meaning. Rather than seeing mind as the subjective epiphenomenon of brain, however, we prefer a view of mind as fundamentally social and tool-using, even as extended beyond the brain (Clark & Chalmers, 1998; Hutchins, 1995; Kirmayer, forthcoming; Vygotsky, 1978). Habitually used tools and close others are partially incorporated into one's mind: the online calendar can become *part of* the mind's memory system; the close friend can become *part of* the mind's emotion regulation system.

Culture and brain. It does not necessarily follow from a tripartite model of culture, mind, and brain in this way that mind mediates all culture-brain links. The human brain is adapted to acquire culture and responds to cultural inputs with marked plasticity, especially early in development (Wexler, 2006). Indeed, the emergence of a recognizable human mind may require these transactions between culture and brain. At the same time, biology constrains culture. There are a large number of possible ways in which culture can be configured, yet the number of impossible configurations is practically infinite (Gilbert, 2002; Mealey, 2005; Öhman & Mineka, 2001). That this is true does not compromise the equally important observation that human possibilities are many, diverse, and deeply shaped by culture (Marsella & Yamada, 2010; Tseng, 2006).

The ecology of culture–mind–brain. Describing the interrelations of culture, mind, and brain as a triangle of linked associations might imply three interrelated systems. We prefer to think of culture–mind–brain as one dynamic multilevel system, an information network instantiated in neuronal pathways, cognitive schemata, human relationships, culturally-mediated tools, global telecommunications, corporations, political actors, health care systems, and so on. Cultures, minds, and brains cannot be understood in isolation from one another. As yet, there is little research that engages with all three levels simultaneously, although a promising avenue has been opened by Kim, Sherman, Taylor, et al. (2010a). These researchers showed that cultural context and variations in certain serotonin receptor genes interact to predict locus of attention. Specifically, one of the variants predicts a tendency to attend to context in Korean participants, and the same variant predicts an especially strong tendency to attend to the focal object in Euro-American participants.

Psychopathology is an emergent property of culture–mind–brain, with no ultimate cause at any one level. While changes at one level affect all levels, it does not follow that disorder at one level means disorder at other levels, let alone that disorder at a higher level must be caused by disorder at a lower level. A disordered brain circuit does not require malfunctioning neurons, nor does a disordered neuron require malfunctioning molecules, although neither makes sense in the absence of neurons or molecules. Pathology can emerge from problematic feedback loops in which the response to a problem exacerbates the problem, even when all components of the loop are working normally (Hacking, 1995; Kirmayer, forthcoming). A conditioned fear that goes on to cause problems in living is a disorder, it involves the brain, but it does not require a disordered brain. Values conflict between Mr. Cho and his wife can create a stressful environment for their children, but not because a lower-level disorder leads them to adhere to pathological values.

Disorder at higher levels can also lead to disorder at lower levels. Cultural norms, economic conditions, and political response might interact to produce violent conflict, with consequences that include damage to brains from traumatic stress. It is incomplete at best

to claim that psychological consequences of that damage are *caused* by the brain without acknowledging political or economic causes. Similarly, Mr. Cho's depression might make sense as psychosocial stress coupled with preexisting vulnerability, but the depression has lasting consequences for the brain (Kendler, Thornton, & Gardner, 2000). A mind-level intervention such as Cognitive-Behavior Therapy (CBT), moreover, impacts on the brain (DeRubeis, Siegle, & Hollon, 2008) – unsurprising, as culture–mind–brain is a single system (Appendix: 3.2).

Before considering an example of three recent cultural–clinical psychology lines of research focused on an interrelated set of questions, let us briefly return to the case of Mr. Cho.

After the initial assessment, Mr. Cho began a 16-week course of CBT for depression. The case at first appeared to be a textbook case of 'Chinese somatization'; somatic symptoms were discussed almost exclusively, unlinked to psychosocial stressors. Sustained discussion of these stressors would sometimes lead to marked tearfulness and inability to maintain emotional composure. Once rapport was established, depressed mood was acknowledged fairly quickly, along with guilt and pessimism, primarily described as reactions to how the physical symptoms had impacted his business and family life.

Mr. Cho asked several times how CBT could help him with his primary concern – the somatic symptoms – and as treatment turned to depressed mood, guilt, and pessimism, he began to miss sessions. We reframed treatment in line with CBT approaches to Chronic Fatigue Syndrome – emphasizing holism of mind and body, talking more openly about somatic symptoms, and incorporating some somatic approaches such as sleep hygiene and diet regulation. Psychological and physical causes, psychological and physical symptoms, all became legitimate topics for discussion.

Cultural–Clinical Psychology: Empirical Examples

We are each involved in independently developed lines of research taking a cultural psychology approach to clinically-relevant questions about Chinese-origin participants and depression. To illustrate the potential of cultural–clinical psychology, we turn to a more sustained discussion of this work.

Cultural psychology research on depression

Somatic and psychological symptoms. In a now classic study, Kleinman (1982) argued that Chinese psychiatric patients tend to emphasize somatic symptoms relative to 'Western' norms (see also Parker, Cheah, & Roy, 2001). Ryder et al. (2008) used multiple assessment methods with Han Chinese and Euro-Canadian psychiatric outpatients. Results generally showed greater somatic symptom reporting in the Chinese group and greater psychological symptom reporting in the Euro-Canadian group. The tendency to devalue the importance of one's emotional life was also higher in the Chinese group and mediated the relation between cultural group and symptom presentation.

Devaluation of one's emotional life does not fit well with readily accessible cultural scripts in North America. This tendency was measured using a tool designed to measure pathology, the Externally-Oriented Thinking (EOT) subscale of the Twenty-item Toronto Alexithymia Scale (TAS-20; Bagby, Parker, & Taylor, 1994). Whereas EOT might capture pathological beliefs in a cultural context that fosters ideals of healthy emotional expression, it may simply represent adherence to an accessible cultural script in Chinese contexts (see Dion, 1996; Kirmayer, 1987). In a comparison of Chinese- and Euro-Canadians, group difference in EOT was mediated by adherence to

'Western' values (Dere, Falk, & Ryder, forthcoming). People vary in accessibility of cultural scripts about emotional expression, and cultural contexts vary in terms of how normal these scripts are perceived to be. Mr. Cho had access to multiple scripts but the Chinese somatic script predominated – he emphasized somatic symptoms while increasingly considering psychological symptoms, and tended to see the latter as consequences of somatic symptoms.

Emotional expression. Studies comparing depressed Euro-Americans and Asian-Americans to their non-depressed counterparts show that depression is associated with culturally-specific patterns of emotional reactivity. For Euro-Americans, depression is characterized by dampened emotional reactivity in response to positive and negative emotional films (see Bylsma, Morris, & Rottenberg, 2008). Chentsova-Dutton et al. (2007) replicated this pattern with negative films in Euro-Americans using self-report, facial coding, and physiological measures, but failed to find it – and at times, found the inverse – in Asian-Americans (primarily Chinese-Americans). More surprisingly, Chentsova-Dutton, Tsai, and Gotlib (2010) replicated the pattern using positive films, so that on certain measures such as cardiac reactivity, depressed Asian-Americans were actually more reactive than non-depressed Asian-Americans.

Cultural contexts provide people with shared scripts for how to feel and express emotions. Failure to enact culturally normative emotional scripts may contribute to depressed mood, and may also be exacerbated by such mood. The Euro-American pattern of dampened reactivity when depressed may reflect failure to enact accessible cultural scripts for open and prominently displayed emotional responses (Bellah, Sullivan, Tipton, Swidler, & Madsen, 1985). The Chinese-American pattern of heightened reactivity when depressed may reflect failure to enact readily available cultural scripts of moderated experience and expression of one's emotions (Russell & Yik, 1996). Exemplifying the latter, Mr. Cho was at times strikingly expressive discussing difficult topics despite retrospectively denying depressed mood.

Explanatory models. It is normative in 'Western' cultural settings to not just emphasize psychological symptoms but also to link distress to psychological causes. Ban, Kashima, and Haslam (2010) explored the extent to which behavior is deemed pathological if it violates this cultural script. A vignette describing someone with depression, including or not including a psychological cause, was presented to Euro-Australian and Chinese-Singaporean university students. Euro-Australian students were more likely to perceive depression as 'normal' when their vignette included a psychological explanation. For Chinese-Singaporean students, psychological explanations made the depression seem *less* normal, and they preferred moral to psychological explanations on a questionnaire.

For Euro-Australians, living in a cultural context with a readily accessible script equating abnormality with irrational psychological functioning, psychological explanations help restore a sense of order. Chinese-Singaporeans, by contrast, live in a cultural context where the predominant script equates emotional maturity with adjustment of behavior to situational demands (Kirmayer, 2007). Indeed, Chinese-Singaporean moral explanations centered on failed social obligations. These modes of explanation represent scripts that are available, to varying extents, in different cultural contexts. Mr. Cho initially presented along the lines of a medicalizing script, which soon gave way to a moralizing script about failing his family. Eventually, he was willing to consider a psychologizing script without fully endorsing it.

Reinterpreting the research

How can we understand these findings in light of culture–mind–brain? Before depression emerges, people have access to culturally shaped scripts about what depression is and assume others have access to these scripts as well (Ban et al., 2010). Once depression emerges, its implications cascade rapidly through all levels of culture–mind–brain, motivating people to make sense of what is happening to them (Philippot & Rimé, 1997). Scripts focus attention on certain symptoms, magnifying some experiences and minimizing others. A looping effect takes place – experiences that best draw upon the cultural symptom pool in ways that fit available scripts about depression are focused upon, further contributing to their severity (Shorter, 1992). Multiple cultural scripts can coexist and draw upon this pool, so that patients in a single cultural context can nonetheless present many different kinds of symptoms (Ryder et al., 2008).

In keeping with the idea of mind as social, we have real and imagined audiences for this process: what do we tell other people; what are they going to notice; how are they going to react? (Chiu et al., 2010) These others are specific others, with their own experiences, relationships with the sufferer, social roles, and functions within societal institutions. The real and imagined presence of specific others shapes the explanations chosen, the emotions expressed, and the symptoms emphasized (Chentsova-Dutton & Tsai, 2010; Jakobs, Manstead, & Fisher, 1996; Lam, Marra, & Salzinger, 2005; Matsumoto, Takeuchi, Andayani, Kouznetsova, & Krupp, 1998). Sufferers generate additional stressors as others react to evident and unusual signs. It is not simply that depression is associated with non-normal emotional expressions (Chentsova-Dutton et al., 2007, 2010), but that another loop is generated where reactions of others to these expressions lead to censure and withdrawal, hence to rejection and further depression.

As per the cultural dynamical approach (Kashima, 2000), we should expect actual experiences of depression – what is experienced, expressed, talked about, witnessed, shared with mental health professionals, discussed in the local community – to shape cultural scripts pertaining to depression. There is emerging evidence in China that rapid social change is shifting public understanding of depression, altering cultural scripts, and in turn shaping symptoms presented by successive cohorts. In consequence, exposure to modernization and Westernization values is lessening the tendency for Chinese patients to emphasize somatic symptoms of depression (Ryder et al., forthcoming).

Contributions and limitations

These studies represent three independent attempts to bring together cultural and clinical psychology to investigate a particular clinical phenomenon in a particular cultural group, drawing on both fields for theory, methodology, and interpretation. These studies go beyond cataloguing group differences, examining how various aspects of Chinese – and 'Western' – cultural contexts, including scripts, values, cognitive styles, norms, and attributions, shape depression. They are methodologically varied, including self-report questionnaires but also interviews, open-ended response coding, psychophysiology, facial coding, vignettes, mediation analysis, and experimental designs.

Our studies have limitations, notably including failures to adhere to some of the recommendations summarized in the Appendix. Cultural and diagnostic groups, for example, could be more clearly defined. The studies are compatible with a dynamic view of culture but do not go very far in advancing that agenda. Culture is not assessed in a multi-method way. More fundamentally, however, what is missing so far is the brain,

and thus the potential synthesis implied by culture–mind–brain. Somatic and emotional experiences are connected in the brain (Craig, 2008) and may be emphasized or deemphasized in the mind based on cultural scripts (Wiens, 2005). Kim, Sherman, Sasaki, et al. (2010b) have shown that variations in oxytocin receptor genes interact with cultural context and level of subjective distress to predict help-seeking, a rare example of how levels of culture–mind–brain can be included in a single study.

Even with improvements in conception, sampling, methods, and interpretation, we do not expect that any given study, or even research program, would cover everything discussed here. Cultural–clinical psychology already exists in a sense, including researchers who have been making important contributions for years. At the same time, there is as yet little sense of a shared enterprise, let alone of the institutional markers of such. What is needed is a greater degree of coherence and integration, where individual research groups approach different pieces of the overall puzzle, but with a shared framework and an ongoing commitment to putting this puzzle together.

Conclusion

There is much to be gained from greater connection between cultural and clinical psychology, with a core of researchers at the intersection. Cultural psychology can benefit from testing the limits of cultural influence across the full range of psychological functioning, including psychopathological extremes and difficult environmental conditions. Likewise, clinical psychology can consider a wider range of sociocultural phenomena that may affect mental illness. The two fields together point to a dynamic model of culture–mind–brain that can serve as a central pillar of this interdisciplinary field. Cultural–clinical psychology advances attempts to conceptualize mental health phenomena as dynamic and context-dependent, rather than fully reducible to physiological deficits or environmental stressors. We emphasize 'cultural' aspects because we believe that explanations at this level are often neglected in mental health research, but hope that ultimately no discussion of mental health will seem complete without consideration of all levels.

The case of Mr. Cho illustrates how knowledge of cultural context and its accessible symptom scripts help us to better assess clients and modify treatment approaches to better adapt to these scripts. We observe how the clinical encounter becomes a space in which cultural scripts are negotiated, influencing both participants and shifting over the course of treatment. Training programs, internship sites, and licensing bodies increasingly insist on training in diversity and cultural competence without a clear vision of how to proceed or what evidence to use. Cultural competence is more than simply using good clinical skills with ethnic minority patients; cultural–clinical psychology can aspire to provide an evidence base (Ryder & Dere, 2010). At the same time, cultural competence includes questioning that evidence, considering dangers of reducing people to cultural categories (Kleinman & Benson, 2006). As we conclude our case history, we catch a glimpse of how seeing a patient's symptoms only through the lens of cultural explanations can yield surprises.

By the end of treatment, Mr. Cho was still struggling but wanted to try implementing some changes by himself. He continued to prioritize somatic symptoms, but agreed that psychological symptoms were part of his experience. At six-month follow-up, Mr. Cho reported ongoing appetite and gastrointestinal problems, but much better sleep, energy level, and mood. He mentioned that he was now working with a specialist, who was finding that the ongoing gastrointestinal and appetite problems might be related to a specific medical issue. The possibility of this separate issue may have been lost in the context of the other symptoms.

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Short Biographies

Andrew G. Ryder received his doctorate in psychology (clinical) from the University of British Columbia and currently directs the *Culture, Health, and Personality Lab* in the Department of Psychology at Concordia University, where he holds the position of Associate Professor. He is also an adjunct faculty member in the *Culture and Mental Health Research Unit* at the Sir Mortimer B. Davis–Jewish General Hospital in Montreal. Dr. Ryder's research lies at the intersection of cultural, clinical, and personality psychology. Most of his published work combines at least two of these areas, including papers in *Journal of Abnormal Psychology*, *Harvard Review of Psychiatry*, *Journal of Affective Disorders*, *Journal of Personality and Social Psychology*, and *Journal of Personality Disorders*. Current research focuses on: (a) the intersection of cultural and personality variables in shaping depressive symptom presentation in China and South Korea; and (b) acculturation and adaptation in complex multicultural societies. His work is supported by a New Investigator Award from the *Canadian Institutes for Health Research (CIHR)* and grants from CIHR and the *Fonds de la recherche en santé du Québec*.

Lauren M. Ban received her doctoral degree in psychology (social) from the University of Melbourne. At time of writing she was a postdoctoral fellow in the Department of Psychology at Concordia University and the *Culture and Mental Health Research Unit* at the Sir Mortimer B. Davis–Jewish General Hospital in Montreal, under the supervision of Dr. Ryder and Dr. Laurence Kirmayer. Her dissertation research explored folk perceptions of mental disorder comparing people with East Asian (primarily Chinese–Singaporean) and European–Australian cultural backgrounds, and a study from this work has been published in the *Journal of Cross-Cultural Psychology*. Current research takes a cultural psychology perspective on self-construals, explanatory models of mental illness and internalized stigma.

Yulia E. Chentsova-Dutton received her master's degree (clinical science and psychopathology) from the University of Minnesota and her doctoral degree (affective science) from Stanford University. She holds the position of assistant professor in the Department of Psychology at Georgetown University in Washington, D.C., where she directs the Culture and Emotion Lab. Her research spans cultural psychology, emotions, and mental health, and her publications include papers in the *Journal of Abnormal Psychology*, *Journal of Personality and Social Psychology*, and *Cultural Diversity and Ethnic Minority Psychology*. Her specific research interests include the cultural shaping of: (a) emotions, including conceptions and functions of emotions, emotional reactivity, and interoception); and (b) social support, including advice-giving and support networks. Her work is supported by the Social Psychology Program of the National Science Foundation.

Endnotes

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[1] Horace Cho is based on a composite of two cases. Identifying information has been fictionalized.

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Appendix: Practical recommendations for conducting cultural–clinical psychology research

1. Defining cultural and diagnostic categories. When we use categories, we have a tendency to assume that these categories are clearly separated from one another and capture fundamental differences. We essentialize groups when we assume that all people

from a certain cultural background or carrying a certain diagnosis are the same as one another, and different from people in other groups. At the same time, however, it is very difficult to conduct research without relying on groupings of individual people. *Researchers should therefore adopt a pragmatic rather than essentialized approach to describing cultural groups and diagnostic categories:*

1.1. For cultural groups, specify on a study-by-study basis how each group is defined and for what purposes, and interpret results in light of a more nuanced and dynamic view of culture. Doing so not only means more accurate reporting of methods, but also serves as a reminder that group membership is not self-evident, especially around the edges of a given category.

1.2. For diagnostic categories, consider a 'lumping' approach for syndromes and a 'splitting' approach for symptoms – very few broad categories for communication and comparison purposes (e.g., emotional disorders, psychotic disorders) followed by a fine-grained approach to individual symptoms. We might define the problem being compared across groups very broadly – for example, how do people in different context cope with loss? – and then seek to answer that question in part by looking at differences in how individual symptoms are presented.

2. Understanding and measuring culture. Culture is complex, deeply interconnected with all aspects of human life, often implicit, rarely straightforward, and can shape different people in different ways. It is therefore difficult to study, and it is hard to conduct good research without already knowing a lot about the context being studied – much as mainstream psychology researchers have a lot of tacit and unexamined knowledge about their own contexts. *Researchers should therefore know the cultural context well, aided by personal immersion in the context, selected cultural informants, and/or multicultural research teams:*

2.1. Tell a cultural story about the phenomena under study, aiming to explain ways in which culture shapes mental health rather than cataloguing group differences. At the start of a line of inquiry, that should involve using knowledge of the cultural context to propose potential explanations. Later on, studies should incorporate these potential explanations into the research design; for example, by testing the extent to which they can mediate group difference effects, or by manipulating them experimentally.

2.2. Pay attention to and assess contradictory cultural scripts, rather than assuming that cultural contexts foster a single script for a particular domain. Doing so helps move away from cultural determinism and helps counteract the tendency to essentialize culture, serving as a reminder that culture is complex and can influence different people in different ways.

2.3. Aim to measure culture in a multi-method way, as it exists in the head (e.g., via self-report or implicit cognitive tasks) and in the world (e.g., via behavioral observation or examination of cultural products). While not always possible within a single study, use of different methods strengthens a line of research and captures some of the complexity of culture. Indeed, it is not always the case that these different methods will agree; points of contradiction may be important.

3. Situating research within the culture-mind-brain system. We have described culture, mind, and brain as a deeply interactive and non-reductive multilevel system. It is not possible to capture such a system within a single study, or even in a line of research. What is possible, however, is to focus on aspects that are important to the research question and compatible with one's training and resources. These aspects should be iden-

tified and studied carefully while we remain mindful that our work is embedded within a broader system. *Researchers should therefore remember that a complex and dynamic system requires one to enter at a certain point, chosen for reasons of practicality or training:*

3.1. Use culture–mind–brain as the overarching framework, clearly delineating a certain part of the system within a study for pragmatic research purposes. A more narrowly-defined study (e.g., described by the methods and results) can be framed within a broader conceptual argument (e.g., described by the introduction and discussion). A series of more specific empirical papers can be supported by a more general theoretical review.

3.2. Given that one is focusing on part of the system, frame causal arguments as proximal rather than ultimate. It is unlikely that one has identified a causal explanation for anything that itself has no need of explanation. This does not take away from the possibility that we might have identified a crucial link in the causal chain, or the importance of doing so.

Guidelines for Prevention in Psychology

American Psychological Association

The effectiveness of prevention to enhance human functioning and reduce psychological distress has been demonstrated (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2002; Greenberg, Domitrovich, & Bumbarger, 2001; National Research Council & Institute of Medicine, 2009). Successful preventive interventions are typically theory driven, culturally relevant, developmentally appropriate, and delivered across multiple contexts (Nation et al., 2003). Preventive services and interventions help to further the health and well-being of individuals, communities, and nations (Satcher, 2000; World Health Organization, 2008). Expanding preventive services reduces the costs of mental health care (Tolan & Dodge, 2005), while emerging technological innovations (e.g., telehealth) offer promise for preventive interventions (Bull, 2011; Chinman, Tremain, Imm, & Wandersman, 2009).

From infancy through adulthood, access to preventive services and interventions is important to improve the quality of life and human functioning and reduce illness and premature death (Grunberg & Klein, 2009; Konnert, Gatz, & Hertzsprung, 1999). Prevention has typically taken a developmental approach, focusing on children and adolescents, in order to facilitate trajectories leading to positive outcomes (National Research Council & Institute of Medicine, 2009). Children and adolescents are at significant risk for substance abuse, violence, and sexually transmitted infections, and their access to quality health services is limited (Centers for Disease Control and Prevention, 2007; Weissberg, Walberg, O'Brien, & Kuster, 2003). Thus, normal development may be impeded at large costs to society, and additional strains imposed on families. In any given year, 14%–20% of children and adolescents experience a mental, emotional, or behavioral disorder (National Research Council & Institute of Medicine, 2009). In addition, national surveys show that the majority of youth who could potentially benefit from mental health services do not receive services (Ringel & Sturm, 2001). Early and focused interventions can limit the length and severity of symptoms and enhance functioning (Cicchetti & Toth, 1992; Durlak, Weissberg, & Pachan, 2010). Prevention also includes the collaborative design and delivery of strengths-based health promotion and environmental improvement strategies (e.g., Cowen, 1985). Health promotion approaches equip people with life skills and coping competencies, such as problem-solving skills, contributing to their capacity to live more fully while being better able to withstand future stressful life events.

Preventive services and interventions also address issues of health, educational, and social inequities that reflect disparities across demographic groups such as those based on race, gender, and socioeconomic class. Environmental improvement prevention strategies, such as consultation to improve community–family–school coordination or interventions to help communities create well-paying jobs, aim to inform social policy, which can minimize or eliminate factors contributing to unhealthy functioning.

The importance of prevention is consistent with the Patient Protection and Affordable Care Act (2010), which calls for expansion of preventive services to maximize positive health outcomes, as well as with the U.S. National Prevention Strategy (National Prevention Council, 2011), which "provides an unprecedented opportunity to shift the nation from a focus on sickness and disease to one based on wellness and prevention" (National Prevention, Health Promotion, and Public Health Council, 2011, p. 1) throughout the life span. Several disciplines other than psychology have been historically and currently active in prevention (e.g., public health, social work). However, beginning in the mid-20th century with the field of community psychology, psychology began to play an increasingly important role (e.g., Eby, Chin, Rollock, Schwartz, & Worell, 2011). Even with the increased focus on prevention, psychology training programs rarely require specific courses on prevention (O'Neil & Britner, 2009). In particular, conceptualizations about best practices in prevention, particularly at the environmental level, are lacking (Snyder & Elliott, 2005). In addition, the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association [APA], 2010) do not fully address unique ethical issues that may arise in prevention (e.g., Schwartz & Hage, 2009). Therefore, psychologists engaged in prevention can benefit from a set of guidelines that address and inform prevention practices.

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These guidelines were approved by the American Psychological Association (APA) Council of Representatives in February 2013. The guidelines were developed by APA's Prevention Guidelines Work Group. The Work Group members, listed alphabetically after the chair, included John L. Romano (chair), G. Anne Bogat, Robert K. Conyne, Sally M. Hage, Arthur M. Horne, Maureen E. Kenny, Connie Matthews, Jonathan P. Schwartz, Anneliese Singh, Michael Waldo, and Y. Joel Wong.

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This document is scheduled to expire as APA policy in February 2020. After this date, users are encouraged to contact the APA Practice Directorate to confirm that this document remains in effect.

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Purpose

APA (2002, p. 1050) refers to 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 an enforcement mechanism . . .. guidelines are aspirational . . . intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice . . .. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists.

Accordingly, the Guidelines for Prevention in Psychology (cited as Prevention Guidelines or Guidelines for the remainder of this document) are intended to "inform psychologists, the public, and other interested parties regarding desirable professional practices" (APA, 2002, p. 1049) in prevention.

The Prevention Guidelines are, in part, practice guidelines and different from treatment guidelines as defined by APA (2002). The Guidelines are recommended for the practice of psychology across areas that engage psychologists. The Guidelines are consistent with federal and state laws and regulations. In the event of a conflict between the Guidelines and any federal or state law or regulation, the law or regulation in question supersedes these Guidelines. Psychologists are encouraged to use their education and skills to resolve any conflicts in a way that best conforms to both law and ethical practice. The Guidelines are consistent with the Ethical Principles of Psychologists and Code of Conduct (APA, 2010), particularly Principles D (justice) and E (respect for people's rights and dignity).

Background

APA convention symposia (Hage & Romano, 2006; Kenny, 2003; Romano, 2002) initiated the development of these Guidelines, followed by an article describing prevention best practices (Hage et al., 2007). These Guidelines were later introduced as new business for the APA Council of Representatives, whereupon they underwent significant review, including APA governance and public comment periods, in accordance with Association policy relevant to guidelines (APA, 2013, Association Rule 30-8). The Guidelines were approved by the APA Board of Directors in December 2012 and by the APA Council of Representatives in February 2013.

Definitions

Prevention has been conceptualized as including one or more of the following: (a) stopping a problem behavior from ever occurring; (b) delaying the onset of a problem behavior, especially for those at-risk for the problem; (c) reducing the impact of a problem behavior; (d) strengthening knowledge, attitudes, and behaviors that promote emotional and physical well-being; and (e) promoting institutional, community, and government policies that further physical, social, and emotional well-being of the larger community (Romano & Hage, 2000). This conceptualization is consistent with Caplan's (1964) definition that identified prevention interventions as primary, secondary, and tertiary prevention, and with the definition by Gordon (1987) that identified prevention interventions as universal, selected, and indicated for those not at risk, at risk, and experiencing early signs of problems, respectively. Gordon's conceptualization was adopted by the Institute of Medicine (1994). A follow-up report from the Institute of Medicine broadened this universal, selective, and indicated framework to include "the promotion of mental health" (National Research Council & Institute of Medicine, 2009, p. 65).

Throughout this document, the terms *prevention, preventive intervention(s), preventive program(s),* and *preventive services* are used. Activities subsumed by these rubrics could focus on any of the five aspects of prevention included in the Romano and Hage (2000) conceptualization of prevention. Although space precludes a thorough exegesis of all types of programs, decisions about how and when to intervene might lead to different outcomes, different ancillary effects, and different ways of approaching issues within cultures and settings.

Documentation of Need

The Prevention Guidelines are recommended based on their potential benefits to the public and the professional practice of psychology. The Guidelines support prevention as an important area of practice, research, and training for psychologists. The Guidelines give increased attention to prevention within APA, encouraging psychologists to become involved with preventive activities relevant to their area of practice.

The National Research Council and Institute of Medicine's (2009) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions stated, "Infusing a prevention focus into the public consciousness requires development of a shared public vision and attention at a higher national level than currently exists" (p. 5). The Guidelines provide added visibility to the importance of prevention across professional practice areas and among the public. The Guidelines also support the U.S. Department of Health and Human Services' calls for health promotion and prevention in its *Healthy People* publications outlining national health goals (e.g., U.S. Department of Health and Human Services, 2000). *Healthy People 2020* (U.S. Department of Health and Human Services, 2010) continues the tradition of earlier publications by setting goals to eliminate preventable disease, achieve health equity, eliminate health disparities, create social and physical environments to promote good health, and promote healthy development and healthy behaviors across the life span. Other U.S. government bodies have also emphasized the importance of prevention to the overall health and well-being of the population (Mrazek, 2002).

The Patient Protection and Affordable Care Act (2010) includes preventive services as an important component of overall health care. The legislation strives to make wellness and preventive services affordable and accessible by requiring health plans to cover preventive services without copayments. These services include counseling to improve habits of lifestyle (e.g., proper nutrition, weight management), counseling to reduce depression, and preventive services to foster healthy birth outcomes.

The contributions and leadership of psychologists are critical in implementing a prevention focus in the health care system. Evidence increasingly suggests that mental illness, such as depression, is linked to chronic health issues such as heart disease and diabetes (Volgelzangs et al., 2008). Therefore, the Guidelines identify best practices for psychologists who engage in preventive activities relating to the interface between physical health and emotional well-being.

The Guidelines also respond to policies and legislation that aim to prevent and reduce problems such as chemical addictions, depression, suicide, school bullying, social violence, and obesity (Institute of Medicine, 1994). The Guidelines respond to social disparities, discrimination, and bias against people based on (but not limited to) their race, ethnicity, immigrant status, sexual orientation, age, gender identity, socioeconomic status, religion, HIV serostatus, physical and psychological health status, and gender (APA, 2003, 2007; Kenny, Horne, Orpinas, & Reese, 2009). The Guidelines offer recommendations to psychologists as they respond to public policy and legislative initiatives that promote positive health behaviors in the name of prevention and health promotion (National Research Council & Institute of Medicine, 2009). In addition, the Guidelines endeavor to apply the science and practice of psychology to address major social issues and real-world problems through education, training, and public policy positions (Anderson, 2011).

The Guidelines offer guidance to psychologists on several levels, including supporting the value of prevention as important work of psychologists and providing recommendations that give greater visibility to prevention among psychologists regardless of specialty area or work setting (Snyder & Elliott, 2005).

Expiration

Given the evolving nature of prevention, the Guidelines are scheduled to expire in the year 2020. After this date, users are encouraged to contact the APA Practice Directorate to determine if the document remains in effect. The year 2020 was selected because it coincides with the decennial *Healthy People* publications, which set national health goals for the United States every 10 years. In addition, it is expected that the Patient Protection and Affordable Care Act (2010) will be implemented fully by 2014, providing a reasonable time frame for these Guidelines, given the evolving nature of health care and psychology's place within the spectrum of health care services and research.

Guidelines

Guideline 1. Psychologists are encouraged to select and implement preventive interventions that are theory- and evidence-based.

Rationale. Preventive interventions that demonstrate sustained effectiveness can be considered as meeting the highest standard for efficacy and maximum benefits to the consumer (National Institute of Mental Health, 1998). Consistent with foundational principles in psychology, theory and research should be inseparably tied to prevention practice. Research suggests that programs developed from a sound theoretical framework are more effective than programs that are not theoretically based (Weissberg, Kumpfer, & Seligman, 2003). Also, preventive programs that are based on theory and regularly evaluated are more likely to consider risk and protective factors that operate across multiple contexts (Black & Krishnakumar, 1998), especially for groups who are historically marginalized (e.g., women, people of color). Accountability to client populations, funding agencies, and policymakers demands that prevention practices be grounded in theory and research (Vera & Reese, 2000).

Application. Psychologists are encouraged to conduct preventive programs that have been rigorously evaluated (Guterman, 2004; Weissberg, Kumpfer, & Seligman, 2003). While no single theoretical perspective is suggested, psychologists are encouraged to select theoretically based preventive approaches when considering their prevention goals. The theoretical frameworks and intervention strategies of positive psychology, positive youth development, applied developmental science, risk and resilience, health promotion, competence enhancement, and wellness, among others, can be selected and integrated when designing preventive interventions that will simultaneously prevent negative outcomes and enhance positive outcomes (Weissberg, Kumpfer, & Seligman, 2003). It is recommended that preventive programs be selected based on a careful review of empirical evidence in order to choose programs that are empirically supported for their specific contexts and specified goals, in addition to identifying how these relate to both multicultural issues and concerns generated by social inequities. Therefore, it is recommended that psychologists stay informed regarding current outcome research in prevention science to help ensure that the preventive programs they implement offer the most promise for the identified goals and population.

Guideline 2. Psychologists are encouraged to use socially and culturally relevant preventive practices adapted to the specific context in which they are implemented.

Rationale. Given the increasing diversity of the U.S. population, it is crucial that preventive programs be designed, selected, and implemented with consideration of cultural relevance and cultural competence. Historically, many preventive programs were developed by professionals working with urban and suburban middle-class com-

munities and reflect heterosexual European American values and methods; furthermore, many did not address the unique issues faced by persons with disabilities. Preventive programs that lack relevance to the lives of participants will often fail (Lerner, 1995). Even when a preventive program is effective in one setting, it may not be effective in another setting with different populations (e.g., rural vs. urban communities, individuals above and below the federal poverty guidelines). Research suggests that programs perceived as socially and culturally relevant by their constituents have a greater likelihood of being sustained (Vera & Reese, 2000). As Trickett et al. (2011) noted, "Culture is not seen as something to which interventions are tailored; rather, culture is a fundamental set of defining qualities of community life out of which interventions flow" (p. 1412).

Because risk and protective factors are found within individuals and in the multiple social contexts in which individuals are situated, prevention programs that attend to both individual and contextual factors are most advantageous. Focusing only on individuals and the more proximal context of the family may place undue responsibility and blame on the individual and the individual's milieu without recognizing the roles played by social institutions and culture in determining and sustaining positive human outcomes (Kenny & Hage, 2009). Therefore, psychologists strive to understand the cultural worldviews and community contexts of individuals in order to strengthen prevention interventions, especially interventions that have been developed for one cultural group and implemented in another (National Research Council & Institute of Medicine, 2009).

Application. Psychologists are encouraged to be aware of and to articulate the evidence that supports their selection of specific prevention programs for implementation in different cultural contexts (Reese & Vera, 2007). Along this line, existing programs may need significant adaptation, or new programs may need to be developed, to meet social, cultural, community, and developmental norms of program participants and to ensure access to all members. Technological advances, such as the use of web-based preventive interventions and social media to promote, deliver, and assess prevention interventions, can assist with this process. Psychologists are encouraged to recognize the diversity that exists within cultural groups as cultural values may differ by race, ethnicity, social class, family income, gender, gender identity, sexual orientation, geographic region, education, ability, and acculturation level (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Psychologists are encouraged to examine cultural assumptions and biases of specific preventive programs and to consult the APA's (2003) "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" and its "Guidelines for Assessment of and Intervention With Persons With Disabilities" (APA, 2012a) in integrating considerations of culture in the design, implementation, and evaluation of prevention interventions. It is important for psychologists to acquire and demonstrate cultural competence across prevention activities and to strive to work sensitively with diverse populations. This typically means that the psychologist must immerse him- or herself in the community and culture in order to be a sensitive partner with the community.

Psychologists endeavor to include relevant stakeholders in all aspects of prevention planning and implementation to ensure program fit with the local culture and to build community investment in the program. In order to ensure that preventive programs meet local norms, it is recommended that psychologists engage in careful planning and ongoing monitoring and evaluation of programs (Nation et al., 2003). Dynamic trial designs have been proposed that avoid problems associated with randomized clinical trials and focus on whether significant information is lost as the intervention proceeds (Jason & Glenwick, 2012), whether there are unintended consequences (positive and negative) that result from the intervention, and how to consider issues of diversity when statistical power may be low (Rapkin & Trickett, 2005).

Guideline 3. Psychologists are encouraged to develop and implement interventions that reduce risks and promote human strengths.

Rationale. Early prevention interventions focused on reducing risks or causes of psychological dysfunction (Conyne, 2004). However, psychological research has identified personal and environmental protective factors that may also mitigate the probability of negative outcomes in the face of risk and that contribute to optimal health. Research indicates that prevention is most beneficial when attempts to reduce risk are direct and are combined with efforts to build strengths and protective factors (Eccles & Appleton, 2002; Vera & Reese, 2000). Focusing only on building competencies or only on preventing problems may not be as effective as addressing both competencies and problems (Catalano, Berglund, et al., 2002).

Application. Psychologists are encouraged to consider and ameliorate factors that contribute to risk and also to recognize and promote factors that enhance human strengths. Prevention programs can seek to reduce or eliminate factors, such as socioeconomic disparities, negative peer influences, family dysfunction, and school failure, or they can seek to increase social competencies and other protective factors (National Research Council & Institute of Medicine, 2009). Although psychologists may consider only the benefits of either a risk-reduction or a strength-promotion approach, an optimal approach is to address both. Protective factors, such as socioemotional skills, interpersonal connection, ethical decision making, graduating from high school, school-to-work transitions, civic engagement, and proper nutrition, might be selected as foci of interventions based upon their malleability and their relevance to daily life (Eccles & Appleton, 2002; Nation et al., 2003; Stone et al., 2003). For instance, a focus on expanding the resilience that historically marginalized groups have demonstrated despite obstacles might also serve to enhance strengths in other arenas of life (Singh, Hays, & Watson, 2011; Singh & McKleroy, 2011).

An emphasis on simultaneously reducing risks and developing competencies is consistent with research on

positive youth development, empowerment, advocacy, and participatory community research. Positive youth development posits that (a) protective factors reduce the likelihood of maladaptive outcomes under conditions of risk and (b) freedom from risk is not synonymous with preparation for life (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002; Pittman, Irby, Tolman, Yohalem, & Ferber, 2001). The APA Presidential Task Force on Prevention: Promoting Strength, Resilience, and Health in Young People recommended that prevention encompass the goals of reducing health problems and promoting health and social competence (Weissberg, Kumpfer, & Seligman, 2003).

Similarly, empowerment interventions focus on helping individuals master and maintain control over life situations. Inherently, empowerment is concerned with competencies and strengths (Zimmerman, 1995; Zimmerman, Israel, Schulz, & Checkoway, 1992). Advocacy interventions also have been implemented with populations such as adjudicated youth (e.g., E. P. Smith, Wolf, Cantillon, Thomas, & Davidson, 2004), and women experiencing intimate partner violence (Allen, Bybee, & Sullivan, 2004). Finally, participatory action research (PAR) interventions, which focus on researcher–participant collaborations and, thus, on utilizing strengths and competencies of the participants, have been successfully implemented with diverse groups of youth (e.g., Foster-Fishman, Law, Lichty, & Aoun, 2010; Jason, Keys, Suarez-Balcazar, Taylor, & Davis, 2003; L. Smith, Davis, & Bhowmik, 2010). It is recommended that PAR be a genuine community–researcher partnership (i.e., the development of shared goals, shared methods, and shared sense of the value of the project and the findings) to successfully implement the methodology (Trickett, 2011).

Guideline 4. Psychologists are encouraged to incorporate research and evaluation as integral to prevention program development and implementation, including consideration of environmental contexts that impact prevention.

Rationale. Prevention research encompasses "theory and practice related to the prevention of social, physical, and mental health problems, including etiology, methodology, epidemiology, and intervention" (National Research Council & Institute of Medicine, 2009, p. xxvii). At its best, prevention research addresses multifaceted contexts (biological, psychological, and sociocultural levels) and functions (preintervention epidemiology, preventive interventions, and preventive service delivery systems; National Institute of Mental Health, 1998). The contexts and functions of prevention research can inform each other. Problems and their prevention occur at interrelated biological, psychological and sociocultural levels. Epidemiological research can identify targets for preventive interventions; evaluation of interventions can identify preferred approaches that can be incorporated into service delivery systems; the effectiveness and efficiency of service delivery systems can be assessed by examining their impact on epidemiology. At all stages of the research process, the dynamic interactions between biological, psychological, and sociocultural environments are important to consider (Albee, 1996). Research solely examining intrapersonal factors that affect behaviors might ignore the context in which the individuals' behaviors occur and could result in incomplete or misleading conclusions (National Institute of Mental Health, 1998). It is important that prevention research examine the etiology of maladaptive behaviors and potential determinants, including biological, intrapersonal, interpersonal, community, and societal risk and protective factors. It is also recommended that evaluations of prevention interventions address how adaptive behavioral changes promoted by a specific program are valued within different environmental contexts.

Application. Psychologists conducting research on prevention are encouraged to take into account the interface between biological, psychological, and sociocultural variables and the best available evidence regarding epidemiology, intervention, and service delivery. Resources are available to identify evidence-based prevention interventions for different demographics, topical areas, and contexts. One such resource is the National Registry of Evidence-Based Programs and Practices (http://www.nrepp.samhsa.gov/Index.aspx), compiled by the U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Psychologists are encouraged to consider the social ecology of the community in which they work (Bronfenbrenner, 1979) and to collaborate with community stakeholders on research goals and methods (Caplan & Caplan, 2000; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Sullivan et al., 2001). Researchers are encouraged to assess the differential impact of prevention programs on specific communities. Prevention researchers may unknowingly design and evaluate programs using criteria from their own cultural perspectives and worldviews and may miss important contextual factors that contribute to the success or failure of prevention interventions within specific communities and cultures (e.g., diverse social classes and socioeconomic groups; Trickett, 1998; Turner, 2000). Community collaboration is important in the interpretation and application of research findings and for the provision of oversight and monitoring of community-based research. PAR is one example of collaborative research that appreciates environmental contexts and recognizes that knowledge is coproduced through collaborative actions with those who have traditionally been left out of the research process and whose lives are most affected by the research problem (Prilleltensky & Nelson, 2002).

Guideline 5. Psychologists are encouraged to consider ethical issues in prevention research and practice.

Rationale. Psychologists are required to adhere to ethical standards of the profession and to be mindful of its highest ideals (APA, 2010). Prevention efforts may raise unique ethical issues (Bond & Albee, 1990; Waldo, Kaczmarek, & Romano, 2004). Prevention is typically conducted with numerous participants and has individual, sys-

temic, and societal implications. It is important to evaluate possible negative impacts that preventive interventions may have on individuals, the community, or the larger society (Bloom, 1993; Caplan & Caplan, 1994). For example, conducting preventive interventions that identify higher risk within a historically stigmatized group could be harmful to members of that group. Thus, it is important that confidentiality be adhered to during the prevention intervention process (Bloom, 1993). Additionally, targeted behavior may serve one or more purposes for the individual and community; eliminating the behavior without attention to its possible protective functions may lead to negative consequences for a segment of the community.

Application. Psychologists are encouraged to be knowledgeable regarding methods and designs in prevention research and practice within their boundaries of competence (APA, 2010, Ethical Standard 2.01). It is important that preventive interventions and research include considerations of the ethical implications of new or promoted behaviors before, during, and after a prevention intervention. Informed consent poses particular challenges with regard to ensuring that individuals and multiple stakeholders comprehend the implications of their participation. Other ethical issues to consider include equitable selection, confidentiality, cultural relevancy, socially and culturally competent research and practice (APA, 2010, Ethical Standards 8.02 and 2.01b), and researcher bias (Schwartz & Hage, 2009). It is important to evaluate the long-term effects of preventive interventions (Brown & Liao, 1999), especially as they relate to historically marginalized groups.

Guideline 6. Psychologists are encouraged to attend to contextual issues of social disparity that may inform prevention practice and research.

Rationale. Considerations of social disparities can provide a context for prevention work in which the causes and effects of oppression can be identified and considered. Reducing social disparities is essential for preventing the myriad of problems that they spawn (e.g., Vera, Buhin, & Isacco, 2009). For example, children living in disadvantaged neighborhoods are at risk for childhood behavioral difficulties, including conduct disorders, mental health problems, academic failure, and teen pregnancy (e.g., Goodnight et al., 2012; Harding, 2003; Leventhal & Brooks-Gunn, 2000; Nikulina, Widom, & Czaja, 2011). For adults, those living at or near poverty level have a greater incidence of major depressive disorder than those with higher incomes (e.g., Kessler et al., 2003). Furthermore, numerous health problems (e.g., diabetes, obesity, coronary heart disease) have been associated with living in poverty (e.g., Kittleson et al., 2006; Ludwig et al., 2011). Consistent with these considerations, the importance of creating contexts of fairness in order to improve the health and wellness of those served by prevention programs has been emphasized (Lawson, Noblett, & Rodwell, 2009; Prilleltensky, 2001, 2012; Tepper, 2001).

Application. Psychologists strive to be cognizant of the social implications of the preventive services they offer. For example, interventions that fail to consider those structural inequalities and contextual factors (e.g., social class, socioeconomic status) that influence behavior may inadvertently suggest that the problem lies within a particular group instead of acknowledging the influence of being marginalized in society (Walker, 2009). Prevention interventions may have maximum impact if societal inequalities related to social class, economic status, discrimination, and exploitation are considered (M. J. Perry & Albee, 1994). Dissemination of prevention findings grounded in the social ecology of the community may aid in acknowledging inequalities that may contribute to or exacerbate a particular behavior that is the target of intervention. For example, lesbian, gay, bisexual, transgender, and queer young people who are bullied in school may be experiencing not only homophobia reactions from peers but also bullying based on racial/ethnic, gender, and/or class identities (American Psychological Association, 2012b; Singh & McKleroy, 2011).

Guideline 7. Psychologists are encouraged to increase their awareness, knowledge, and skills essential to prevention through continuing education, training, supervision, and consultation.

Rationale. The *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (APA, 2009) stress the importance of education and training that cover the breadth of psychology. Research suggests that prevention helps to reduce the need for remedial interventions (Schwartz & Hage, 2009; Vera et al., 2009). Therefore, remediation and prevention are best viewed as complementary to one another, not in conflict. However, despite psychology's history with prevention practice and research during the 20th century (Cowen, 1973; Elias, 1987), the education of psychologists continues to emphasize crisis interventions and remedial approaches, giving much less attention to prevention as a core component of training and education (Matthews, 2003; O'Byrne, Brammer, Davidson, & Poston, 2002; Snyder & Elliott, 2005). Although some psychologists learn about the development and implementation of prevention activities in graduate school (e.g., community psychologists), most new prevention interventionists do not have a high level of training in the established content areas of prevention, and more-established professionals report low levels of knowledge in newer areas of prevention (e.g., gender and culture issues, economic analysis of prevention; Eddy, Smith, Brown, & Reid, 2005). This research suggests that much of the education and training in prevention is learned through less formal methods than graduate education. In psychology graduate education, there is a need to expand opportunities to learn about prevention by developing prevention-based courses and/or infusing prevention-related content into existing courses (Conyne, Newmeyer, Kenny, Romano, & Matthews, 2008; Matthews & Skowron, 2004).

Application. The training and continuing education of psychologists in awareness, knowledge, and skills related to prevention provide psychologists with resources to be proactive in reducing human suffering and in promoting positive aspects of human functioning. Psychologists are encouraged to obtain education and training in preventive approaches through various pathways, including respecialization programs, postdoctoral fellowships, continuing education programs, self-study, conferences, professional societies that focus on prevention, and combinations of such alternatives. Other avenues include service learning and experiential work in community settings less typical for psychologists (DeLeon, Dubanoski, & Oliveira-Berry, 2005). Predoctoral psychology graduate students may also consider taking advantage of coursework, practicum experiences, and predoctoral internships that have a prevention focus. Psychology training programs can also encourage enrollment in prevention courses in other disciplines, such as public health, thus encouraging training in interdisciplinary perspectives important to prevention. Those already in practice and unable to participate in concentrated, formal training programs may be able to utilize continuing education programs. Psychologists may also gain supervised experience and consultation working with psychologists, or other professionals, skilled in prevention. Because public health has a strong focus on prevention, increased training and collaboration with professionals in the field of public health are encouraged. Through more formal education, psychology trainees and psychologists may consider earning dual degrees in public health (e.g., a master's in public health) and psychology. The collaborative training, which pairs psychologists' understanding of human behavior and public health professionals' knowledge of health and prevention at community or population levels, may be particularly effective at creating change at the societal level. Literature relevant to prevention is available through professional journals, including a growing number of applied journals in, for example, psychiatry, public health, and psychology. Prevention research and applications are also disseminated through professional organizations and their respective conferences.

Scholars have noted several knowledge and skill domains important to psychologists engaging in prevention (Conyne, 1997; Hage et al., 2007; O'Neil & Britner, 2009). The domains include (a) understanding distinctions between preventive and remedial approaches; (b) designing and implementing educational programs; (c) assessing community needs; (d) understanding systemic approaches that incorporate cultural and contextual factors into preventive interventions; (e) using group skills and approaches, when appropriate, in program design and implementation; (f) collaborating with interdisciplinary teams that include professionals and community leaders; (g) grant-writing and marketing skills to address sustainability of preventive efforts; (h) promoting positive development across the life span; (i) empowering individuals and communities to work on their own behalf; (j) developing strength-based approaches that reduce risk and enhance resilience in individuals and communities; (k) influencing policy decisions and their impact on preventive efforts; and (l) evaluating preventive interventions. Each of these domains of knowledge and skill in prevention ideally would include attending to the needs and concerns of historically marginalized groups and would consider power differentials as they relate to cultural differences and concerns of social inequalities. In addition, training in newer technologies, such as telepsychology and social media, is important as these technologies are emerging methods for preventive efforts.

Guideline 8. Psychologists are encouraged to engage in systemic and institutional change interventions that strengthen the health of individuals, families, and communities and prevent psychological and physical distress and disability.

Rationale. Applications of prevention through systemic interventions are important across many domains. Systemic preventive interventions include those that affect families, schools, communities, and work environments. Individuals may not be able to achieve maximum health or full social participation if systemic barriers, such as classism, racism, sexism, and poverty, prevail. Preventive programs that focus only on changing individuals are likely to be less effective than those that also address the contexts that support or inhibit development and optimal health. Systemic interventions can be delivered across the life cycle, but the earlier prevention occurs, the greater the likelihood of reducing risk and strengthening protective factors (E. J. Smith, 2006). Systemic preventive programs that focus on developing community norms that promote healthy lifestyle behaviors are effective in reducing societal problems (Orpinas, Horne, & the Multisite Violence Prevention Project, 2004).

Application. Psychologists are encouraged to engage in activities that produce positive systemic, institutional, and organizational change. Psychologists can contribute to systemic change that strengthens protective and resiliency factors of individuals, families, schools, workplaces, faith communities, community centers, and health care centers (Johnson & Millstein, 2003; Kumpfer & Alvarado, 2003; Morsillo & Prilleltensky, 2007; Wandersman & Florin, 2003). For example, organizational psychologists can assist in the development of corporate policies to reduce work stress and stress-related illnesses and to increase worker satisfaction and productivity (Murphy, Hurrell, & Quick, 1992). Other examples include school-based preventive programs that address the multiple needs of students across the school and community. Such programs have yielded positive results and enhanced students' emotional, social, and academic development (e.g., August, Hektner, Egan, Realmuto, & Bloomquist, 2002; Greenberg et al., 2003; Newman-Carlson & Horne, 2004). School-based interventions that incorporate health promotion, competence enhancement, and youth development as frameworks for prevention can reduce youth risk behaviors and enhance protective factors (e.g., C. L. Perry, 1999; Weissberg & Greenberg, 1998). A recent meta-analysis of

after-school programs indicated that programs that foster personal and social skills of youth provide the greatest benefit (Durlak et al., 2010). School-based systemic interventions may also inform policies that address inequities and discrimination among groups of students (Morsillo & Prilleltensky, 2007).

Psychologists can influence the structure, role relationships, premises, rules, and assumptions governing systems to empower communities and to promote justice and equity (Evan, Hanlin, & Prilleltensky, 2007). Psychologists in health care settings can promote employee programs that strengthen employee resiliency in order to inoculate employees against the physical and psychological demands of the work setting (Freeman & Carson, 2006). Another area of systemic application is advocating for healthy food choices in cafeterias, lunchrooms, and vending machines to promote healthy nutrition, which, when coupled with an active lifestyle, can reduce obesity and resulting health risks (Hawkes, 2007; Suarez-Balcazar et al., 2007).

Parent- and family-based interventions can help parents and other caregivers learn effective child-rearing skills to strengthen adult and child relationships, which, in turn, reduce child and adolescent behavior problems and enhance learning (Thornton, Craft, Dahlberg, Lynch, & Baer, 2002). Applications of systemic prevention interventions at later stages of life include community-based programs that support older adults living in their homes. Elders with sufficient physical and emotional capacity will benefit from community preventive programs that involve them in community volunteer opportunities, public policymaking, neighborhood networking, and social support groups (Konnert et al., 1999).

Guideline 9. Psychologists are encouraged to inform the deliberation of public policies that promote health and well-being when relevant prevention science findings are available.

Rationale. Psychologists are well positioned to educate and inform policymakers about the importance of prevention to enhance health and well-being (Kiselica, 2004). For example, public policy–based prevention programs such as Project Head Start have been an integral part of preventive initiatives that promote human functioning and reduce negative health outcomes (Ripple & Zigler, 2003). Psychologists are encouraged to apply their expertise by informing policymakers about the value of evidence-based preventive initiatives and to communicate their research findings clearly and concisely to policymakers (Coates & Szekeres, 2004; Hage et al., 2007; Ripple & Zigler, 2003).

Application. Psychologists are encouraged to become informed about public policy debates in which prevention research and programs may have relevant information to contribute to the discourse. Psychologists strive to enter such discussion and inform policymakers at local, state, and national levels by using their expertise and scholarship in prevention science as appropriate. For example, at the Surgeon General's Conference on Children's Mental Health in 2000, psychologists provided recommendations to help formulate a national policy on children's mental health (Levant, Tolan, & Dodgen, 2002). It is suggested that psychologists become familiar with APA resources that are relevant to health care policy and health promotion. They are also encouraged to consider strengthening their efforts by forming multidisciplinary partnerships that include government, legal, and policymaking experts, as well as professionals from the health, social, and educational sciences. For example, Jason (2012) described a 20-year collaborative effort between psychologists and patient advocacy organizations to effect change in multiple areas regarding the problem of chronic fatigue syndrome, including epidemiological evidence, criteria for diagnosis, and leadership at the Centers for Disease Control and Prevention. As another example of collaboration, in 1965, Head Start began as a White House initiative that included the collaboration of psychologists, sociologists, and pediatricians focused on the goal of reducing the deleterious effects of poverty on young children (Styfco & Zigler, 2003). Furthermore, it is recommended that graduate programs teach students about the relationship between research and its relevancy to informing policy (Ripple & Zigler, 2003).

Conclusion

The Prevention Guidelines encourage psychologists, including those within the policymaking process, to strive to engage in prevention practice, research, and education to enhance human functioning. Prevention has numerous benefits, including the potential to strengthen the integration of science and practice in psychology (Biglan, Mrazek, Carnine, & Flay, 2003). Moreover, as discussed throughout the Guidelines, the benefits of prevention have been demonstrated through the reduction of illness and problem behaviors, the enhancement of human functioning, and the potential to reduce health care costs (Durlak et al., 2010; Institute of Medicine, 1994; Nation et al., 2003; National Research Council & Institute of Medicine, 2009). An increased focus on prevention has the potential to mobilize psychologists to respond more effectively and sensitively to conditions that place individuals, communities, and institutions at risk for various problems and to promote strengths that contribute to human functioning.

The Guidelines provide a framework for best practices in prevention and the promotion of health and well-being, regardless of an individual psychologist's specialty area, employment setting, or professional interests. Infusing prevention across the profession will help to orient psychologists to a broader application of psychological research and practice, with the goal of more effectively and sensitively responding to major societal needs for all individuals, especially those with the fewest resources and groups historically underserved by the profession.

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Appendix
Guidelines for Prevention in Psychology

Guideline 1. Psychologists are encouraged to select and implement preventive interventions that are theory- and evidence-based.

Guideline 2. Psychologists are encouraged to use socially and culturally relevant preventive practices adapted to the specific context in which they are implemented.

Guideline 3. Psychologists are encouraged to develop and implement interventions that reduce risks and promote human strengths.

Guideline 4. Psychologists are encouraged to incorporate research and evaluation as integral to prevention program development and implementation, including consideration of environmental contexts that impact prevention.

Guideline 5. Psychologists are encouraged to consider ethical issues in prevention research and practice.

Guideline 6. Psychologists are encouraged to attend to contextual issues of social disparity that may inform prevention practice and research.

Guideline 7. Psychologists are encouraged to increase their awareness, knowledge, and skills essential to prevention through continuing education, training, supervision, and consultation.

Guideline 8. Psychologists are encouraged to engage in systemic and institutional change interventions that strengthen the health of individuals, families, and communities and prevent psychological and physical distress and disability.

Guideline 9. Psychologists are encouraged to inform the deliberation of public policies that promote health and well-being when relevant prevention science findings are available.

• **Rejoinder**

Walking the Talk:
Implementing the Prevention Guidelines and Transforming the Profession of Psychology

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The Major Contribution aimed at strengthening a prevention focus in psychology, so as to more effectively and equitably promote the well-being of all members of psychology communities. The 3 reactions (L. A. Bond & A. Carmola Hauf, 2007 [this issue]; L. Reese, 2007 [this issue]; E. Rivera-Mosquera, E. T. Dowd, & M. Mitchell-Blanks 2007 [this issue]) give strong support for the best practice prevention guidelines, while providing new insights for their implementation in the field of psychology. In this rejoinder, the authors make an effort to build upon their colleagues' ideas, by addressing the topics of community-based collaboration, prevention across the life span, and implementation of the best practice guidelines. The authors urge further interdisciplinary collaboration by members of the American Psychological Association, and others interested in prevention, and invite genuine action to expand prevention efforts.

Undoubtedly, the expression—"You can talk the talk, but can you walk the walk?"—is familiar to many people. A shortened variation of the original phrase, "Walk the talk," may be less well known but can be found in the *Encarta World English Online Dictionary* (2006), and is defined as "to act on what you profess to believe in or value." The words suggest that real

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change happens when leaders not only say they want change and advancement but also match their words with actions. We are grateful to the authors who provided reactions to our article (Bond & Carmola Hauf, 2007 [this issue]; Reese, 2007 [this issue]; Rivera-Mosquera, Dowd, & Mitchell-Blanks, 2007 [this issue]). Their thoughtful commentary and suggestions highlight the importance of moving these Prevention Guidelines (Hage et al., 2007 [this issue]) from a publication in a scholarly journal to genuine actions for change in the field of psychology. We are also grateful to *The Counseling Psychologist* (*TCP*) Editor Robert T. Carter who gave us the opportunity to develop the article into a Major Contribution manuscript, and to receive reactions to these guidelines by eminent scholars in the field.

The reaction articles in this Major Contribution include authors from specialties in social work, clinical psychology, and counseling psychology. In addition, they represent work settings as diverse as university psychology departments, a government mental health department, a community advocacy agency, and a medical school. The work of prevention is multidisciplinary, and it is critically important that researchers, practitioners, and policy makers from across the professional landscape collaborate and form partnerships to advance a prevention agenda. We are extremely pleased and honored that these scholars, from different specialties and professional work environments, have given their reactions to the guidelines. In the limited space in this rejoinder, we will address several of the issues presented by the reaction articles.

COMMUNITY-BASED COLLABORATION

Bond and Carmola Hauf (2007), Reese (2007), and Rivera-Mosquera et al. (2007) all identified the importance of collaboration as a central component of best practices in prevention. Although our guidelines did not explicitly address collaboration, our third practice guideline emphasizes the importance of including "clients and other relevant stakeholders in all aspects of prevention planning and programming" and thus recognizes the necessity of forming community partnerships in prevention work (p. 508). That being said, the reactants did a service by further emphasizing the importance of collaboration as an integral component of best practices at several levels. All three reaction articles note that the perspectives and knowledge base of any single profession are limited in informing and guiding the practice of prevention. Indeed, these authors collectively describe why collaboration should occur at the local community level, with other helping professionals, and with scholars and researchers from other disciplines.

Bond and Carmola Hauf (2007) maintain that interdisciplinary scholarship should provide the theory and research base for effective prevention. They effectively explain how community collaboration is critical to the development of comprehensive and multisystemic interventions. In addition, Rivera-Mosquera et al. (2007) advocate for collaboration across the health and mental health professions, including counseling and clinical psychologists, social workers, nurses, and public health workers. Reese (2007) similarly notes that the knowledge base of multiple disciplines, such as epidemiology, health, economics, and sociology, are integral to public health practice and prevention. By insulating ourselves from other disciplines and professions, we are likely to miss important research knowledge. Similarly, by cutting ourselves off from the communities we serve, we may miss an understanding of local needs and knowledge. Furthermore, from a training perspective, learning the art of collaboration represents an example of an area where even more "how to" guidance is needed. Some authors (e.g., Kenny, Sparks, & Jackson, in press) are documenting their work in collaboration in efforts to identify lessons to further guide training and practice in interprofessional collaboration. Developing and sustaining effective collaborations with multiple stakeholders and then negotiating and reconciling the competing needs represented by varied perspectives are challenging tasks.

Similarly, as Bond and Carmola Hauf (2007) suggest, community-based collaboration enables more accurate and relevant prevention research. One potential function of Waldo and Schwartz's (2003) prevention research matrix presented in this issue is to point out how diverse sources of expertise available through community and interdisciplinary collaboration can be integrated to conduct comprehensive prevention research. For example, community members can provide unique information on the epidemiology of problems within their community; they can inform the design of preventive interventions, ensuring they are targeted on the most salient variables and are sensitive to community norms; and they can identify the systems and resources within a community that will allow wide and sustained delivery of prevention services.

The expertise of different disciplines may also make unique contributions in each of these service areas. For example, the field of public health is especially suited to clarifying epidemiology, clinical psychology is strong in the design and evaluation of interventions, and the social work profession is adept at creation and assessment of service delivery systems. Rivera-Moquera et al. (2007) eloquently state that "each of us brings a unique experience and set of skills that are needed to begin to address the serious societal problems facing our country and our world" (p. 590). Hence, the diverse communities and professional disciplines must work

together in "sharing our skill sets, lessons learned, and methodology to bring about real social change" (Rivera-Mosquera et al., 2007, p. 590).

Nevertheless, in spite of our strong agreement with all three of the reactants that collaborative community partnerships are critically important to the work of prevention specialists, we are reluctant to identify the forming of such partnerships as the "overarching best practice" of prevention. The major reason for our hesitation to adopt this perspective, as argued by Bond and Carmola Hauf (2007), is that "community" is too often interpreted narrowly. A framework of "community" may not give sufficient visibility to educational training of psychologists or political advocacy for prevention. As Rivera-Mosquera et al. (2007) comment, the four conceptual areas of the guidelines, which include practice, research, training, and social advocacy, provide a necessary conceptual framework. In addition, a community is not a single voice and may, for example, include parents, teachers, businesses, workers, social services agency leaders, clergy, and youths. In addition to a divergence in voices emanating from the field, these voices may not be congruent with those from multiple professions and scholarly disciplines. Thus, although better practice may eventually emerge, the processes through which this happens are not always clear. Indeed, Bond and Carmola Hauf (2007) recognize the tensions that often exist when preventionists attempt to apply prevention interventions across diverse groups of people.

One method to address specific needs across divergent groups or to assess in-group differences is through a process called "elicitation research" (Flores, Tschann, & Marin, 2002). This research process collects information during the development phase of a prevention intervention to better understand relevant personal cognitions and social norms important to a group or population receiving the intervention, thus strengthening the relevancy of the intervention for those receiving it. Conducting elicitation research prior to finalizing a prevention intervention increases the chances of a successful outcome for behavior change by addressing variables important to the group being served. Romano and Netland (in press) demonstrated how elicitation research and the theory of reasoned action (Ajzen & Fishbein, 1980; Albarracin, Fishbein, Johnson, & Muellerleile, 2001) can address within-group differences in the development and implementation of prevention interventions.

PREVENTION ACROSS THE LIFE SPAN

Reese (2007) notes that many of the examples of prevention interventions provided in our set of Prevention Guidelines were drawn from practice with

young people, despite the fact that prevention theory and practice cut across the life span. We concur with Reese on his point and hope that our examples of effective interventions with youths do not lead readers to think of prevention as an activity only for the early years. Prevention is not only for children and adolescents but also must be applied throughout the life cycle, including the development of preventative interventions for diverse groups of women and men at midlife and communities of older adults. Indeed, developmental challenges, risks, and opportunities for positive development occur across the life span, and these many stages of life represent significant opportunities for prevention-minded psychologists to engage in active collaborative efforts across the disciplines. It is possible that many of our examples emerge from youth work because schools and colleges have been available settings for prevention interventions, and they also offer opportunities for funding of prevention research. As we move to increase the reality of prevention across the life span, we will need to find mechanisms to fund and house prevention activities for all phases of life.

There are indications that the field of psychology is increasing its attention to the unique needs of older adults. For example, interventions have addressed the prevention of suicide and depression in older adults (Heisel & Duberstein, 2005; Whyte & Rovner, 2006). In addition, the American Psychological Association (APA) Public Interest Directorate has established an Office on Aging, which coordinates APA activities pertaining to aging and geropsychology. The Office on Aging also supports the work of the APA Committee on Aging, which has published a handbook on psychology and aging (American Psychological Association Committee on Aging, 2006). This work recognizes that not only are people 65 years of age and older the fastest growing segment of the U.S. population, with an increasing number of these older adults of immigrant status or members of ethnic or racial minority groups, but that more than 5 million older adults have incomes below the poverty level or are classified as poor. Adulthood is also a period of life where adults confront a variety of changes related to families, interpersonal relationships, careers, health, and end-of-life issues. Prevention has a role to play in helping adults manage and prevent the adverse effects of these changes.

Hence, we welcome Reese's (2007) reminder to "cast a broad net" in the goal of expanding our prevention efforts. He insightfully challenges psychologists to more effectively address the interface of physical and mental health, and reminds us of the imperative to decrease health disparities and improve the quality of life of communities in the United States and abroad. His remarks reflect the social justice orientation out of which the Prevention Guidelines emerge. This perspective demands that we become aware of how the numerous systems that are part of U.S. society, including economic, governmental,

and educational structures, define truth for the entire community (Dounce, 2004; Dworkin & Yi, 2003). Prevention work can and should begin within the local context (e.g., to apply the social justice model in our own communities) but also needs to be thoughtfully concerned with systemic practices and the state of power and oppression around the globe. Our efforts must aim to enhance personal and collective well-being and to create social and political change aimed at improving environments where people live, learn, and work (Hage, 2005).

Similarly, we endorse Bond and Carmola Hauf's (2007) recognition of the importance of moving beyond a focus on strengths and protective factors at the individual level, to also address such strengths at multiple systemic levels (e.g., microsystem, organizations and institutions, community, sociopolitical, cultural–environmental). While strength-based models related to individuals have received attention in the literature, there is much less focus on strengths and protective factors of communities, organizations, and institutions. Hence, it is important to consider the strengths, as well as the limitations, of institutions, such as schools, cultural centers, faith communities, and community organizations, when planning and implementing prevention interventions.

IMPLEMENTATION OF THE PREVENTION GUIDELINES

In their reaction articles, Rivera-Mosquera et al. (2007) and Reese (2007) recognize the significance of moving beyond the "ivory tower" and the level of "rhetoric" to make the Best Practices Prevention Guidelines a reality. Similarly, Bond and Carmola Hauf (2007) remind us that prevention review articles of this nature have been presented in other professional journals, with remarkably similar conclusions. We would like to recognize the validity of these concerns, while also providing further explanation of the process of development of these guidelines. Members of the Prevention Section of Division 17 developed these Prevention Guidelines with the goal of eventually bringing them forth for adoption by APA and other professional organizations and government entities, as suggested by Reese (2007). Therefore, the Prevention Guidelines were formulated in accordance with Criteria for Practice Guideline Development and Evaluation, developed by APA in 1995 and later revised and approved by the APA Council of Representatives (American Psychological Association, 2002). The APA criteria specify that proposed guidelines, such as those presented in our article, need to focus on educating and informing the practice of psychologists, as well as stimulating debate and research. As such, the APA document specifies that guidelines "must be reasonable, well researched, aspirational in language, and appropriate in goals" (Section 1.1). Hence, the specificity of these requirements meant

that content related to the implementation of the Prevention Guidelines was mostly left out of our article. However, despite this limitation, the Prevention Guidelines are the first set of comprehensive prevention guidelines that encompass the major areas of prevention work (i.e., practice, research, training, and social advocacy) that have been prepared for eventual adoption by APA. Finally, as noted in our article, these guidelines are an "initial step" in what we hope will be a broader collaboration of psychologists working together to enhance and implement these recommendations for prevention within the Society of Counseling Psychology, other appropriate APA divisions, as well as APA and other professional organizations.

We share the concern voiced by Rivera-Mosquera et al. (2007): If further efforts beyond the publishing of these guidelines are not made, this work may likely "fail to provide forceful guidance for significant change" (p. 587). Hence, while the guidelines may be recognized, as Reese (2007) notes, as a "next step" in stimulating counseling psychologists to engage in prevention, they represent just one step, and further discourse on implementation and process is essential to move prevention more visibly from the fringes of the field to center stage in the profession. Similar comments were made by two past presidents of Division 17, Rosie Bingham and Derald Wing Sue, at the 2006 APA Symposium addressing the implications of these guidelines (Hage & Romano, 2006). In their presentations, Bingham and Sue drew comparisons between the Prevention Guidelines and the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (American Psychological Association, 2003) in terms of their movement from an academic article to implementation and action. In summary, the challenge for prevention specialists as well as the larger community of scholars and practitioners is to develop creative ways to advance a prevention agenda, and we hope that these Guidelines provide guidance.

We appreciate the specific recommendations put forth by the reactants for how best to advance the dissemination of the Prevention Guidelines, and would like to highlight some of their suggestions. Education and training, both at the pre- and the postdoctoral levels, was cited as one essential area for implementation. We strongly concur with Rivera-Mosquera et al. (2007) and with Reese (2007) in their recommendation that prevention theory, research, and practice need to be included within counseling psychology curricula at all levels. The challenge that demands further attention is how we move forward to infuse prevention practice and research not only in counseling psychology training but also throughout psychology education.

Reese's (2007) suggestion that the Prevention Guidelines become part of "any reading packet for courses on prevention" is well taken, as is the recommendation to include implementation of the Prevention Guidelines on the

agenda for discussion at the annual meeting of the Council of Counseling Psychology Training Programs. We would also suggest that the guidelines be included in the training of doctoral students and be discussed by other psychology training groups (e.g., Council of School Psychology Training Programs). Reese also suggests partnerships with professional organizations outside of psychology (e.g., public health), government entities (e.g., U.S. Department of Health and Human Services), and stakeholders in the community. We would add other academic disciplines (e.g., social work, counseling) as well as accreditation bodies such as the APA's Committee on Accreditation, the Council for Accreditation of Counseling and Related Educational Programs, and psychology as well as other mental health licensing boards to the list of disciplines and partnering organizations. Moreover, Rivera-Mosquera et al. (2007) note the importance of addressing the ethics of prevention. This need has begun to be addressed, although not as broadly as we would like (e.g., Hage & Schwartz, 2006; Schwartz & Hage, in press). Prevention practica are also urgently needed, as Reese (2007) suggests. Finally, developing the equivalents of "preventive medical residency programs" for counseling psychologists, as well as pre- and postdoctoral internships in prevention research and practice, are excellent suggestions that deserve careful consideration.

In addition, one of the most innovative ideas for dissemination of these guidelines comes from Rivera-Mosquera et al. (2007), who point out that the economics of prevention has been a major obstacle in furthering prevention efforts. Their unique contribution is the suggestion that preventive services be viewed as a type of therapeutic program. They argue that by conceptualizing prevention as a "therapeutic intervention," new avenues to support the work of prevention (e.g., third-party reimbursement) may emerge. By extension, if third-party reimbursement were to become possible for prevention, then the place of prevention in psychology education and training programs will be more fully secured. This perspective is an interesting one to consider and merits close attention and further discussion among scholars, practitioners, and policy makers. However, it may be more effective to develop financial models that can prove the cost-effectiveness of prevention, rather than compromising the conceptualization of prevention. For example, several recent studies have found that teaching clients interventions based on cognitive–behavioral therapy is cost-effective in preventing the onset of a full-blown depressive disorder (Churchill et al., 2001; McCrone et al., 2004; Schulberg, Raue, & Rollman, 2002; Smit et al., 2006). The dissemination of more findings like these studies on depression is critical in convincing policy makers and funding organizations that prevention is cost-effective.

Reese (2007) issues a similar call for prevention research that is relevant, disseminated, and utilized. We agree that too much good prevention research

remains academic, and thus fails to realize its potential to improve lives, particularly in communities disadvantaged by disparities in resources. We believe that including a focus on service delivery systems as an integral component of programmatic prevention research has significant potential for correcting this deficit. For example, we recommend that investigators examine the practical utility and economic feasibility of their research by utilizing the prevention research matrix presented in this issue, and by examining how a research project relates to the third category—Prevention Service Delivery Systems. The prevention research matrix provides a tool to understand the need for research and how the outcome of this research can inform the field. Understanding this process will often lead to more open and informed communication with participating communities about the meaning and scope of the prevention program at each step of the intervention.

CONCLUDING OBSERVATION

A final observation we would like to make is to underline the significance of the reaction articles being intentionally authored by a clinical psychologist, a counseling psychologist, and a social worker. This effort by *TCP* represents an excellent attempt at reflecting an important reality about prevention: It is an interdisciplinary science and practice that requires interdependent collaboration in order to be effective. We need more efforts like this one, including applications to education and training in prevention. In addition, Reese (2007) provides a valuable perspective as a counseling psychologist who previously was employed by the Centers for Disease Control and Prevention, and currently is in the Department of Community Health and Preventive Medicine, Morehouse School of Medicine. He observes that psychology must move prevention more forcefully from the margins of the field to the heart of the profession, and that the Society of Counseling Psychology ought to take the lead for all of psychology in making this transformation happen. We whole-heartedly agree with this perspective, and we invite psychologists and others interested in prevention to join this effort by becoming involved in the Prevention Section (http://www.div17.org/preventionsection).

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Prevention Activities in Professional Psychology:
A Reaction to the Prevention Guidelines

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In this reaction article, the authors provide a historical context for prevention activities and their place in psychological practice. They then discuss the prevention guidelines in the Major Contribution authored by S. M. Hage et al. (2007 [this issue]) and provide their critique. Finally, the authors offer ideas for the future specific applications of these general guidelines and illustrate with a case example.

Hage et al. (2007 [this issue]) are to be commended for their comprehensive, thorough, and thoughtful contribution. They have managed to pull together the relevant literature regarding prevention efforts and its supporting research, as well as organize this work into a set of aspirational guidelines. The scope of their efforts is truly impressive—a scope that has its own problems as well as its obvious successes. This response will first provide a brief historical context for prevention activities, and then provide a general response to these guidelines. We will conclude with ideas of our own for future applications of these guidelines and prevention in general.

HISTORICAL OVERVIEW OF PREVENTION

Hage et al. (2007) correctly state that prevention activities have historically been an important aspect of the practice of counseling psychology (p. 497). This is consonant with counseling psychology's developmental approach to mental health as compared with the more remedial approach of clinical psychology and the more case management approach of social work. Community psychology as a professiponal psychological specialty was

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originally intended to focus more on prevention (and ironically consists primarily of clinical psychologists), but it has never had the impact its founders envisioned. Although prevention has been an important part of counseling psychology since its early years, the authors note the paradoxical finding that despite a growing interest in prevention, counseling psychologists' actual prevention activities are quite limited (Hage et al., 2007, p. 498). The reasons, we suspect, are largely economic. The field of mental health, like that of physical health to which status it has consistently aspired, is now and always has been remedial in orientation. There is little money to be made in prevention, and during the 1970s and 1980s counseling psychology attempted to play "catch-up" to clinical psychology in obtaining third-party reimbursements for its services to individuals. Third-party payers in both medicine and psychotherapy typically do not pay for prevention, although in the long run it is cheaper than remediation. Therefore, advocating for preventive mental/physical health activities is likely to be a hard sell indeed, especially given the comprehensive, multiple causal factors, contexts, and domains to which Hage et al. argue we should devote our efforts (p. 529).

REACTION TO THE GUIDELINES

Overall, the guidelines appear to be well grounded in research, and the authors do a superb job of building their case for prevention. They demonstrate how the development of these guidelines evolved over time and were based in sound research as well as systemically discussed by key stakeholders before they were promulgated. This process gives the guidelines much more credence and potential for acceptance by the entire psychological community. The authors have taken a complex and convoluted area of practice/research and narrowed it down to guidelines that can help psychologists conceptually organize how they might best begin to engage in prevention work. While the guidelines are phrased in very cautious language that may make them more politically acceptable in some quarters, they may also fail to provide forceful guidance for significant change in the practice of psychology.

The authors' categorization of the guidelines into four conceptual areas (practice, research and evaluation, education and training, and social and political advocacy) is critical because it sets up the conceptual framework for the areas in which psychologists should be engaging in order to do prevention (Hage et al., 2007, p. 501). These domains will be discussed in more detail in the following sections.

Practice

The practice guidelines set the broad overarching guidelines for the practice of prevention. Guidelines 1–5 describe the basic elements necessary for the practice of prevention. Hage et al. (2007) use this section to call for psychologists to actively engage in the practice by (a) developing proactive programs that prevent human suffering; (b) basing prevention programs in empirical research; (c) using culturally relevant prevention practices as well as engaging key stakeholders in all levels of the planning and implementation process; (d) addressing both individual and social contextual factors; and (e) focusing on both reducing risks and promoting the strengths of the targeted groups (pp. 501-519). These best practices build upon the general principle of justice and respect for people's rights and dignity (Hage et al., 2007, p. 495). We agree that these should be the core components in the practice of prevention, and are especially pleased that culturally relevant prevention was included as one of the top three guidelines. It is critical that programs targeting marginalized groups such as ethnic minorities, the hearing impaired, Appalachian, lesbian/gay/bisexual/transgender, and other cultural groups adapt their programs to meet the cultural and linguistic needs of the population as well as involve the stakeholders from these communities at all levels of the planning and implementation process (Reese & Vera, 2007).

Research and Evaluation

This domain (Guidelines 6–9) was the most difficult for us to "wrap our heads around" conceptually; in part, this may be because of the sheer complexity of prevention literature. Although the term *prevention science* was coined at a National Institute of Mental Health prevention conference in 1991, it does not appear to have infiltrated the field of psychology to its fullest extent. Thus, psychologists may not be as familiar with the field as other disciplines such as public health and social work (Hage et al., 2007, pp. 519-533). Undoubtedly, the field of psychology needs to actively engage in prevention efforts that are accurately targeted, efficiently executed, rigorously evaluated and that focus on the systemic empirical study of risk and protective factors impacting health and psychological dysfunction (Bloom, 1996).

We liked the authors' use of the National Institute of Mental Health's categorization of prevention research that classifies prevention research into three functions (preintervention epidemiology, preventive intervention [primary, secondary, and terciary], and prevention service delivery system) and three levels (biological, psychological, and sociocultural; Hage et al., 2007, p. 520). This classification matrix can guide prevention researchers toward literature

they need to examine prior to conducting their studies, as well as help them identify future directions for research based on their findings (Waldo & Schwartz, 2003).

We agree wholeheartedly with Guideline 7 that calls for psychologists to be competent in a variety of cross-disciplinary research methods, both qualitative and quantitative. We want to point out that the potential number of contextual variables and the possible interaction effects that Guideline 8 alludes to, which may occur in prevention research, are truly mind-boggling. Guideline 9 (ethical issues) is very important and perhaps deserves a domain of its own because prevention research can be fraught with ethical dilemmas.

Education and Training

This domain (Guidelines 11 and 12), in our estimation, is one of the most important sections because psychologists must be educated early in their training on the how and why to engage in prevention and social justice issues, if they are to do so later in their careers. The guidelines appear to be geared toward psychologists who have completed their PhD training rather than current PhD students. We would like to see prevention theory, research, and practice worked into the curriculum of every psychology student at all levels (BA, MA, PhD, and PsyD) in order to prepare future psychologists in the prevention field, much like social work has done in the National Association of Social Workers' policy statement on mental health (National Association of Social Workers, 2003–2006). This prevention training should seek to expand psychologists' repertoire of skills to include cross-disciplinary training in advocacy, grant writing, program development, and grassroots community involvement needed by psychologists to perform prevention work (Bluestein, Goodyear, Perry, & Cypers, 2005). It could also include training on the ecological prevention approach espoused by the field of social work (Kriste-Ashman, 2000).

SOCIAL AND POLITICAL ADVOCACY

This domain is made up of Guidelines 13–15, which are equally as critical because they call for psychologists to step out of their traditional roles and engage in political processes in order to improve the world in which they live. Many decisions affecting physical/mental health care are made on the basis of political considerations, rather than on scientific or educational merit. Whether because of insecurity, disinterest, or disdain, it is tempting for psychologists to leave this work to others, not recognizing that psychologists are the experts in behavior change. The skills psychologists possess

could be applied to any arena in which behavior change is warranted, including but not limited to the political process as well as the more traditional areas of schools, health care, violence prevention, and so forth. Psychologists need to become part of solving these serious social problems facing our country and world (Albee, 1986). Unfortunately, these are exactly the areas in which our efforts may be most controversial and, thus, uncomfortable for our profession.

WHERE DO WE GO FROM HERE?

Although these guidelines provide an overarching set of best practices, they fall short in that they do not provide the necessary information for "how to" do this work. These guidelines are broadly stated and therefore may not provide the direction or structure a psychologist may need in order to become competent in prevention work. Nevertheless, the guidelines serve as the springboard for further investigation into how the field of psychology will actually train, cultivate, and develop psychologists who will engage in proactive, socially just prevention work.

The choice to have a clinical and a counseling psychologist as well as a social worker respond to this article was purposeful. Clearly, each of us brings a unique experience and set of skills that are needed to begin to address the serious societal problems facing our country and our world. We must work together as professional disciplines, sharing our skill sets, lessons learned, and methodology to bring about real social change. As eloquently argued by Hage et al. (2007), prevention work needs to be at the forefront of a comprehensive mental health agenda (p. 494). We would argue, however, that the term *prevention* may need to be expanded in order for this to occur. Prevention is often juxtaposed with remediation, as if they were dichotomous constructs. It is our premise that prevention and remediation lie on a continuum, with group-based interventions occupying a space somewhere in between.

We would argue that prevention should be viewed as one of the tools on the continuum of therapeutic/treatment services and that the paradigm shift should consist of the acknowledgement that some of what we are labeling as prevention could actually be considered therapeutic interventions that are empirically based, well grounded in theory, and developed from a thorough assessment of need (Nation et al., 2003). For example, the first author (a clinical psychologist), along with her training director and fellow counseling psychology interns, while on their American Psychological Association internship at the University of Akron's Testing and Career Center, developed a grassroots career and college preparation program called Latinos on the Path to Higher Education (Rivera-Mosquera, Phillips, Castelano, Martin, &

Mowry, 2007). The goals of the program were to reduce the dropout rate and improve the college entrance of Latino youths—both serious societal problems facing the United States. The interns, utilized the first author's strong clinical assessment and treatment skills, in addition to the counseling psychology interns strong career development and educational prevention skills, to design and implement the program in a local Hispanic church. Most of the students recruited for this program could have been treated individually by any number of disciplines within psychology in an office environment, and the therapist could have secured third-party payment based on issues of learning/academic difficulties. The difference was that insurance covered interventions provided under the individual remedial model and not under the prevention model. It is our premise that prevention programs that are grounded on clinical and counseling theories of psychological behavioral change are actually psychotherapeutic in nature and, thus, should be called psychotherapeutic prevention programs that could be reimbursed as treatment interventions by third-party payers.

The question then becomes: How do psychotherapeutic prevention programs differ from group therapy? The goal of group therapy is, of course, for the group process to facilitate behavior change in the individuals in that group. This is also true for psychotherapeutic prevention. Perhaps the primary difference is the targeted audience. Psychotherapeutic prevention programs are generally larger in scope, may address more issues simultaneously, and usually reach a larger audience. We propose that well-researched and well-designed psychotherapeutic prevention programs be viewed as a form of group therapy and, thus, be considered as psychological treatment interventions. Viewing prevention as a treatment tool opens the doors for innovative programs to be developed and funded that may not only prevent symptoms from developing in targeted populations but could also provide a group therapeutic process to change behavior on a larger scale.

There are several skills that psychologists will need to develop in order to conduct prevention work, particularly when working with difficult-to-reach communities such as ethnic minorities. First and foremost, psychologists need to develop a strong personal relationship with the targeted community. The success of the Latinos on the Path to Higher Education program was based primarily on the quality of the relationship between the first author and the community. We recommend that psychologists and other mental health providers go out into the community and cultivate these essential relationships of trust early on in their training so that the stage will be set for program development later. Professors and students must venture out of the "ivory towers" and into the community (churches, mental health clinics, and social service agencies) to explore and experience the social environment and issues surrounding them. Ethically, psychologists should not develop prevention

programs if they have not ever ventured into or experienced firsthand the community in which they plan to research or work.

In addition to developing a trusting relationship, psychologists will also need to cultivate a number of other skills such as advocacy, program development, grant writing, cultural competence/cultural humility, social justice, and qualitative and quantitative evaluation skills—just to name a few (Romano & Hage, 2000). Unfortunately, these skills are not necessarily taught in traditional psychology programs, not even at the doctoral level. Psychology programs should embrace a cross-disciplinary model and allow students to take courses in other fields that focus on systemic change and/or advocacy such as social work, public health, nursing, anthropology, and forth. Training models such as the one used in the Latinos on the Path to Higher Education program could be readily taught and integrated into doctoral training programs. The program benefited all of those involved because the youths and their parents obtained a set of self-efficacy skills, and the interns had an enriched training experience that enhanced their skills in the area of community engagement, outreach, advocacy, and cultural competence. In addition, models of training such as the two pedagogical strategies (service learning and problem-based learning), which Hage et al. (2007) discuss in their article, could be quite effective in teaching psychotherapeutic prevention models in psychology courses (p. 539). The authors even include a mock syllabus for one of the strategies, making it easier for instructors to develop a prevention course. Throughout their article, Hage et al. offer practical advice and exposure to practical prevention research, which can be quite useful to psychologists seeking to engage in prevention work.

CONCLUSION

Hage et al. (2007) have provided a valuable service to the field of psychology by providing a set of guidelines that can be used as a springboard for further research and development in the field of prevention. Undoubtedly, an increased emphasis on prevention will require that the field cultivate psychologists who are community-oriented and committed to social justice as well as to political advocacy so that psychotherapeutic prevention programs may flourish. Students of psychology must be exposed to important issues faced by American society early in their training. Practical experiences with marginalized individuals such as ethnic and cultural minorities, the hearing impaired, lesbian/gay/bisexual/transgender groups, and others are needed so that students can begin their training on psychotherapeutic prevention development and programming. Psychology students should first understand and acquiesce to the social justice model as well as develop an empathic connection with the

movement of marginalized groups or affected societal segments before they can effectively develop, plan for, and engage in psychotherapeutic prevention work. Psychology students also need to volunteer and become active in the targeted group in order to develop a strong relationship of trust with that community. This relationship is the cornerstone for the effective delivery of prevention work. Psychology departments, as well as placement and internship sites, must make a concerted effort to not only integrate prevention into their curriculums but also to help students connect to and engage in experiential learning in the targeted communities. In addition, psychologists need to become active and lobby for the funding of psychotherapeutic prevention programs as treatment interventions. Fortunately, the President's New Freedom Commission, which President George W. Bush established in 2002, seems to be leading the charge for establishing prevention as a viable treatment tool in the arena of mental health. This prevention-focused paradigm shift may have finally begun to take root.

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