

the Behavior Therapist

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ACCESS AND EQUITY

Development and Implementation of a Diversity Training Sequence in a Clinical Psychology Doctoral Program

Anna M. Bardone-Cone, Casey D. Calhoun, Melanie S. Fischer, Ashly L. Gaskin-Wasson, Shawn C. T. Jones, Scott L. Schwartz, Erica H. Wise, and Mitchell J. Prinstein, University of North Carolina at Chapel Hill

IT WAS 2012 AND WE WERE STARTING a new academic year in our clinical psychology doctoral program at the University of North Carolina at Chapel Hill (UNC). Our diversity training committee of a half dozen students and a faculty member were meeting to discuss the year ahead. In our discussion it became clear that while our program started out strong with a multicultural orientation attended by first-year students, and ended strong with a course on multiculturalism for advanced students, these felt like bookends. Although there were diversity-related events that occurred during the year, and students were encouraged to be mindful of diversity during their time at UNC and to bring up diversity-related topics in classes and with their advisors, nothing concrete was in place to ensure training continuity from start to end in the program. Committed to rectify this, our group set out to develop discrete experiences that would benefit our students,

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the Behavior Therapist

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building on their integrated awareness, knowledge, and skills related to multiculturalism (Sue, 1991; Sue & Sue, 2013). Consistent with research and best practice recommendations in multicultural training, it was important to incorporate a range of pedagogical approaches incorporating research and experiential components (e.g., Johnson & Jackson Williams, 2015; Morgan Consoli, & Marin, 2015). In this article, we share some background to our diversity training committee along with our philosophy and goals, and we describe the nature and timing of the core discrete experiences that make up our diversity training sequence.

The UNC clinical psychology program has had an active diversity training committee since 1998, when it was formed in response to students and faculty identifying a need for better diversity training following an American Psychological Association (APA) site visit. (See the *APA Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists*; APA, 2002.) Created as a joint student-faculty initiative, the committee was developed to be a forum where we could discuss diversity topics; organize diversity-related events, such as movie nights that brought forth relevant topics for discussion; and help recruit diverse students via, for example, hosting an admissions brunch for racial/ethnic minority applicants. Over the years, our committee's activities have grown and are now guided by three main goals: (a) to increase representation of diverse faculty, students, and staff in our program; (b) to integrate diversity training throughout our curriculum, thus infusing multicultural perspectives into all aspects of training; and (c) to contribute to the ongoing work of making our program a safe space for each person's individual multicultural development. Our efforts since 2012 have focused, in particular, on developing the training initiatives we will describe below and which reflect our second and third goals. While this is an evolving effort and subject to change based on our experiences each year, we hope that we can contribute to a fruitful conversation across doctoral programs about ways to integrate multicultural training initiatives into the curriculum.

Based on our experiences and substantial published research, we believe that all of the members of our clinical program, students and faculty alike, are engaged in a developmental process in which we are constantly developing and refining our

multicultural perspectives. Progression through this developmental process is based on continuous exposure to opportunities that promote awareness, knowledge, and skill development. No one reaches complete multiculturalism "competence" per se, in the same way that no one completes their development. A fundamental premise that undergirds all of our training experiences is that we must confront and challenge the assumptions we make when we encounter someone who is similar to or different from ourselves in their demographics, cultural background, and/or identities.

With this philosophy in mind, our diversity training sequence was designed as an interactive developmental sequence with experiences earlier on in a student's training focusing more on awareness and progressing toward a greater focus on knowledge and skills. Thus, before the first-year students have their first classes, they participate in a multicultural orientation. Near the end of their first year, they complete and reflect on their cultural genogram. In their second year, students participate in a cultural plunge experience intended to challenge them to gain exposure to aspects of diversity unfamiliar to them. Next, in their third or fourth years, students take a course on multiculturalism in clinical psychology. As fourth years, students return to the cultural plunge experience as facilitators who are charged with leading discussions about diversity in a multiculturally sensitive way. The participation of fellow (advanced) students provides the second-year students with a safe environment for exploring assumptions, values, and perspectives. Lastly, students participate in a multicultural case conference, in which an advanced student (fourth to sixth year) presents a clinical case where diversity played an important role. In addition to the above, students take a course on clinical supervision (fourth year) where supervision related to diversity is discussed and, across all years, students attend program-wide lunch seminars that focus on diversity-related topics with an emphasis on interaction and the practice of skills. Below we elaborate on some of these discrete experiences in their developmental order. Of note, just as we are always growing in our multicultural perspectives, so are the aspects of our diversity training sequence; in some cases, we will describe various iterations of a given training activity.

Multicultural Orientation

The main goals of the multicultural orientation are: (a) to increase awareness regarding one's personal lens, both in terms of how we may perceive our clients (and others with whom we work: students, research participants) and how they may perceive us; and (b) to recognize the impact of our personal assumptions and biases on our work as psychologists. As part of seeking to achieve these goals, we introduce the students to the "Big 9" of cultural identity: race, ethnicity, national origin, gender, religion, age, socio-economic status/class, sexual orientation, and ability. Students reflect on which identities are salient to them, participate in an activity that demonstrates that we all make assumptions based on limited information, and brainstorm ways to negotiate situations when a diversity-related offense may have occurred. Also as part of this orientation, we introduce the training model of building awareness, knowledge, and skills related to diversity (Sue & Sue, 2013)—and stress that this is an ongoing process. This orientation is facilitated by three faculty members who help create a safe atmosphere by modeling through their self-disclosures as well as by creating an open dialogue on these topics. Faculty facilitators not only discuss their individual identities through the Big 9 framework, but they also discuss their personal multicultural journeys, which include their challenges and struggles. This is important not only to establish teacher credibility, which has been found to be a critical component of training (Morgan Consoli & Marin, 2015), but to also normalize the challenges that are inherent in exploring aspects of identity and privilege that are different for minority versus majority students (e.g., Boatright-Horowitz & Soeung, 2009; Maton, Wimms, Grant, Wittig, Rogers, & Vasquez Melba, 2011).

Because our program wants to demonstrate the faculty-wide commitment to diversity training and our understanding about the ongoing exploration of personal cultural identities, the responsibility of leading this orientation is rotated among faculty members. This rotation also provides students with access to working with faculty representing different areas of diversity in the discussion of multiculturalism, which is important for allowing diverse students to see themselves in these professional roles. In particular, in recent years, faculty involved in the multicultural orientation have expressed their diversity

in terms of race, ethnicity, gender, religion, and age. Thus, with the multicultural orientation at the very start of students' time in our program, we set the stage for commitment to and openness to discussions about diversity in a safe, welcoming environment. We acknowledge that we all have biases and highlight that what is important is to be aware of this, to recognize our personal lens, and to challenge our biases and assumptions by considering alternate hypotheses and conceptualizations.

Cultural Genogram

The cultural genogram, which occurs during the first year in the program, was chosen as a tool to enhance multicultural awareness and encourage self-reflective practice. A cultural genogram builds on traditional genograms by including a greater focus on the cultural identity of family members across multiple dimensions of diversity, changes over time, and explicit or implicit messages an individual may have received about various domains of diversity (Hardy & Laszloffy, 1995; Shellenberger et al., 2007). For the purpose of the genogram activity in our program, the training objectives are: (a) to develop greater awareness of one's cultural heritage and ability to trace one's cultural heritage related to cultural identity (e.g., "Big 9") and mental health, as well as messages received about these areas; (b) to understand how one's practice of psychology (therapy, research, teaching) is impacted by their cultural heritage; and (c) to learn more about the cultural genogram as a tool to potentially use with therapy/assessment clients.

Students are oriented to the activity during an initial group meeting and are given a few weeks to complete their cultural genograms on their own following a written guide, which includes a range of prompting questions for reflection (e.g., "What would be situations—with a client, with a student, etc.—that could be particularly difficult or uncomfortable for you to face because of your cultural heritage?"; see Hardy and Laszloffy, 1995, and Shellenberger et al., 2007, for other examples). Some students also choose to speak to family members to gather additional information about their cultural background, broadly defined, across three generations. A second meeting serves as a forum for students to reflect on their experiences (although students are not required to show their genogram to anyone or share personal information) and to have a dis-

ussion focused on implications for their practice of psychology.

Fostering increased awareness of the multidimensional nature of cultural identity as well as one's own privilege is an important part of this exercise. Students are explicitly encouraged to trace aspects of privilege and oppression in their family history and reflect on the impact these experiences have had on the student's own identity and experiences. At the most basic level of building awareness about one's own privilege, we first ask students to note aspects of their own and their family members' identities that spontaneously come to mind. Students are then asked to review the Big 9 list and reflect upon dimensions of diversity that are not as salient a part of their identity, especially in regards to dimensions where they belong to majority or privileged groups (e.g., being White, able-bodied, and cis-gendered).

We have had both advanced graduate students facilitate these meetings and the diversity training committee faculty member do so. An advantage we see from graduate student facilitators is that this avoids concerns about being evaluated on performance as much as possible. Because students are at different developmental stages with regard to their awareness, it is important to reduce any potential barriers to self-exploration. Faculty members are always available for consultation if desired, however. Another variation relates to the format of the second meeting. Having a group meeting for the second meeting underscores our belief that conversations about multiculturalism among students are important to establish early on in training. However, depending on the group size, individual family histories, and range of prior experiences and level of multicultural awareness, a group discussion with a limited timeframe may pose a challenge to provide the individualized guidance that each student may need to get the most out of the activity. An alternative to a group meeting for a second meeting would be individual meetings (e.g., each first-year student with an advanced graduate student or faculty facilitator), but these meetings must be constructed so that there is no pressure to share specifics of the cultural genogram, with the focus being on a discussion about the process and implications for clinical work. One last alternative that we have considered is to embed the cultural genogram activity in a class—for example, our ethics class, which relies heavily on reflection. In this scenario, we would be clear that the cultural genogram is not an

evaluative part of the course and for the second meeting we would have advanced graduate students take the lead, with the instructor available as necessary.

It is important to note that students may differ widely in their reactions, ranging from finding the creation of their cultural genogram and the ensuing reflection and discussion enjoyable and interesting, feeling pride or gratitude, to a host of negative emotions. For most individuals, reflecting on their own history and potential biases can be expected to cause some discomfort, but this should be introduced at the beginning of the genogram activity as a normal part of the process.

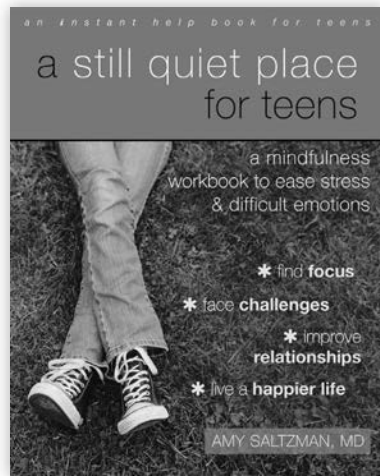
Cultural Plunge

The cultural plunge activity is an experiential learning opportunity involving students in the second and fourth years of the program. It was intended to continue second-year students' ("plungees") exploration of their own cultural backgrounds and development of knowledge and competencies, and to provide fourth-year students ("facilitators") with an opportunity to guide discussions about multiculturalism. Because the experience can be quite sensitive and personal in nature, the goal for the second-year students is not to achieve some arbitrary level of cultural competence, but rather to thoughtfully select an area of diversity to "plunge" into and to demonstrate a willingness to engage in meaningful exploration and understanding of other cultural experiences.

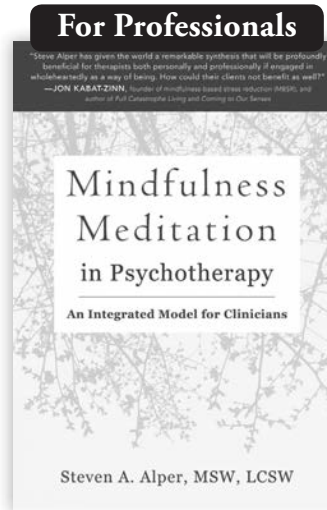
The diversity training committee set up the cultural plunge as an adaptation of work by Neito (2006) and other proponents of cultural plunges in the field of education. In particular, the cultural plunge, as part of our diversity training sequence, is an experience in a culture different from one's own, where the experience is of being in a minority position rather than in a position of privilege (based on a range of cultural areas—i.e., the Big 9). The criteria for the plunge experience include the following: (a) the majority of the people at the event/activity are from the focal group (i.e., cultural group different than the plungee's own); (b) the plungee is on the "turf" of the focal group (e.g., not in a school/restaurant); (c) the experience is not one that the plungee has had before; (d) the experience lasts at least 1 hour; (e) the experience pushes the plungee out of their comfort zone, but not in a way that would be overwhelming; (f) there is some interaction with people from the focal group (i.e., not

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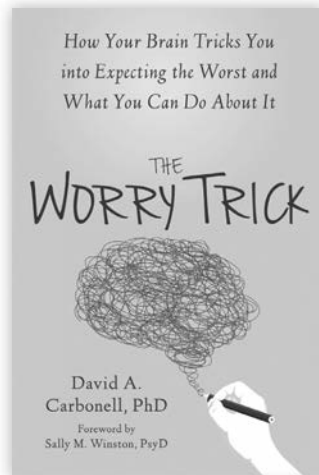
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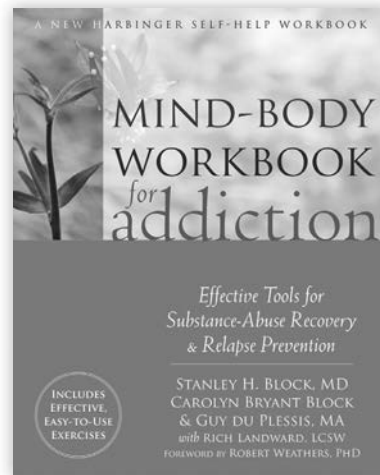
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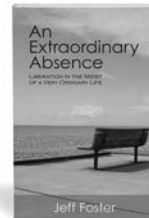
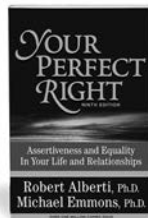
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just watching a parade); and (g) the plungee engages in the plunge experience on their own (i.e., not with other second-year students, significant others, friends, etc.). An example of an appropriate plunge experience is attending a religious service of a religion that is unfamiliar or to which the plungee believes they may have some stereotype-driven reactions. Students may engage in plunges that involve multiple different cultural experiences—for example, some White nonreligious students have attended predominantly Black Christian churches, thus providing an opportunity to interact with individuals who differ on both religion and race, as well as an opportunity to mimic some aspects of being a visible minority. Other examples have included: eating lunch with individuals at a homeless shelter; visiting a gay bar; presenting as a transgender individual for a day; attending a rally of a political party seen as opposite to the party with which one identifies; and spending a day in a wheelchair. Thus, a variety of experiences can fit the criteria for a plunge; the key is to tailor it to what would be a useful growth experience for the student. In the subsections that follow, the roles of the plungee and facilitator will be further explained.

Cultural Plunge-Plungee Experience

Plungees are given a packet that contains an explanation of the cultural plunge experience, an outline of the purpose behind it, a definition of “culture” and a list of the Big 9 cultural identifiers, an anonymous list of previous plunge experiences and impressions from other students, and a set of questions for plungees to contemplate in advance of an individual meeting with their facilitator. For example, plungees are told to think about the aspects of their cultural identity that are most salient to them, as well as aspects of diversity with which they are less familiar or comfortable. Each plungee is assigned a facilitator who is most typically a fourth-year student. The diversity training committee does its best to ensure that individuals are not paired with their close friends, peer supervisors, or teaching assistants to create a safer space for plungees to process their experiences.

Plungees then meet with their facilitator to discuss their initial feelings about the plunge and any apprehensions. They are able to discuss various plunge ideas with their facilitator and how they anticipate each experience could impact them. Within a few days after the meeting, they notify the facilitator about which experi-

ence they have selected. The committee designates the month following these initial plungee/facilitator meetings as “Plunge Month.” During that month, all plungees engage in their plunge experience.

The final component of the plunge experience involves processing the experience; this is done one-on-one with the facilitator. As with the first meeting, plungees are given a set of questions to contemplate. They have a chance to share with their facilitator what they did, how they felt, and what they learned not only about the other culture, but about themselves. The diversity training committee has also hosted a discussion evening in which dinner is provided for both plungees and facilitators. Taking into account that the group setting could feel less safe, the facilitators and plungees collaboratively developed a set of ground rules at the start of the evening, followed by a discussion of how plungees’ experiences made them feel, what they learned, and how what they experienced could be relevant and applied to their training as clinicians, researchers, teachers, and policy influencers. At the end of the evening, each person in attendance wrote a goal for themselves related to growth in an area of cultural competence. They placed this goal in a sealed envelope with their name on the outside that remained unopened and was mailed to them 6 months later so that they could assess for themselves how they were growing in that area.

Of note, we noticed that there was less open discussion in the large group setting than in the plungee-facilitator dyads. This is not surprising given that plungees are at different developmental levels with regard to multicultural competence, with some people, but not others, able to word comments carefully to avoid committing offenses and able to react to offenses in constructive ways. Larger settings may feel more intimidating with students more hesitant to contribute to conversations because they are either not comfortable with their own developmental level or fear that others will not provide feedback in a constructive manner. Thus, we are considering replacing the large group meeting with meetings of pairs of plungee/facilitator dyads in order to continue the processing, but extending it by also hearing about another plungee’s experience, reactions, and growth. Although the program’s goal is to establish and create a safe atmosphere within the program as a whole, multicultural training and subsequent discussions are challenging because of the range of per-

sonal experiences and individual developmental trajectories of each student. Because we view multicultural competence as a developmental process, we also want to make sure that students are all prepared for challenging discussions. The consideration of moving from a larger group discussion to pairs of dyads would allow for each individual student to have an opportunity to explore these topics further within a smaller setting, which would facilitate subsequent exploration in larger group settings within subsequent case conferences and classes. Furthermore, this smaller group setting is more representative of how these conversations would likely take place in individual, couple, or family therapy sessions. Lastly, these discussions are being facilitated by upper-level graduate students who are also continuing their personal developmental growth, and facilitating a larger group discussion can be challenging even for experienced faculty members.

Cultural Plunge Facilitator Experience

The facilitator assigned to work with a plungee is most typically a fourth-year student, but on some occasions may be a more advanced student (e.g., if there are more students in the second-year cohort than in the fourth-year cohort). These students have already completed our program’s multiculturalism class, which generally includes a cultural plunge. Additionally, fourth-year students in our program are required to take a course in supervision, which includes preparation for how to productively discuss multiculturalism. Facilitators receive training related to the cultural plunge from a faculty member with extensive training in multiculturalism as well as other members of the diversity training committee. This training consists of reviewing the facilitator guide (which mirrors the aforementioned plungee packet), discussing issues that might arise and ways to prevent them and/or respond to them, and answering questions. Our goal for facilitators is to practice skills in navigating discussions in multiculturally sensitive ways that promote growth, thus helping students process thoughts and emotions related to multicultural topics.

Following the training and assignment of plungee/facilitator pairings, the facilitator meets with the plungee to assist them in exploring various plunge options (i.e., “pre-plunge” meeting). More specifically, during their first individual meeting, the facilitator and the plungee discuss the plungee’s cultural background (to the extent that the plungee feels comfortable).

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The facilitator helps the plunger to identify the cultural identity areas that they would like to further explore through the plunge, in the spirit of broadening their cultural knowledge, sensitivity, and awareness. This is accomplished using suggested questions in the facilitator guide, as well as through other exercises (e.g., the “I am . . .” exercise which elicits salient components of identity). Facilitators also help the plunger to identify a specific plunge option that will be a good match for the plunger’s level of openness and comfort, such that the experience will be challenging and rewarding, without being overwhelming or excessively anxiety-provoking. Facilitators are encouraged to share their personal plunge experiences, as well as to consult with other facilitators and diversity training committee members to identify other plunge ideas and resources. Following the plunge experience, the facilitator and plunger meet again (i.e., “post-plunge” meeting) where the facilitator helps the plunger process the experience.

Courses Related to Multiculturalism

Course on Multiculturalism in Clinical Psychology

This course, taken by third- and fourth-year students, explores the role of diversity, broadly defined, in clinical psychology. The course addresses topics such as multicultural counseling competence, privilege and oppression, cultural identity development, and multiculturalism as it relates to research, assessment, and therapy. Besides using a textbook (Sue & Sue, 2013) and an array of articles to convey information and generate thoughtful discussion, the course includes a variety of other components intended to further broaden a student’s awareness, knowledge, and skills related to multiculturalism. For example, in this course the students have: (a) performed a cultural “audit” that includes a systematic examination of their cultural background as well as reflection on their current cultural competence; (b) participated in a cultural plunge that, unlike the aforementioned cultural plunge, is accompanied by a paper reflecting on the choice of plunge experience, the assumptions/biases noticed, the emotional response to the plunge, and insights learned that may be relevant to themselves as clinicians and researchers; (c) presented on a specific topic of diversity, which includes reviewing the literature, developing and presenting a PowerPoint presentation, guiding the class in a relevant experiential experience (e.g.,

role-plays), and generating an annotated bibliography on the topic of diversity and clinical psychology; and (d) led discussions of the book *The Spirit Catches You and You Fall Down* (Fadiman, 1997), which poignantly conveys cultural miscommunications and generates conversations on our roles as clinicians with diverse client populations. Where unique, relevant opportunities arise, they are pursued as important sources of discussion—for example, in a recent version of the course, the class attended a one-person show entitled “Rodney King,” by Roger Guenveur Smith, that focused on race and race relations and watched the documentary *Rich Hill* on rural poverty.

Course on Clinical Supervision

The clinical supervision course taken by advanced students (fourth-year cohort) in the fall semester has both a didactic component and an applied component, both of which involve explicit discussions/connections with diversity. Across the semester of weekly seminar meetings, one class session is devoted to examining research and theory related to multicultural supervision; these topics are also incorporated into other class discussions. In regard to the applied component (year-long), the student supervisor provides clinical supervision to a second-year clinical psychology graduate student using the vertical team model (i.e., receiving “supervision of supervision” from a licensed psychologist). The supervision received by the fourth-year student supervisor includes a focus on noticing and incorporating multicultural perspectives into the treatment and supervision. This often includes discussing and role-playing how the student supervisor might effectively recognize and “coach” the student therapist to raise multicultural issues that are clear in the room, all the while keeping in mind the case conceptualization. Common examples include acknowledging differences between the therapist and client and directly discussing experiences of racial/ethnic or sexual minority clients on campus or in the community, or may involve addressing especially challenging situations. For instance, in a case where the client of a second-year student therapist made a racist comment in therapy (not directed to the therapist), supervision of supervision included discussion of the following questions: Should this be addressed in session? If so, how might this occur? What are the clinical considerations? How could a second-year student therapist be empowered and given some

skills (e.g., via role-play) to productively address the situation?

The APA *Guidelines for Clinical Supervision in Health Service Psychology* state that “Supervisors are encouraged to infuse diversity into all aspects of clinical practice and supervision, including attention to oppression and privilege, and the impact of those on the supervisory power differential, relationship, and on the client/patient and supervisee interactions and supervision interactions” (APA, 2014, p. 16). In the spirit of these aspirational guidelines, the clinical supervision course provides an opportunity for advanced students to develop their multicultural competence as they learn to be clinical supervisors while enhancing the second-year training experience through the intentional and explicit incorporation of diversity broadly defined (e.g., race/ethnicity, sexual orientation, religion). Further, we have been pleased to see that many students opt to include some aspect of multiculturalism in their final reflection papers for the clinical supervision course.

Multicultural Case Conference

The multicultural case conference was integrated into the diversity training sequence in response to student feedback that more applied examples of culturally informed clinical practice were needed. This activity occurs once per year in the fall semester and is intended to build on students’ cultural awareness, knowledge, and skills in ways that are directly relevant to their provision of clinical services. All students and faculty in the clinical program are expected to attend the multicultural case conference to reinforce the message that multicultural competence is a never-ending professional aspiration, regardless of your stage in career. Having faculty present is also helpful for contributing more experienced perspectives to discussions and for ensuring that consistent messages about multiculturalism are being communicated in their coursework and clinical supervision. One way we facilitate the attendance by all in the clinical program is by having the multicultural case conference occur during a regular clinical lunch seminar time slot. The audience is limited to only clinical students and faculty to protect client confidentiality.

For the multicultural case conference, students present a clinical case where diversity played an important role in case conceptualization, diagnostic impressions, measure/test selection, rapport-building,

case management, and/or treatment planning. A more interactive format for multicultural case conference presentations is preferred to encourage all members of the audience to actively engage in thinking through diversity-related topics. For example, the presenter may share several diversity-related clinical facets for a particular case, each followed by a thought-provoking question. Questions are first discussed in a small group format before initiating a larger group discussion, with every small group including a faculty member as well as students of advanced and junior status to ensure a range of developmental levels for the discussions. Student presenters are strongly encouraged to incorporate empirical findings into their presentation, if possible. Empirical references could include information such as typical symptom presentations, assessment tools, therapeutic rapport, or treatment effectiveness for a particular population. The presenter may discuss ways that empirical information aligns or does not align with their own observations and experiences with a client.

To date, student presenters for the multicultural case conference have been identified by the diversity training committee as advanced students with experience with a

clinical case where diversity played a prominent role and who would be interested in presenting. In the future, we plan to be more systematic with the selection process. For example, we may invite students applying for internship (i.e., students in their fourth to sixth years) to submit their internship essay on diversity. From these essays, we would invite a student to present at the multicultural case conference, a recognition that would give them a rich experience and an addition to their vita. Regardless of how the student presenters are selected, members of the diversity training committee work with the presenter(s) beforehand to select the most important information and discuss the structure of the presentation, including the development of questions that focus on the process of providing multiculturally sensitive clinical services, rather than on testing individuals' cultural knowledge.

It is important to note that students are not expected to be experts at providing multiculturally sensitive clinical services at the time of the case or at the time of their multicultural case conference presentation. They are encouraged to present on clinical situations where they felt confident in their approach or situations in which they did

not know how to proceed effectively. A disclaimer is given at the beginning of the multicultural case conference in which the developmental nature of multicultural competence is emphasized; this disclaimer is given to set the tone for a supportive, yet productive atmosphere.

Summary

Our multicultural curriculum was developed to address in-program goals: to allow students more opportunity to consider multiculturalism, to help augment students' confidence in their diversity-related skills, and to help increase within-program dialogue about diversity. (See Appendix for our program's list of multicultural competencies.) On all of these measures, we believe our burgeoning diversity training sequence has been successful. Self- and program-evaluation ratings from current and former students reveal that over the past several years, our students report increased satisfaction with their multiculturalism training (although satisfaction is not sufficient given that it does not necessarily index learning and growth). We have seen two other informal signals that our emphasis on multicultural

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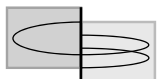
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training may have paid dividends as well. One of these is the richness and quality of students' internship application essays regarding multiculturalism, and the second is our students' desire to help plan and host our Diversifying Clinical Psychology weekend event for emerging racial/ethnic minority scholars who wish to enter doctoral clinical psychology programs.

Thus far, we have elicited anonymous feedback from students after each diversity training activity, and to date we have used those responses to assess if the activities are achieving the intended goals, to gauge the perceived safeness for multicultural discussions, and to inform modifications to existing activities. Although we believe that eliciting such feedback is an important component to the ongoing development of diversity training, we must state that we have not collected formal data to indicate that our training has led to statistically meaningful change in our students' research/clinical/teaching skills. Nor do we have data to examine whether this training curriculum has improved the experience of research participants, clients, or undergraduate students with whom our graduate students have interacted. These are important next steps, and as with any intervention, it will also be critical to determine whether there are components of our curriculum that are most efficacious in producing any putative improvements. We are currently developing a survey to assess in more depth satisfaction related to our diversity training program and potential changes in multicultural competence.

Nevertheless, we wanted to share our experiences to date in this article to begin a dialogue among training sites and students to think creatively about multiculturalism training in clinical psychology. We hope that the information we have shared will encourage programs who have a similar commitment and a set of training activities in place to continue with their efforts, and will stimulate others to develop diversity training experiences that are tailored to best benefit their students' growth in multicultural awareness, knowledge, and skills. Of note, while these training activities have been geared toward students, we have found that faculty also reap benefits in terms of greater multicultural awareness and competence and that the program as a whole has benefited in terms of fostering a greater sense of community. As our country becomes increasingly diverse, it is our hope that our field will be at the forefront among health care providers in preparing

Appendix

UNC Clinical Program: Multicultural Competencies

Awareness

- of one's own personal cultural place/heritage, including concepts of oppression and privilege (including but not limited to aspects of identity such as race, ethnicity, SES, gender, sexual orientation, religion)
- of how one's own personal cultural place/heritage has shaped one's values, perspectives, and biases
- of how one's own personal cultural place/heritage has a potential impact on their work as a psychologist
- of clients'/research participants' cultural place/heritage and how it influences their view of therapy, research, mental health, and response to intervention

Knowledge

Cross-Cutting

- of cultural identity models and the impact of oppression, privilege, and discrimination on psychological functioning
- of strengths and limitations of assessments in different groups, and when assessment instrument norms should and should not be used
- of how to conduct a cultural assessment as well as how to evaluate traditional assessment tools for appropriateness
- of the current state of the research literature on cultural tailoring of clinical interventions, and how to help advance this literature and/or adapt evidence-based interventions accordingly
- of issues that are often salient for a particular multicultural group (e.g., acculturation differences for migrants vs. refugees; safety issues with clients who are coming out), and the potential limits of applying this work to understanding individuals
- of how to work with translators

Clinical

- of health disparities (i.e., differential access to treatment; institutional or cultural barriers to treatment; the degree to which seeking help through therapy is acceptable in one's culture), and how to adapt one's behaviors as a clinician accordingly
- of how to assess whether diversity issues may be relevant to one's client and/or provision of treatment, and how to address these issues in treatment, if necessary/applicable
- of the role of multiculturalism in case conceptualization, assessment, and treatment

Research and Teaching

- of conducting research with diverse groups and subsequent strategies for gaining entry, increasing participation, etc.
- of the limits to "generality" of research findings to diverse groups, why findings are not applicable to all groups, and what would be needed to examine and enhance generality
- of diversity in learning styles of students in the classroom, how this affects classroom behavior, and how to tailor pedagogical and supervision approaches to accommodate this diversity

Skills

- ability to address issues of difference in a nondefensive and nonjudgmental manner (with client, with supervisor/supervisee, colleagues)

[Appendix, continued]

- ability to seek out cultural information relevant to one's client—e.g., journals to look into, ways to identify researchers examining the relevant issues
- ability to recognize when one's biases are influencing perceptions as a clinician, researcher, or teacher, and how to use skillful questioning (curious, nonjudgmental) to educate oneself and dispel perceptions
- ability to build rapport in cases where significant differences may make this difficult
- ability to recognize when outside consultation is needed and when one's competence may be limited due to inexperience or unfamiliarity with relevant cultural issues
- ability to skillfully and appropriately make use of possible allies that are culturally relevant to the client (e.g., extended family, healers, clergy)
- ability to adjust/tailor research protocols or clinical interventions in response to an assessed cultural issue/factor
- ability to conduct a cultural assessment
- ability to use diverse teaching strategies that can foster increasing engagement of diverse students

the workforce to adopt a sensitive perspective towards multiculturalism.

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Ways to Boost Your Research Rigor Through Increasing Your Cultural Competence (Part 1 of 2)

Lauren P. Wadsworth, Lucas P. Morgan, Sarah A. Hayes-Skelton, Elizabeth Roemer, Karen L. Suyemoto, *University of Massachusetts Boston*

THIS BRIEF ARTICLE IS PART ONE of a two-part series on ways that we might boost our research rigor by increasing our cultural competence. We provide specific goals and rationalization for ways that we can all increase our engagement in the process of becoming more culturally competent. Though brief, and certainly not exhaustive, we hope to contribute to an ongoing discussion of ways that we can increase the effectiveness and generalizability of our research through culturally sensitive practices. Further, we believe that being culturally competent can increase the validity of our research.

“Cultural competence” is a term we have heard a lot about in a number of our professional realms. We would all like to be culturally competent researchers, teachers, and clinicians. However, institutions range greatly in their diversity training, and it can be hard to recognize how much we know and do not know. Even if we have had diversity training in the past, our knowledge can quickly become dated. Maintaining cultural competence is a continuous process that requires active engagement. It can be hard to ask questions and admit that we might not be as culturally competent as we would like. The purpose of this article is to offer a few ways that we can all increase our cultural competence and, in turn, our research rigor.

In our opinion, one of the most difficult things about increasing cultural competence is that, unlike many areas of our work, this goal has no endpoint. There is no achievement of full cultural competence, no number of facts one can know, no box to check off. Instead, cultural competence is choosing to embark on a path, moving toward a horizon, while acknowledging that we will never reach it. This might sound intimidating at first, but it is meant to include and be encouraging of all individuals. To us, being a culturally competent psychologist means: (a) admitting

that we do not know everything we can know about all cultures and the variety of human experiences, (b) recognizing that we are all socialized to have biases in understanding and working to recognize and counteract these biases, and (c) taking responsibility to address the inevitability of our lack of complete knowledge and socialized biases by choosing to actively engage in a continuous learning process, approaching research and therapy with an informed curiosity about how experiences might vary based on the many areas of our participants’/clients’ identities, and continually modifying and updating our approaches based on our expanding knowledge and awareness. The work of becoming more culturally competent is never “done”; it involves making a choice to be involved in a continued process of learning, self-reflection, and seeking out one’s hidden assumptions.

Throughout the long and careful process of writing this paper, we learned a great deal. We struggled with the level of detail to provide in each item, eventually deciding to choose brevity, in hopes of increasing the approachability and dissemination. We also struggled with what to include, knowing that that would mean excluding a vast amount of information and historical details. We hope that readers will be understanding, and see this as a small step toward a large movement we are undergoing as a field. We also encourage readers to use this article as a stepping stone to additional literature and resources.

Disclaimer

We would like to start with a disclaimer that we are always limited by language that may never be fully inclusive, may reify categories, and may unintentionally contribute to marginalization. Examples of this include referring to gender as categorical (i.e., people are languaged as female, male, or transgender) when gender identity is in

fact better described by a continuum; or using terms like “minority” that might reify marginalization even as it attempts to describe power differentials (Wirth, 1945). The terms we use for different categories are socially derived constructs that are as complex and evolving as the individuals they attempt to explain. Because one of the main difficulties in the field is the lack of consistency in use of terms like race and ethnicity, we will focus on maximizing the *usefulness* and specificity of terms and their operational definitions with full acknowledgment here of their imperfection. Also, we are writing this paper from a U.S. perspective, and speak from our own personal and research experience. This is not to say that similar issues do not extend to other countries: we assume they do to varying extents, but also recognize that there will be important differences that may prohibit direct application or generalizability.

This is a two-part article, where part one will discuss clarifying constructs in research, particularly related to operationalization and data collection, and part two will discuss data analysis and dissemination, all with the aim of increasing research rigor via increasing cultural competence.

Part A: Clarifying Constructs

As culturally competent psychologists, we strive to be precise in language use, understand definitions (and limits) of words often used incorrectly, and eliminate harmful language from our vocabulary. Being thoughtful and precise with identity-based language is important in research for accurately measuring identities of participants, analyzing/interpreting findings, and reducing painful experiences for participants filling out self-report forms (“do no harm”). We acknowledge that this is challenging, as societal meanings of words change over time, and there are no “catch-all” rules. Rather, this is a continual process that we hope the points below will help you to navigate.

1. Accurately Operationalize Race, Ethnicity, and Culture by Differentiating Between the Concepts

Take home. *Race, ethnicity, and culture are most usefully thought of as differentiated constructs, even if we recognize that they are also related. These terms are complex, evolving, and highly contextual. However, we (and others) argue that they each provide unique information that is relevant to and improves the validity and generalizability of*

	Race	Culture	Ethnicity
Definition	Categorizes people into socially constructed groups based on external characteristics like skin color, facial features, and hair texture for the purpose of creating or maintaining hierarchies of power.	Learned and transmitted patterns of behaviors, interactions, norms, values, communication, and beliefs shared within a particular identifiable social group.	A type of culture most often related to shared heritage from a geographical location that develops from within groups. May be panethnic or ethnic specific.
Examples	Asian, Black, Latinx, ¹ Native American, Multiracial, ² Middle East and North African (MENA), White, etc.	African American culture, European American culture (dominant culture in U.S.), Gay culture, Queer People of Color culture, Southern culture, Republican culture, Hip hop culture, etc.	Japanese, Japanese American, Cuban, Irish, Syrian, Syrian American, Wampanoag, Lumbee, Filipino, European American, African, African American, etc.
Some Mechanisms of effects on peoples' psychology	Stereotyping, racism, oppression, privilege differences, identity.	Shapes worldview, goals, interpersonal interactions, social norms. Particularly evident when individual's culture(s) are different from each other and/or from the socially dominant norm. Effects through acculturation, enculturation, ethnocentrism. Evident in psychodiagnostics and meanings of health and pathology, language meanings, etc.	As with culture, plus: effects through ethnocentrism leading to pathologizing of ethnic differences as deficits.

mental health research. These definitions are not intended to reflect fixed or ultimate truths, but are an attempt to maximize their usefulness in psychological research. For corresponding guidelines for our field, we recommend the APA multicultural guidelines (APA, 2003).

Ethnicity and race are constructs that represent significant forces present in the lives of every person in the U.S. (and likely other countries; APA, 2003; Markus, 2008; Smedley & Smedley, 2005). They shape how other people, systems of power, and access to resources interact with each individual. Validity and generalizability of research results begin with the conceptualization and operationalization of constructs, which includes clearly characterizing your sample. However, because race, ethnicity, and culture are often conflated, the generalizability

and interpretability of results is often limited. For example, if everyone in a sample who is racially Black is erroneously considered ethnically African American, then the research may miss important differences based on whether individuals are multigenerational African Americans or are newer African immigrants, or are second-generation Haitian Americans. For us in Boston, these are three very different groups, each with a different culture and lived experience. Below, we provide what we think are helpful definitions of race, ethnicity, and culture.

Race. Although historically thought by many to reflect genetic differences between groups of biologically distinct people, research and theory have consistently refuted this myth (Littlefield, Lieberman, & Reynolds, 1982; Marks, 1996; Smedley &

Smedley, 2005; UNESCO, 1950). Race is a social construct that has developed over time in Europe and the U.S. in order to create or maintain power differences (and may function differently in different countries, due to differing histories of the enactment of race by government and other institutions), and typically categorizes people into groups based on external characteristics like skin color, facial features, and hair texture (APA, 2003; de Gobineau, 1853; Markus, 2008; Smedley & Smedley). Interpersonal, institutional, and internalized racism are phenomena that result from these racially defined interactions, are linked to existing health disparities and mental health issues, and deserve much more focused attention in the clinical psychology field (e.g. Eisenhower, Suyemoto, Lucchese, & Canenguez, 2014; Ford & Kelly, 2005; Jones, 2001). Race impacts people's everyday experiences through how other people explicitly or implicitly racially categorize them (Smedley & Smedley; Suyemoto & Dimas, 2003; Tashiro, 2002) and how those racial definitions then shape interactions (e.g., through behavioral

¹Although the US census measures "Hispanic" only as an ethnicity, there is significant literature regarding Latina/o (Latinx) as both a racialized group and a pan-ethnic group (Gracia, 2007; Vidal-Ortiz, 2004).

²Multiracial is typically a better term to use than Biracial if exact racial identity is unknown, as it allows for more than two racial identities, acknowledging the complexity of multiracial identities.

expectations, stereotyping, or discrimination; Cook, Arrow, & Malle, 2011). Understanding and studying race is important for understanding the lived experiences of racial minorities as well as understanding and addressing the significant disparities among racial groups in the U.S. in areas of health, education, wealth, and mortality (Betancourt et al., 2003; Brondolo, Gallo, & Myers, 2009; Burk & Espinosa, 2012; U.S. Department of Health and Human Services, 2001).

Culture. Culture may be most usefully thought of as a broad term that describes the learned and transmitted patterns of behaviors, interaction, communication, and beliefs shared among members of a particular social group (Markus, 2008; APA, 2003). Importantly, culture is not simply limited to expressions of ethnic culture. One can show behaviors and beliefs consistent with a particular ethnic culture, such as Mexican American culture, or European American culture, but one could also show behaviors, and hold norms and beliefs consistent with male culture, gay culture, Deaf culture, working-class culture, military culture, or Christian Evangelical culture. Any social group can develop patterns of thinking, talking, dressing, eating, interacting, etc., and these patterns can be used to describe the culture of that group. Studying culture/cultural influences, or simply considering them, increases our ability to make more accurate interpretations. For example, in our research coding social interactions, we often need to take into consideration any known cultural norms of the participant that differ from our own, when we make ratings on things like eye-contact or sentence length (which vary in terms of what cultures deem appropriate in different contexts and in relating to different types of people or roles).

Ethnicity. Like race, ethnic identities are historical and are socially created and maintained (APA, 2003; Suyemoto & Kim, 2005). Unlike race, however, ethnicity is largely an identity that develops from within groups based on shared culture (e.g., language, dress, customs, beliefs, norms, etc.; Markus, 2008) related to common geographic location and history (often proxied as nationality). Examples of some ethnic identities found in the U.S. include Somali American, Haitian, Navajo, Jamaican American, Filipino American, Finnish, Armenian American, and Iraqi American. Within a given racial identity, individuals may express a wide range of

different ethnic identities. For example, some Mexican Americans, Egyptian Americans, and Irish Americans may all be categorized racially as White. Ethnic identity can vary widely and be expressed differently by members of a particular ethnic group, and in the U.S. is often influenced by growing up in multi-ethnic families and communities and by the impacts of immigration and acculturation on ethnic identity and expression across different generations. Studying ethnicity is important for understanding how ethnic norms and beliefs may impact critical areas of psychology, including the validity of psychological diagnoses, acceptability of and response to evidence-based treatments, and how to increase culturally competent care (González-Prendes, 2013).

Intersectionality. Importantly, intersections of subgroupings across cultural and demographic groups often influence different cultural expressions and experiences within the group. For example, Latino or Hispanic American military culture may differ from White American military culture in terms of preferred language use, norms of interaction, and expressions of emotion. In this example, we are highlighting the intersection of military and ethnic culture. Considering intersectionality, caution is advised against making sweeping statements about culture or about ethnic groups—such as “in military culture . . .” or “in American culture”—since there are arguably many important differences between whose “Military/American culture” one may be referring (further, which “American” country or continent?). Further, ally and advocate groups developed to support marginalized populations typically address only one area of identity (e.g., sexual orientation, race), thus limiting their inclusion and support for individuals with intersecting marginalized identities (e.g., a Black lesbian has to choose to seek out a group for lesbians or a group for people who identify as Black or a woman’s group). Although psychologists seek to understand modal experiences, we can simultaneously demonstrate awareness of the heterogeneity of groups (especially systemically oppressed groups), consider important intersecting statuses, and be wary of over-aggregations that may contribute to already existing stereotypes.

Considerations for research. Researchers often conflate race and ethnicity in operationalization, sample description, and interpretation. As a common example, many people confusingly use the term African

American to describe all people who might identify racially as Black into the same category, when there are, in fact, many different ethnic categories within the U.S. population who are racialized as Black (e.g. Caribbean American, Sudanese American, Kenyan American), not to mention those who ethnically identify with a culture that is not interacting with the U.S. culture such as Kenyan, or Haitian (Agyemang, Bhopal, & Bruijnzeels, 2005). We argue that measuring and reporting on both race and ethnicity as differentiated constructs is more useful and valid from a research methods perspective than having one poorly defined and confounded race/ethnicity/culture term. Although our experience is that fully reporting all ethnicities represented usually requires a lot of space in a methods section, we recommend a minimal standard of differentiating race from ethnicity, and gathering data on specific ethnicity, even if that data is then used to construct pan-ethnic categories that capture the most salient variability in the sample.

2. Eliminate Inaccurate or Offensive Terms From Your Vocabulary

Take home. *Educate yourself on the history of terms/words and eliminate harmful vocabulary.*

Meanings, connotations, and weights associated with terms in our society change at a pace that is often difficult to keep up with. While we recognize that language is always changing, cultural competence requires the recognition that language matters, that denotation and connotation are not always congruent, and the accompanying attention to understanding current meanings. While we do not have the space to provide an extensive list of words and terms that have taken on a harmful/marginalizing meaning, we will highlight a few below that we believe are current and important for our field to come to understand. Going forward, we suggest listening and adjusting when a group expresses that a term or word or label is hurtful toward them. We also recommend that psychologists educate themselves about the history of terms used to label or marginalize groups, which can be done via a quick online search.

Caucasian. Instead, say “White.” The term Caucasian is still widely used, often to represent an undefined and confounded race/ethnicity construct. For a number of reasons, we (and others) argue that rather than using Caucasian, “White” be used for a racial category and “European American”

for an ethnicity category (Mukhopadhyay, 2008). First, the term Caucasian comes from the same antiquated categorical system as the terms “Mongoloid” and “Negroid,” which were developed for various pseudoscientific classifications of human “races” by European biological anthropologists in the 18th and 19th centuries (Isaac, 2004). Caucasian factually refers to people who live in, or have ancestors from, the Caucasus Mountains region (present day Azerbaijan, Armenia, and Georgia). To increase the validity and generalizability of our research, we strongly suggest doing away with the ambiguous and archaic term “Caucasian,” and instead use “White” and “European American” (or “Hispanic,” “Arab-American,” etc.) for race and ethnicity, respectively, if these categories best represent the race and ethnic identities of the participant.

Gypsy. Instead, say “Roma people.” The term Gypsy has been historically used as a derogatory term to refer to a subculture of European individuals who have been pushed out of many countries and denied services. The term “Gypsy” refers to stereotypes of the Roma people, which include

“drifters who steal anything they can.” This example can also be applied to other Indigenous peoples who have historically been renamed by groups in power ignoring the groups’ self-given names (e.g., Sami vs. Laps). Since words change over time (e.g., we no longer use the word “Oriental”) as self-determination is reclaimed, we can engage in a practice of staying informed and open to learning about changing meanings.

Homosexual. Instead, say how the person self-identifies (e.g., Gay, Lesbian, Queer, etc.). Homosexuality as a term has been predominantly used to label same-sex attracted individuals by parties or groups who have systemically oppressed those individuals. Though many could argue it is a scientific term, the connotations that have historically come with using it are negative and harmful. Additionally, using a blanket term like “homosexual” denies the complexity of nonheterosexual attrac-

tion (e.g., bisexual, pansexual, etc.). For more information, please see the APA LGBT guidelines (APA, 2012) and guidelines for Transgender and Gender Nonconforming People (APA, 2015), for excellent resources for increasing your cultural competence working clients and research participants who do not identify as heterosexual and/or cis-gender.³

Transgendered. Instead, say “Trans” (less formal) or “Transgender” (more formal; note: gender is much more complex than trans or not trans—additional information at www.gladd.org). The word “transgendered” is usually used to describe a person, in a fashion that is not person-first (i.e., “a transgendered”) denying the complexities of their many identities. Just like it would not make sense to say one is “Whited,” it also does not make sense to call someone “Transgendered.” Second, similar to “homosexual,” the term “transgendered” has been used significantly by

³Cis-gender is a term that refers to individuals whose gender identity matches the biological sex they were assigned at birth (e.g., if someone was assigned “female” sex at birth and also identifies as a woman).



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groups that oppress individuals who identify as trans. The recent APA guidelines require psychologists to understand that gender is a nonbinary construct and is not tied to sex assigned at birth (APA, 2015).

Handicapped. Instead, use person-first language (e.g., a person unable to hear; APA, 2012). Some prefer “differently abled” while others prefer “disabled” or “with a disability.” Similar to the remarks on “transgendered” above, it is recommended that we not refer to people as “handicapped,” as it ignores other parts of their identities, overfocusing on their disability, and is an umbrella term that historically has connoted “lesser than.”

Note: While we recommend these guidelines, we also recommend never assuming you know how someone identifies or the language they personally prefer; instead, ask the individual (or research participant) how they self-identify and use that language (even if it contradicts our suggestions or your understanding of what is sensitive!).

Part B: Measurement Tools and Data Collection

Creating more culturally competent measurement tools is important for both research rigor and participant experiences. Imagine if you were asked to “select your gender,” but the way you identified was not listed. Asking participants to engage with materials that do not include their identity sends the message that they are not “normal,” a message they are already getting constantly from society. As psychologists, we aim to further our understanding of people in hopes of improving their conditions, not contributing to their difficulties. We believe that making our research process as painless as possible is not only good ethical practice (Haverkamp, 2005), but also is in the interest of collecting more accurate and precise data.

3. Use Inclusive Demographic Forms and Measures to Increase the Validity and Sensitivity of Your Research

Take home. Ask for race and ethnicity, as well as biological sex and gender identity.⁴ Research your likely participants (e.g., geographical area) to inform your categorical choices. Offer write-in “not listed, please describe” categories for all demographic

variables to more accurately collect (and analyze) these characteristics. We recommend adapting the University of Massachusetts Boston comprehensive demographic form (Suyemoto et al., 2016; see Appendix).

As society evolves over time, identity categories (sexual orientation, race, gender) also evolve and change. It is important that we as researchers move with society, as our goal is to capture and understand the current human experience as best we can. We suggest taking the time to adapt demographic forms to be more inclusive, including offering write-in “not listed, please describe” responses to all questions, which allow participants to self-define if the available options do not fit their experience. Regardless of the type of demographic measure used in a given study, we encourage scientists to fully describe how their demographic data were collected when reporting the data, including the specific questions used for self-identifying race and/or ethnicity.

Offering a limited set of identities for participants to select from may compromise data and research validity. Indeed, in a recent study of the current (close-ended, check-box approach) NIH demographic questions, Eisenhower et al. (2014) found missing data rates at 26% for race and 43% for ethnicity. Alternatively, when an open-ended, write-in response was employed, only 11% and 18% of data for race and ethnicity were missing. When self-identification and NIH race responses were compared within participants, they matched only 44% of the time, suggesting that current NIH guidelines do not adequately capture participants’ identities.

In addition to compromising validity, offering a limited set of identity options has negative emotional repercussions, which authors argue can be viewed as unethical (Townsend, Markus, & Bergsieker, 2009). Asking a participant to fill out a form and check boxes that do not include an important part of their identity or experience can be harmful and off-putting (Suyemoto & Dimas, 2003). Feeling like researchers do not understand, make space for, or value this person’s experience may impact the person’s comfort level and reduce participation in this and future studies. Further, individuals’ perceptions of psychology as a field at large (including therapy) could be impacted negatively. It is our job as psychologists to do our best to avoid con-

tributing to participants’ feelings of marginalization and/or discrimination, as these experiences have been related to higher risk for stress and mental health difficulties (sexual orientation: Cochran & Mays, 2009; SES, race, and ethnicity: Karlamangla, Friedman, Seeman, Stawski, & Almeida, 2013).

Though ideally we would be able to perform powerful analyses looking at each self-defined race and ethnicity label offered by participants, we know that this is not often realistic in research studies, particularly if that is not the primary question being asked of the data. We acknowledge that check boxes are helpful for quantitative research, so we suggest offering a write-in response for participants, then later coding/collapsing groups together if necessary. Since rich demographic data can be easily collapsed based on analyses, choosing not to collect these data is making a choice to not take the participants into account. Offering participants the freedom to self-identify and valuing transparent and full demographic description of one’s sample will likely help us recruit more diverse samples by not invalidating potential participants, identify new categories to be considered in our research, and accurately represent the demographic makeup of our samples.

4. Provide Your Definition of Demographic Variables Like Race and Ethnicity for Participants on Demographic Questionnaires

Take home. Providing participants with a brief explanation about how you define demographic variables will ensure you are on the same page, increasing the validity of your research.

Similar to the history within the field of psychology, the confounding of race and ethnicity and the lack of clarity about the meaning of these variables is widespread colloquially (Omi & Winant, 2012; Smedley & Smedley, 2005). Thus, participants might not only offer unclear (and less valid) data when operationalization confounds the variables but may also be confused if they are asked to separately indicate their race and ethnicity. Though we want to be careful not to impose specific content for demographic variables, which would impose categories, we find it helpful to provide some guidance of basic meaning for participants, as it helps increase the validity of our research. Therefore, including some explanatory text before your demographic questions, specifically regarding

⁴Ask for both biological sex and gender identity to be inclusive of participants who do not identify as cis-gender.

race and ethnicity but also in relation to gender identity, may help orient participants to what you are asking about, as will clarifying your perspective of the difference between race and ethnicity and giving a few examples (e.g., Black vs. African American and Dominican American). Being up front and clear about the operationalization of these complex concepts allows participants to answer questions in line with how their data will be analyzed. Most self-report questionnaires involve some introductory text orienting participants to the survey, and demographic assessment forms need not be different. Please see the UMass Boston demographic form (Suyemoto et al., 2016; see Appendix) as an example of text used to orient participants to reporting racial and ethnic identifications.

In summary, we encourage readers to engage in additional reading and discussion about terminology and research methods, as we believe that this process will lead to both increased cultural competence as a field, as well as more accurate data collection. Engaging in the process of becoming “culturally competent” is a lifelong one, and we hope that increased discussions in the field will lead to greater learning and more refined suggestions for data collection and analysis. This article is part one of a two-part series. Part two will discuss how we can increase our cultural competence with data analyses and dissemination.

Note

We include in the Appendix (pp. 83-89) the UMB Comprehensive Demographic Questionnaire, as an example of a demographic assessment that can be adapted for use in specific research contexts. The measure should be cited as follows: Suyemoto, K. L., Erisman, S. M., Holowka, D.W., Fuchs, C., Barrett-Model, H., Ng, F., Liu, C., Chandler, D., Hazeltine, K. & Roemer, L. (2016). *UMass Boston comprehensive demographic questionnaire, revised*. As cited in Wadsworth, L. P., Morgan, L. P., Hayes-Skelton, S. A., Roemer, L., & Suyemoto, K. L. Ways to boost your research rigor through increasing your cultural competence. *the Behavior Therapist*, 39, 83-89.

The authors of the measure provide the following note:

As noted by Wadsworth et al., assessment of demographic variables should be revised and adapted to incorporate changes in understandings over time or due to context, including using the language preferred by those from marginalized communities. Demographic questions should also be tai-

lored to best fit research questions. Researchers should particularly review “not listed” write-ins to see if common responses should be added as options.

We attempt here to be “comprehensive” in approaching operationalization of some basic demographics such as race, ethnicity, gender, and sexual orientation. We recognize that some questions included may be more or less relevant, depending on the study and issues of interest. Others may be central as checks or descriptors. For example, assessing English fluency can help evaluate whether there are individuals in the sample who may not fully understand the language within a written survey and should be excluded to ensure validity. In addition, these questions are aimed at general studies with diverse samples. For studies specifically focused on experiences of race, racism, ethnicity, or culture, researchers should more fully operationalize the variables of interest. Race-related variables may include racial identity status, salience, or centrality, as well as the social impact of racial identity and/or ascribed racial identity including experiences of racism. Ethnicity-related variables may include ethnic identity status, salience, or centrality, as well as the social impact of ethnic identity, cultural affiliation with ethnic or dominant American ethnoculture (distinct from identity), acculturation, or experiences of ethnocentrism.

Finally, we recognize that some demographic variables are not represented here (e.g., disability) or minimally represented here (e.g., religion and spirituality). Social class is a particularly complex variable that we feel could be significantly expanded, especially if central to a given research question or interpretation. Social class is more than income, education, or occupation (Lau, Cho, Chang, & Huang, 2013; Liu, 2004). We include questions here that enable the reporting of income, education, and occupational status separately or as a composite; these variables are often seen as indicators of SES or social status, rather than social class (Lau et al., 2013). Lau et al. argue that a composite that includes income with education and occupation may be misleading. However, a composite of education and occupation may be helpful, particularly if a categorical approach accounts for the prestige of a job rather than solely the income associated with it. As indicated in the Appendix, we use the occupation and education categories from The Barratt Simplified Measure of Social Status, which enables a composite (BSMSS; Barratt, 2012) that is based on Hollingshead with

updated occupation categories: it results in a numeric score that is useful if one wants a continuous score. We also include experiential questions of SES, but aim to move beyond simple categorization by using a more descriptive approach to financial situation (e.g., question #15). We do not include here questions addressing social class as a cultural identity (e.g., Kraus, Piff, & Keltner, 2011), but recognize that some researchers should include such questions. Others may choose to consider variables such as food or housing insecurity, which may better capture central demographic social status issues anticipated to be related to the central research question. For education, depending on the setting, one may choose to add to Barratt’s original categories, to acknowledge the achievement of an Associate’s degree or trade school certification. While these would need to be recoded into Barratt’s categories, they offer an opportunity to acknowledge the achievements of less traditional students and of skilled trades and training.

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Appendix A

UMB COMPREHENSIVE DEMOGRAPHICS QUESTIONNAIRE

Suyemoto, K. L., Erisman, S. M., Holowka, D.W., Fuchs, C., Barrett-Model, H., Ng, F., Liu, C., Chandler, D., Hazeltine, K. & Roemer, L. (2016). UMass Boston comprehensive demographic questionnaire, revised. As cited in *Wadsworth, L. P., Morgan, L. P., Hayes-Skelton, S. A., Roemer, L., & Suyemoto, K. L.* Ways to boost your research rigor through increasing your cultural competence. *the Behavior Therapist, 39, 83-89.*

The following questions are to help us get a better sense of who is responding to this survey. Some of the questions may be related to the other things we ask about in the survey, but many of them we don't expect to be related to the other questions. We just want to be able to describe the people who filled out these questionnaires so that we can clearly see how our findings might relate to people from different backgrounds. We know that many of these these categories may not fully capture the complexities of each individual's experience, however they are an attempt to reflect the diversity of people's identities. Remember that you are free to choose not to respond to any questions that you are not comfortable answering.

1. What is your current age? (*please write in answer*) _____

2. What is your biological sex?

Male

Female

Intersex

Not listed (Specify if you choose____)

3. What is your gender identity?

Male

Female

Transgender

Nonbinary/fluid
queer/gender queer

Not listed (please specify if you
choose_____)

4. What is your sexual orientation?

Asexual

Bisexual

Gay or Lesbian

Heterosexual

Queer

Pansexual

Not listed, please specify if you choose _____

5. With what religion or spiritual practice (if any) do you identify?

6. What is the highest grade in school, year in college, or post-college degree work you have completed?

[The categories from the Barratt Simplified Measure of Social Status, BSMSS or similar composite measure are offered here]

7. Do you currently live in the United States?

Yes

No

8. If you do not currently live in the US, how long have you been living outside of the U.S.?

9. Are you currently:

- Part time student Full time student Not a student

10. Are you currently involved in paid work?

- Not at all
 Working 1-20 hours per week
 Working 21-30 hours per week
 Working 31-40 hours per week
 Working over 40 hours per week

11. If you are currently involved in paid work, check the category for your occupation.

[The categories from the BSMSS are offered here]

12. Currently, your total annual *household* income (all earners) is:

- \$0 - \$15,000
 \$15,001 - \$25,000
 \$25,001 - \$35,000
 \$35,001 - \$50,000
 \$50,001 - \$75,000
 \$75,001 - \$100,000
 \$100,001 - \$200,000
 More than \$200,000

13. Were you financially supported by someone else this past year? Yes No

14. What is the total number of people who rely on this income (including yourself)?

15. Currently, how would you describe the financial situation of your family?

- Routinely unable to purchase sufficient food or other basic necessities
 Occasionally unable to purchase sufficient food or other basic necessities
 Have enough money for the necessities
 Have more than enough money for necessities and some luxuries

16. What languages do you currently speak?

- English
 Other (please specify) _____
 Other (please specify) _____

17. How fluent are you currently in English?

Not at all fluent

1

2

Moderately fluent

3

4

Completely fluent

5

18. What language is currently used in your home most of the time?

English

Other (please specify) _____

Racial and Ethnic Background

We're interested in getting a complete picture of your racial and ethnic background. Because this information can be so complex, we are going to ask you several questions about your race and ethnicity in order to get as complete a picture as possible.

19. Racial categories are based on visible attributes (often skin or eye color and certain facial and bodily features) and self-identification. These groupings have social meanings that affect how people see themselves and are seen and treated by others. Race is not the same as ethnicity or culture. **In your own words, what is/are your racial identification(s)?**

20. Although the categories listed below may not represent your full identity or use the language you prefer, for the purpose of this survey, please indicate which group below most accurately describes your **racial identification?** (check all that apply)

Native American/American Indian/Alaska
Native/Indigenous

Middle Eastern/North African (Non-White)

Asian

Pacific Islander/Native Hawaiian

Black

White

Latinx/Hispanic (Non-White)

Multiracial (*please specify*): _____

Not listed (*please specify*): _____

[For multiracial participants:]

21. Multiracial people can identify in various ways, sometimes in relation to specific racial heritage, sometimes as "multiracial," or in various other ways. Which of the following best captures how you racially identify? Please choose one.¹

Mixed/both/multiple—you'll have a chance to tell us about your specific background next.

Primarily Latinx/Hispanic (Non-White)

Multiracial generally—without reference to any particular race or races.

Primarily Middle Eastern/North African (Non-White)

Primarily Alaskan Native/Native American/Indigenous

Primarily Pacific Islander/Native Hawaiian

Primarily Asian

Primarily White

Primarily Black

Primarily in a way not listed (*please specify*): _____

¹ These options are responsive to the multiple ways that racial identity may be experienced by multiracial people and to the historical marginalization experienced by multiracial people in research. They also enable the researcher to make decisions about whether or how to include multiracial people within racialized groupings.

21a. [if the person chooses “Mixed/both/multiple” they should then be asked “Given that you identify as Mixed/both/multiple, please tell us which of the following are part of your identity?” and the categories listed in question #20 should be offered.]

22. How often do people perceive you to be the race you are? (Please circle one)²

<i>hardly ever perceived correctly</i>		<i>sometimes perceived correctly</i>		<i>always perceived correctly</i>
1	2	3	4	5

23. If you indicated that people sometimes or frequently do not perceive you correctly (1, 2, or 3), please indicate the race that people most frequently perceive you to be:

The categories listed in question #20 should be offered here.

24. Ethnicity or ethnic culture refers to patterns of ideas and practices associated with a group of people sharing a common history, geographic background, and/or language, rather than their racial background. It might include things like values, patterns of interacting, food, dress, holidays, or ways of seeing the world, yourself, or other people.

There are hundreds of different ethnic culture backgrounds within the people in the United States. (such as Cuban, Haitian, Cambodian, African-American, American, Ukrainian, etc.). We are interested in the ethnicity that affects your daily experience, which may be the heritage of your ancestors if you continue to practice and be affected by that heritage, but it may also be a more pan-ethnic or pan-American ethnicity. **In your own words, with which ethnic group(s) do you identify?**³

[Researchers may want to develop their own categorical variable for ethnicity to fit the communities they are studying. However, this should be carefully considered, as regional categories frequently reflect overaggregation, may not actually address ethnic culture, and/or may be confounded with nationality or family national heritage.]

25. How much do you embrace the values in the *ethnic culture(s)* you identified above?⁴

<i>not at all</i>		<i>somewhat</i>		<i>very much</i>
1	2	3	4	5

26. How much do you participate in the *ethnic culture(s)* you identified above?

<i>not at all</i>		<i>somewhat</i>		<i>very much</i>
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² This and the following question are important for studies that are using racial self-identification to proxy for social experiences related to race, such as racism. For example, if one plans to interpret that differences between Black Americans and White Americans are related to stress from racism, it is important to understand that participants are actually experiencing Black related racism, which is predicated on being socially perceived as Black.

³ This question is coded by research teams, balancing representation of participants’ self-identifications and conceptual ethnic similarity related to history and ethnocultural similarity with aggregation necessary for creating group sizes necessary for statistical analysis.

⁴ This and the following 3 questions are important for studies that are using ethnic self-identification to proxy for cultural affiliation. For example, if one wants to interpret differences in emotional expressiveness as related to ethnic values of collectivism, or differences in high blood pressure as related to ethnic dietary practices, it is important to know that participants actually embrace the values or engage in the ethnic practices.

37. Who was your primary caregiver while you were growing up? (Choose one: if you had more than one primary caregiver you will be given a chance later to respond to these items for additional caregivers)

- Mother Father Grandmother Grandfather
 Aunt Uncle Other family member
 Legal guardian Not listed (Please specify) _____

38. Please indicate which group below most accurately describes your primary caregiver: (check all that apply)
The categories listed in question #20 should be offered here.

39. Where was this person born?
The categories listed in question #29 should be offered here.

40. If he/she was not born in the U.S., has he/she ever lived in the U.S with an intention of settling in the U.S.?
 Yes No

41. If this person was not born in the U.S. but has lived in the U.S., how old was he/she when he/she first came to the U.S. with the intention to stay?

[Insert questions to assess education and occupation for first caregiver, using options above from BSMSS]

42. Did you have another caregiver while you were growing up?
 Yes No (If no, please skip to question #).

[Insert questions #38 up to #42 as above for second caregiver]

43. Growing up, your family's average annual *household* income (all earners) was:
The categories listed in question #12 should be offered here.

44. What is the total number of people who relied on this income (including yourself)?

45. Growing up, how would you describe the financial situation of your family?
The categories listed in question #15 should be offered here.

46. In what sort of community were you primarily raised?
 Farm/rural Small town
 Medium-sized town/Suburb Small city/Large suburb
 Urban

CURRENT CONTEXT

47. What is your relationship status? *(check one)*

- Single Married Civil Union Cohabiting
 Separated Divorced Widowed Not listed *(please specify):*

48. If you are married or partnered, please answer the following questions about your partner/spouse:

[Insert questions to assess education and occupation for partner/spouse, using options from BSMSS, see footnote 1]

49. Currently my neighborhood is:

[The categories listed in question #34 should be offered here.]

50. Currently my friends are:

[The categories listed in question #34 should be offered here.]

Ways to Boost Your Research Rigor Through Increasing Your Cultural Competence (Part 2 of 2)

Lauren P. Wadsworth, Lucas P. Morgan, Sarah A. Hayes-Skelton, Elizabeth Roemer, Karen L. Suyemoto, *University of Massachusetts Boston*

THIS ARTICLE IS PART TWO of a two-part series on ways to increase your research rigor through cultural competence. We highly recommend reading part one first for a thorough introduction, scoping, and author disclaimers.

To briefly recap, we hope this series will provide information about a few ways to increase our cultural competence as researchers, something that so many of us strive to do. To us, being a culturally competent psychologist means: (a) admitting that we do not know everything we can know about all cultures and the variety of human experiences, (b) recognizing that we are all socialized to have biases in understanding and working to recognize and counteract these biases, and (c) taking responsibility to address the inevitability of our lack of complete knowledge and socialized biases by choosing to actively engage in a continuous learning process, striving to always learn more and approach research and therapy with an informed curiosity about how experiences might vary based on the many areas of our participants'/clients' identities. We acknowledge that we are limited by space, and therefore will not adequately explore and discuss all nuances or growth areas in this life-long process. However, we hope this will be a helpful resource and/or food for thought and contribute to an important, ongoing conversation.

Part C: Avoiding Overgeneralizing and Overaggregation

Though it is important for us as scientists and clinicians to educate ourselves about cultures other than our own, it is also important not to overgeneralize or overaggregate. It is key to consider the ways in which individuals' identities intersect (e.g., race and sexual orientation) and what the implications of those intersections might be. Additionally, as it is essentially impossible to collect a completely generalizable sample on all areas of identity, it is helpful to discuss limitations of

our samples when reporting study findings.

1. Consider Ways in Which Groups Might Vary Based on Multiple Cultural Factors and Intersections of Multiple Identities

Take home. Consider intersections of your variables of interest along with demographic variables and check for differences among identity subgroups that may be affected by experiences of social and economic oppression.

Varying identities come with varying experiences, which is of critical interest in a socially oriented and dependent species like humans. Race, ethnicity, sexual orientation, gender, and disability status are among some of the identities that experience a continuum of privilege and oppression based on one's membership within each group. Identifying as a member of a historically and presently oppressed group is correlated with health disparities both physical and psychological (Jones, 2001; U.S. Department of Health and Human Services, 2001). Thus, it is important that we as a field increase our commitment to investigating potential group differences in our studies. The APA, NIH, and many journals are increasingly stressing the importance of collecting diverse samples for studies exploring the general population (as opposed to studies investigating the role of certain identity characteristics and/or identity intersections, where specific, nongeneralizable samples are methodologically necessary, i.e., the impact of underrepresented Asian identities). If we collect samples with adequate group size on socially relevant factors (i.e., race, ethnicity, sexual orientation, gender) we can check to see if there are significant differences between groups, which would bring to light relevant complexities in our findings.

When analyzing and interpreting data, it is also important to consider differences that might be due to intersecting factors,

both in controlling for variables and looking at between-group differences (for a recent review on intersectionality, see Warner & Shields, 2013). The concept of intersecting identities suggests that experiences of an individual may be qualitatively different from others in their "group," because of the impacts of other parts of their identity. For example, if you are interested in researching the effects of experiences of discrimination in sexual minority groups, you might also want to look at intersections of marginalized racial groups within sexual minority populations (e.g., see Boulden, 2009; Han, 2007; Masequesmay, 2008), as well as differing experiences of bisexual individuals, as both have been shown to be rejected within the LGBTQ community (Weiss, 2003). Additionally, the experiences of minority sexual orientations may differ between states where there are inclusive legal protections and policies, compared to states where there are not (Hatzenbuehler et al., 2009). Thus the intersection of sexual orientation and geography/local political climate may result in significantly different experiences and differentially relate to mental health variables of interest. In other words, studying race and sexual orientation separately may miss the important and unique differences in experiences, for example, between Black gay men, Asian gay men, and White gay men, and between Black gay men and Black gay women, and so on. Investigating the impact of these intersections initially may lead to more impactful research that helps us learn more about the interaction between identities and psychological factors (e.g., depression, treatment response status, neurological measures). As another example, if you performed a study on the role of work stress and anxiety, investigating differences and/or controlling for participants having one or more marginalized identities would be an important consideration, as those identities are associated with greater daily stress in the form of societal oppression. When sample size limitations preclude analyses of these types of intersecting identities, discussion sections can note the importance of exploring these questions in subsequent studies.

2. Addressing Sample Limitations to Generalizability

Take home. Taking the time to collect samples that reflect the demographics of the group(s) you are investigating is valuable. However, there are often constraints (i.e., time, location, accessibility) that limit our ability to collect our ideal samples. There-

fore, it is important that we think deeply about our limitations and the implications, and fully report them in discussion of our findings.

Ideally, we would all collect completely generalizable samples on all demographic characteristics. However, there are often barriers that get in the way of collecting samples high on external validity. For example, sometimes we do not have adequate time, or are in locations that are limited in diversity on demographic variables, or our laboratories have limited accessibility or recruitment resources. Whatever the reason may be, if we are not able to collect a generalizable sample, and our research question refers to the general population (e.g., exploring the relation between rumination and symptoms of anxiety), it is important that we acknowledge our sample limitations, so that our findings are not inappropriately generalized by readers.

For example, imagine we performed the study mentioned above and obtained a sample of 120 people, where 90% identified as White ($n = 109$), 9% Black ($n = 11$), and 1% Asian ($n = 1$). Just like we would not draw conclusions from a sample of 11 or 1, we cannot assume that the findings are generalizable to non-White individuals/groups given their lack of representation in our sample. Nevertheless, the data are still valuable and worth reporting. To engage in more culturally competent practices, we would be sure to mention the study's limitations in the discussion section and recommend that future studies investigate whether findings from a given study hold with different kinds of samples, such as in non-White populations. One might describe these limitations in great detail, or simply list demographic characteristics that are not adequately represented in the study, such as, "the findings are generalizable to White individuals, but we cannot be certain that they generalize to non-White individuals due to limitations in our participant recruitment." Limitations should mention underrepresented groups on all demographic data collected, such as race, ethnicity, sexual orientation, gender identity, and socioeconomic status. As mentioned above, marginalized groups experience physical and mental health disparities that often relate to our research questions in psychology. In hopes of encouraging an increase of culturally competent research, we might also mention if we did not collect some aspects of participants' identities (e.g., if the study did not collect sexual orientation of participants, if a limited check-box approach was used for

gender, such as "check male or female," preventing participants who do not identify as such from reporting). Humans are complex, and while it is our duty as psychologists to do our best to capture that complexity, if we do not, the second best thing we can do is acknowledge our limitations. Acknowledging these limitations not only increases the accuracy of dissemination, but also puts culturally competent strategies on the radar of our readers and will in turn hopefully contribute to positive changes in the field.

Part D: Exploring Yourself, in Context

One of the most integral aspects of engaging in a journey of increasing our cultural competence is to recognize ourselves as beings that have many aspects of our own identity. By understanding our identities, and how we relate to structures of power and privilege in each area of our identity (e.g., race, gender, sexual orientation, disability status, etc.), we can identify areas in which we have limited understanding into the lived experience of someone in a marginalized position. By doing this, we can start to uncover our own biases that might be subconscious, approaching the world from a more decentered (and perhaps scientific!) perspective.

3. Realize and Recognize That You Are a Racial and Cultural Being and Recognize in Which Identities You Experience Power and Privilege or Oppression

Take home. *As social beings, we are shaped by how people and institutions categorize and interact with us. Perhaps less apparent is how we are shaping institutions and others based on our own assumptions, beliefs, and actions. It is important for us to get to know our own biases as researchers in order to better prevent reifying cultural incompetencies, biases, or stereotyping in study design or analysis.*

It has been our experience that one particular complication in studying race and ethnicity (especially in the U.S.) is that many people who would identify as racially White and ethnically European American in the U.S. (both participants and researchers) often feel they have no race/culture/ethnicity. This invisibility of European American ethnic culture and White racial status to many White European Americans is in part due to the dominance and ubiquity—the perception of White and European American as “just

being normal/neutral.” It is also important for us to think individually about the assumptions that Western psychology and science are founded upon (such as the idea of objectivity and universality), which may themselves be European or European American cultural beliefs.

We are all multicultural beings shaped by our families, social interactions, society, media, and other factors. Therefore, all of our decisions are affected by assumptions, worldviews, and biases that we have unconsciously developed. Every decision we make as researchers, clinicians, teachers, siblings, parents, friends, etc., is shaped by these cultural forces (APA, 2003; Sue et al., 1982). For example, coming from an independent orientation (often associated with “Western” culture) might lead to automatic, unconscious favor for individualistic traits and negative judgment of collectivistic approaches that do not even conceptualize “traits” as most salient in predicting behavior (Greenwald & Benaji, 1995). That being said, we have to make decisions, and we can never be 100% conscious of all of our blind spots (including in this article!). So we can all work hard to develop our awareness of biases. This includes seeking consultation with others about our questions and potential blind spots, making mistakes and learning from them, and working with others as they do the same.

We remind readers that there is no such thing as “culture-free research,” and hope that we can increase our curiosity and consideration of potential cultural factors as a field. In other words, every researcher in every study makes decisions about what perspectives and experiences to include in their models, variables, and hypotheses, and implicitly chooses what to leave out. Of course all studies are limited, but we argue that the more explicit we can make these decisions, the less power invisible biases will have on the research process and products, and the more valid, reliable, and generalizable research will be.

4. Step Outside Your Comfort Zone as You Read the Literature

Take home. *Reading outside our specific fields greatly enhances learning across disciplines, helps fill in gaps in understanding or “blind spots,” and provides alternative perspectives to issues across disciplines. Relatedly, seeking out recent publications on multicultural psychology is an excellent way to engage in the process of increasing one's cultural competence.*

Our field is limited by staying insular. During literature searches, step outside your comfort zone and search other literatures to see what other data there is on diversity in other fields. Many other fields and even sections of clinical psychology have done work on diversity that is rarely cited by more “mainstream” journals. If you study PTSD, look at research on PTSD in journals like *Cultural Diversity and Ethnic Minority Psychology* or *Journal of Black Psychology*, as just two examples.

It is possible that other researchers are passionately doing work in our areas, but are being published in journals that we do not typically read. Our field is astoundingly a-historical. Our research and theory are also consistently a-contextual, and do not take into account the influence that history and systems of power and oppression have on people’s mental health right now. Multiculturalism without discussing history, politics, and power is profoundly lacking. For example, after the abolition of slavery, shifting scientific disciplines (medical doctors, to anthropologists, to geneticists, to psychologists) were referenced to argue against interracial marriage, despite the lack of actual scientific evidence supporting claims that interracial marriage would result in psychologically inferior offspring or infertility in the next generation (Tucker, 2004). The lack of knowledge regarding claims being made by multiple isolated fields shielded many people’s understanding that the claims made against interracial offspring were actually without evidence (Tucker).

Reading literature from other fields or journals that we do not normally read can help us connect our work to historical and systemic forces that may be playing a large part in the lived experiences, current symptomatology, and disparities that exist right now, that people in our studies are experiencing, and which are being reflected in your data right now. Thus, by expanding

our scope of historical, contextual literature, we can increase our research rigor and likely increase our ability to understand differences or changes in/between groups that are evidenced in our data.

Closing Notes

Increasing one’s cultural competence as a researcher, clinician, and teacher is a never-ending process that involves continuous learning. Though the process is never-ending, it is the engagement in that process, rather than number of facts one knows, that we may measure ourselves by. That is to say that simply reading this article, and perhaps telling someone about it, is part of the process of being culturally competent. We hope that the above text is informative, and that it might inspire continued learning and exploration of the complexity of those we serve as psychologists, researchers, collaborators, and teachers.

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Assessing the Effectiveness of a Bedtime Behavioral Intervention for Military Children With Deployed Parents

Jessica L. Crawford, Jeremy D. Jewell, Stephen D. A. Hupp, Gregory Everett, Lacey Hall, *Southern Illinois University Edwardsville*

CURRENTLY THE UNITED STATES has 1.4 million active-duty service members worldwide with the majority serving within the United States (Department of Defense [DoD], August 31, 2013). Military deployments affect not only the military personnel, but their family members as well. For example, Lincoln and Sweeten (2011) state that approximately 55% of active-duty military members who have experienced deployment are married, while over 40% of these troops have at least one child who is under age 5. Several well-designed studies have looked at different characteristics and variables of the military child to determine contributing factors to behavior problems while a parent is deployed (Chandra et al., 2010; Chartrand & Siegel, 2007; Flake, Davis, Johnson, & Middleton, 2009). For example, Flake and colleagues (2009) investigated factors such as parental stress, use of available military support and resources, and parental education in relation to the psychological health of a military child. The authors found that approximately one-third of all children in the study were considered to be at risk for psychological difficulties during parental deployment with almost 40% of children experiencing some type of internalizing behaviors consistent with anxiety or depression (Flake et al.). Other studies have found similar increased rates of problem behaviors in children of deployed parents as well (Hardaway, 2004; Kelley, 1994).

The relationship between persistent internalizing disorders such as depression and sleep problems has been the focus of several studies in recent years. While there are many unanswered questions regarding the bidirectional relationship between depression and sleep problems (for a review, see Ivanenko, McLaughlin Crabtree, & Gozal, 2005), the most commonly reported bedtime resistant behaviors that young children exhibit are refusing to go to bed, calling out to parents from bed, leav-

ing bed, difficulty falling asleep, and frequent waking. To address these problems, behavioral interventions have been widely studied as a solution to bedtime resistance in young children. A recent review of the research on this topic revealed several types of interventions that are effective at reducing bedtime behavior problems (Mindell, 1999). The earliest of these studies focused on the behavioral method of extinction (requiring the parent to ignore the child's cries in most instances), but these studies were not well-received by parents due to the amount of stress placed on parents during the extinction period. Studies that compared extinction methods and positive routines found that both interventions were equally effective but positive routines were preferred by parents (Mindell, 1999).

Given the inherent vulnerability of military children for psychological and sleep problems, some programs have been created to improve communication between deployed military members and their families (Chartrand & Siegel, 2007). Related to this, the United States military has recently agreed upon policies that allow military bases and its members to take part in social media sites such as Facebook, Twitter, or Myspace (Dao, 2010). For families that cannot access video chat programs, there are other options available for children who would like to communicate with the deployed parents. Talk, Listen, Connect is a series of DVDs and online activities created by *Sesame Street* to help young children ages 2 to 5 cope with deployments (Sesame Street Family Connections, 2010). The video series explains the process of deployment and the changes that will take place while the military parent is gone in kid-friendly terms that are fun and interactive. A similar deployment intervention, titled *With You All the Way* and designed for children ages 6 to 10, offers support for school-aged children facing a parental deployment (The Trevor Romain Founda-

tion, 2010). *With You All the Way* is an animated DVD that chronicles two characters on a school trip who both have deployed parents. This DVD also offers advice and testimony on dealing with deployment from other military families and children. The deployment kit comes with a stuffed animal, writing journal, and several postcards to help young children express their emotions throughout the deployment. Unfortunately, however, there is currently no research on the effectiveness of either of these programs.

Another recently developed and potentially promising program to allow deployed parents to keep in touch with their families in a unique way is the *United Through Reading* program. This program makes a video recording of service members reading a book to their child (United Through Reading, 2010). The parent is given suggestions and can choose from four different categories of books, ranging from illustrated books for babies to chapter novels meant for teenagers. The parent is recorded reading the book and showing the child the pictures within the book. The DVD recording is sent home, and is meant to help the child and deployed parent cope with their separation. Anecdotal feedback from participants in the *United Through Reading* program has found that the program not only benefits the children but is also psychologically beneficial to the deployed parent (United Through Reading, 2010). Again, however, there is no published research on the effectiveness of this program.

Military deployment affects thousands of families each year, with many children experiencing difficulties with adjustment to new routines as well as symptoms of depression and anxiety related to their parent's temporary absence. Young children may not be able to fully comprehend the deployment but it is apparent that they experience difficulties adjusting to the many changes that take place after their parent leaves. According to Pincus, House, Christenson, and Alder (2004), children ages 1 to 12 years old are at risk for experiencing negative sleep behaviors throughout their parent's deployment. When reviewing bedtime resistance interventions, research shows that making changes to the family's normal bedtime routines is both effective and well-tolerated by parents (Mindell, 1999). By using a positive experience, such as incorporating reading stories into regular bedtime routines, families may experience a decrease in disruptive behav-

ior from their young children as they adjust to the absence of their deployed parent.

Programs such as United Through Reading appear to be a good resource for families experiencing deployment but there is currently no research that examines how the program affects military children. The United Through Reading video could easily be incorporated into a child's bedtime routine even if the routine did not include reading prior to deployment. United Through Reading strongly encourages participants to record videos before their deployment occurs, as locations and volunteers at overseas locations are limited. Unfortunately, scheduling these recordings prior to deployment may be difficult as not all military bases are equipped with official United Through Reading recording centers. Therefore, the current study adapted the procedures of this program to serve as an intervention for young children experiencing disruptive bedtime behaviors implemented after parental deployment. The current study fills a critical gap in the literature as the use of a video-recording of the deployed parent reading books for the specific purpose of addressing negative bedtime behaviors has not yet been studied for a military population. Therefore, it was hypothesized that the intervention of incorporating videos of the deployed parent reading to their children would lead to a decrease in bedtime resistance behaviors.

Methods

Participants

Families from communities surrounding an air force base in the Midwest were recruited through the base Enlisted Spouses Club. In order for these families to be selected to participate in the intervention, they had to have at least one parent currently deployed overseas and that parent had to be scheduled to be deployed throughout the entirety of the intervention, which was approximately 2 months. Families who had a co-sleeping routine with their children were not allowed to participate. Of the population living on this air force base from 2005–2009, nearly 25% of the residents were 9 years old or younger (United States Census Bureau, 2011). Over 85% of the base population ages 3 years and older were enrolled in school with the vast majority attending public school (U.S. Census Bureau, 2011). When examining the race and ethnicity of the air force base, 11% were African American, 1% were Asian, 1% were Native American, 83%

were White, and nearly 4% claimed other or claimed more than one race (U.S. Census Bureau, 2011). Families were screened for participation using the Children's Sleep Habits Questionnaire (CSHQ; Owens, Spirito, & McGuinn, 2000). Families were considered for inclusion in the study if any of the Bedtime Resistance scale items were marked by the parent as problematic. One bicultural family and one Caucasian family were screened for the current study and both families were selected for inclusion based on the previously described criteria. The families were only allowed to identify one target child for the intervention and the child had to be between the ages of 18 months and 7 years old. The children included were an 18-month-old female ("Jane") and a 4-year-old male ("John"). Jane was an only child living with her mother, while her father had been deployed for 1 month at the time that baseline data were collected. John lived with his mother and his 5-year-old brother while his father had been deployed for 3 months at the time that baseline data were collected.

Design

A nonconcurrent, multiple-baseline across participants research design was used to evaluate data. There were two phases to data collection for both participants. Phase 1 was a baseline phase, in which the at-home parent collected data on sleep behaviors using a sleep diary but did not change their child's typical bedtime routines. During Phase 2, the at-home parent was provided with videos of the deployed parent reading to the target child and was required to incorporate a video each night into their child's typical bedtime routine. The at-home parents were required to show a different video each night for the first three nights of Phase 2 but then the target children were allowed to request which video to view for the remainder of the intervention.

The timing for the initiation of Phase 2 was dependent on the Phase 1 baseline data. The data had to be collected for a minimum of three nights and had to be stable or increasing, not decreasing, in order for the intervention to begin. Jane's at-home parent collected Phase 1 baseline data for five nights while John's at-home parent collected Phase 1 baseline data for eight nights. The nonconcurrent, multiple-baselines across participants design allowed for a single intervention phase without having to reverse back to the baseline phase.

Measures

Children's Sleep Habits Questionnaire. The CSHQ (Owens et al., 2000) consists of 45 items related to the sleep habits and behaviors of children. It is a parent-report measure that yields scores in the areas of Bedtime Resistance, Sleep Onset Delay, Sleep Duration, Sleep Anxiety, Night Wakings, Parasomnias, Sleep Disordered Breathing, and Daytime Sleepiness. Parents are able to rate the behaviors as occurring "Rarely," "Sometimes," or "Usually," with "Rarely" meaning the behavior occurs 0-1 times per week, "Sometimes" meaning 2-4 times per week, and "Usually" meaning more than 5 times per week. The parent also indicated if each behavior was a problem by marking "Yes," "No," or "N/A." A study on the reliability and validity of this questionnaire revealed internal consistency ranging from 0.36 on the Parasomnias scale to 0.70 on the Bedtime Resistance scale (Owens et al.). Test-retest reliability ranged from 0.40 on the Sleep Duration scale to 0.79 on the Sleep Anxiety scale (Owens et al.). For the purposes of this study, only items from the Bedtime Resistance subscale were examined. These items are, "Goes to bed at same time"; "Falls asleep in own bed"; "Falls asleep in other's bed"; "Needs parent in room to sleep"; "Struggles at bedtime"; and "Afraid of sleeping alone." Families were considered for inclusion in this study if any of the Bedtime Resistance items were marked as problematic.

Dependent variable. Families completed sleep diaries each night during baseline and intervention phases. Parents were required to record bedtime resistance behaviors that occur each evening. These behaviors included crying out for parents and leaving bed to seek out a parent. The mothers of both participants recorded the frequency of these behaviors as well as the time at which the child was put to bed with lights out, the times at which the child awoke during the night, and finally the time that the child woke for the day. The researcher telephoned the mothers of both participants at the end of each week to receive a report of the data from each parent. At the end of the intervention period, the researcher met with each parent individually to collect the paper-pencil data and validated this data against the previously reported data. Total bedtime resistance behavior was calculated by adding the number of times that a child called out to a parent or sibling and the number of times the child left the bed each night.

Procedures

Approval was obtained from the university's Institutional Review Board prior to the beginning of the study. After the approval was obtained, written informed consent was obtained from the parent for each participant prior to the start of the intervention.

Remote bedtime story intervention. The deployed parent was recorded during a scheduled video-chat session with the researcher while reading three different children's books. The families were provided with hard copies of each book that was recorded. The researcher then transferred the recordings to a DVD for each participating family. The at-home parent then showed the video as a part of the child's typical bedtime routine. During the first 3 days of the intervention, the families viewed a different book each day. After the child had viewed each video, the child was able to request which video and book to read each night for the remainder of the intervention. The researcher requested each at-home parent make no other changes to their child's typical bedtime routine beyond showing the recommended video.

Results

The results from this study indicate that incorporating videos of a deployed parent reading to their child was an effective means of decreasing bedtime resistance behaviors (see Figure 1). Jane's total number of bedtime resistance behaviors decreased from a mean of 9.60 bedtime resistance behaviors per night during baseline ($SD = 4.16$) to a mean of 2.67 bedtime resistance behaviors in the intervention phase ($SD = 1.63$). Effect size was estimated by calculating Cohen's d and percentage of nonoverlapping data (PND), which is most appropriate given the nature of the design and dependent variable (Campbell, 2004). To calculate these statistics, the intervention phase was compared to the baseline phase. The effect size for the intervention phase was Cohen's $d = -1.67$ and $PND = 87.50\%$. Anecdotally, Jane's mother reported that Jane appeared to be teething and not feeling well on night 8 where a higher number of bedtime resistance behaviors was observed (crying out multiple times during the night).

John's total number of bedtime resistance behaviors decreased from a mean of 7.13 bedtime resistance behaviors per night during baseline ($SD = 2.42$) to a mean of

2.00 bedtime resistance behaviors in the intervention phase ($SD = 2.86$). The effect size for the intervention phase was Cohen's $d = -2.12$ and $PND = 92.30\%$. John's mother reported that during one night of the intervention phase (night 17) the family received multiple phone calls from family members due to a family emergency and John left the bed several times that night.

Discussion

The results of the current study suggest that using videos of a deployed parent reading bedtime stories to their child as a part of the child's typical bedtime routine is an effective way of decreasing bedtime resistance behaviors. Despite one outlier per case study, the overall effect of the videos was significant. In both cases, the parents of the child participating in the intervention informally reported positive feedback regarding the videos. Anecdotal evidence regarding parent satisfaction indicated that they enjoyed the intervention and viewing the videos as much as their children. Jane's mother reported that Jane requested to watch the videos each

night and that it was a positive experience. Jane's mother also informally reported that she experienced a decline in her own stress each night due to Jane's decline in bedtime resistance behaviors. Both families reported that they planned to continue watching the videos as a part of their bedtime routines after the study was complete. Although watching TV before bedtime is usually viewed as a maladaptive bedtime routine (American Academy of Pediatrics, n.d.), the virtual interaction with the child's deployed parent appears to be of enough benefit that it may be recommended as an intervention for children already exhibiting bedtime-resistant behaviors.

While this intervention is similar to the United Through Reading program due to the fact that both provide families with video-recordings of the deployed parent reading stories to their children, the current intervention has several advantages. One of these advantages is that this intervention allows parents to record videos after they have already left for deployment. Scheduling recordings through United Through Reading before a deployment

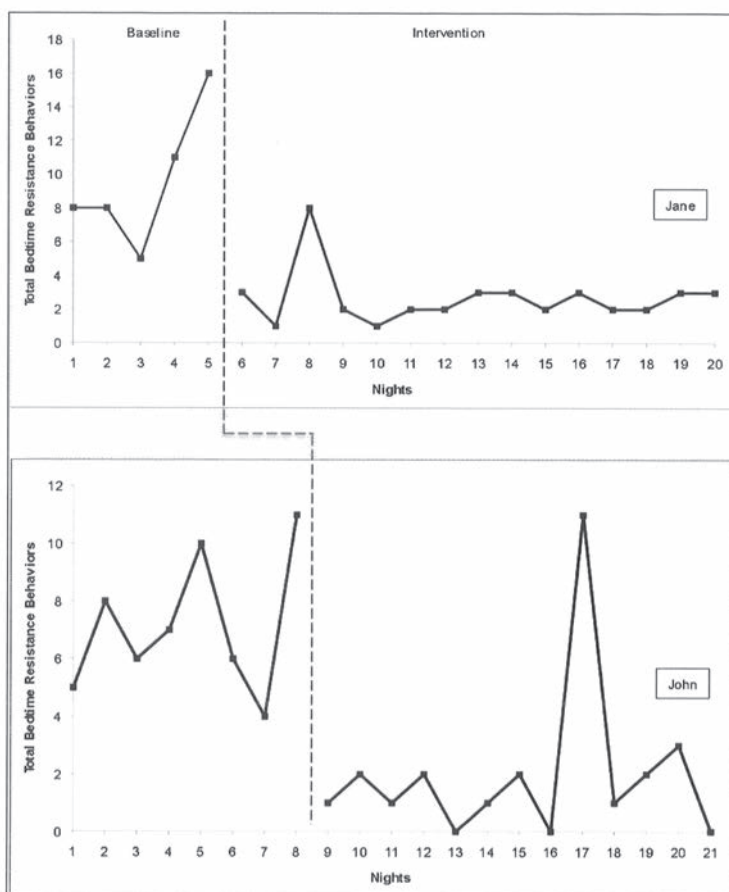


Figure 1. Total bedtime resistance behaviors

occurs can be difficult as the services are only available at each military base for a limited number of days each month. By using a video-based chat program, families can utilize the intervention any time during the deployment, as needed. Another advantage of the current intervention is that the selection of books available to read is not limited. Families can use any of their favorite books to record for the intervention. Scripts of each book were emailed to the deployed military member so that they could read the books aloud to their child, while the child at home followed along with a hard copy of the book.

The results from the current study were similar to those found in other bedtime resistance intervention studies. For example, the studies using positive bedtime routines reviewed by Mindell (1999) were found to be effective by adding calming, enjoyable activities to their bedtime routine. These studies (Mindell, 1999) added multiple calming activities in order to intervene with bedtime resistance behaviors while the current study added only the video to the participants' bedtime routines. Although only the video was added to their routines, the intervention was effective at reducing their problematic bedtime behaviors. While the number of bedtime intervention studies are limited, the current study may be the first to investigate this type of intervention with children of deployed parents. While the results of the current study do not provide direct evidence for the effectiveness of the United Through Reading program, these results could be considered indirect evidence for the effectiveness of that program given the similarities between the current intervention and United Through Reading. As stated previously, however, the current intervention has several advantages over the United Through Reading program, the most salient of which is the added convenience of implementation if the parent is already deployed and not near a recording site.

There were some limitations to this study that were observed. The first limitation is that no follow-up data were collected to determine if the effects of the intervention continued over a greater period of time. Future research in this area should examine the long-term effects of using these videos throughout a military deployment. Yet another limitation would be that only bedtime resistance behaviors were examined to determine treatment effectiveness. Decreases in time of sleep onset, as well as increases in length of time

spent asleep throughout the night, could have been examined but were not reported as areas of concern for the participants in this study. Another variable that could yield interesting results would be the effects that the intervention has on stress as well as sleep behaviors of the at-home parent. It is possible that by decreasing bedtime resistance behaviors in children that the parent may also experience secondary benefits of decreases in stress as well as increases in the amount of time slept and quality of sleep.

Not using a standardized measure of treatment acceptability would also be a limitation to this study and it would be beneficial for future research. Both at-home parents informally reported positive results and feedback for the intervention but a standardized assessment across participants would be a more reliable measure for future studies in this area. Another limitation is that the study did not look at treatment fidelity. The participants were required to view each of the three videos, one per night, on the first three nights of the intervention. Then the participants were allowed to choose which video to watch for the remainder of the intervention. No direct observations or formal treatment fidelity measures were employed to ensure that the intervention was implemented as intended.

Overall, the current study revealed that using videos of a deployed parent reading to their child during a military deployment was an effective way to reduce bedtime resistance behaviors in young children. The specific behaviors addressed were children's calling out to a parent or sibling and leaving bed after bedtime, but any number of bedtime resistance behaviors could be examined in future research studies. This study was designed to be easy for military families to implement as well as allow the military children to experience a positive connection with their deployed parent. This is a unique study with a specialized population that should be investigated further in order to expand the research literature on bedtime interventions for military children.

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CBT Medical Educator Directory

Another indispensable resource from ABCT—an online directory of CBT educators who have agreed to be listed as potential resources to others involved in training physicians and allied health providers. In particular, the educators on this list have been involved in providing education in CBT and/or the theories underlying such interventions to medical and other allied health trainees at various levels. The listing is meant to connect teachers across institutions and allow for the sharing of resources.

Inclusion Criteria

1. Must teach or have recently taught CBT and/or CB interventions in a medical setting. This may include psychiatric residents, medical students, nursing, pharmacy, dentistry, or other allied health professionals, such as PT, OT, or RD. Teachers who exclusively train psychology graduate students, social workers, or master's level therapists do not qualify and are not listed in this directory.
2. "Teaching" may include direct training or supervision, curriculum development, competency evaluation, and/or curriculum administration. Many professionals on the list have had a central role in designing and delivering the educational interventions, but all educational aspects are important.
3. Training should take place or be affiliated with an academic training

facility (e.g. medical school, nursing school, residency program) and not occur exclusively in private consultations or paid supervision.

Please note that this list is offered as a service to all who teach CBT to the medical community and is not exhaustive.

To Submit Your Name for Inclusion in the Medical Educator Directory

If you meet the above inclusion criteria and wish to be included on this list, please send the contact information that you would like included, along with a few sentences describing your experience with training physicians and/or allied health providers in CBT to Barbara Kamholz at barbara.kamholz2@va.gov and include "Medical Educator Directory" in the subject line.

Disclaimer

Time and availability to participate in such efforts may vary widely among the educators listed. It is up to the individuals seeking guidance to pick who they wish to contact and to evaluate the quality of the advice/guidance they receive. ABCT has not evaluated the quality of potential teaching materials and inclusion on this list does not imply endorsement by ABCT of any particular training program or professional. The individuals in this listing serve strictly in a volunteer capacity.

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