Theories, Models, and Practices for Understanding Gender, Race, and Ethnicity in Clinical Assessment

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Introduction

For most psychologists, assessment is an important and commonly practiced clinical activity. Addressing our professional curiosity and understanding about the human experience are a complex process that involves the understanding of factors with varied etiologies, varied course of progress, and varied multidimensional qualities and characteristics. Formal assessment can begin to help us organize these complex factors. Analogous to manipulating and transforming a "ball of wax" handed to us by our clients, assessment is likely to be impacted by who is doing the perceiving and handling of the "wax." That is, the practitioner's level of training, experience, and competency in assessment. The assessment process is also shaped by the referral question. Moreover, results from an assessment have a plethora of outcomes and consequences for the recipient of the evaluation. In this chapter, we discuss assessment as practiced by various psychologists, including clinical, projective, and objective assessment procedures, and explore ways to consider race, ethnicity, gender, and their intersectionality within these various assessment domains. We also provide recommendations for considering race, ethnicity, and gender in the assessment process and conclude with a case study that illustrates how to consider these variables in the scoring, interpretation, and formulation process.

In psychology, formal assessment is second only to psychotherapy (Phelps, Eisman, & Kohout, 1998). While there may be multiple ways to define psychological assessment, Meyer et al. (2001) note that "psychological assessment is concerned with the clinician who takes a variety of test scores, generally obtained from multiple test methods, and considers the data in the context of history, referral information, and observed behavior to understand the person being evaluated, to answer the referral questions, and then to communicate findings to the patient, his or her significant others, and referral sources" (p. 143).

Regrettably, as managed care influenced the mental health delivery system, the practice of psychological assessment was placed under considerable attack, with the challengers questioning its validity and utility. To address these concerns, in 1996, the American Psychological Association (APA) established the Psychological Assessment Work Group, whose primary charge was to examine the current threats of psychological assessment and identify the empirical evidence to support the effectiveness of assessment in clinical practice (Meyer et al., 2001). This workgroup examined data from over 125 meta-analyses

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on test validity and 800 samples involving multimethod assessment. The authors established that the validity of psychological tests was strong and persuasive, establishing that it was equivalent to medical test validity.

Traditionally, in formal assessments, clinicians first identify the problems or areas to be addressed, then they select and implement methods of extracting the information needed (e.g., use of behavioral observation, check lists, projective measures, review of records), and finally, they typically integrate objective sources of information around the problem(s). These steps enable practitioners to derive at conclusions including professional opinions, conceptualization, and recommendations. Lastly, some measures (e.g., objective and cognitive tests) provide population benchmarks (i.e., norms) for comparison. However, comparing an individual's complex presentation to others inherently raises some challenges, especially around race, ethnicity, and gender.

In order to effectively address issues of race, ethnicity, and gender in the practice of assessment, we suggest working interdisciplinarily across and within disciplines, while integrating basic and applied research. For example in psychology, Breckler (2006), APA's Executive Director for Science, succinctly defined the two concepts: "Basic research in psychology typically refers to theory-driven, hypothesis-testing science driven by a quest for fundamental understanding. Applied psychology is motivated more by a desire to solve practical problems and move the fruits of our scientific labor into the real world" (p. 24). Most of us can agree that the aforementioned goal is clearly one of the grand challenges in psychology and other disciplines. These challenges, also known as the wicked problems in the literature (Horn & Weber, 2007), share several of the characteristics highlighted in Table 14.1.

Kazdin (2009) asserts, "What we gain by referring to grand challenges as wicked problems is clarity about the fact that they require novel ways of thinking in relation to problem formulation, evaluation, and intervention strategies" (p. 342). Hence, it is through the integration of our disciplines, through bridging the gap between basic and applied research, and by infusing qualitative data into the study of human experiences that we could begin to identify solutions to the challenge of integrating race, ethnicity, and gender into the assessment process. This proposition is both a complex and arduous process, yet necessary to highlight and address if indeed we are devoted to furthering and enhancing our assessment practices.

Table 14.1 Salient characteristics of wicked problems (grand challenges)

• There is no single, definitive, or simple formulation of the problem
• The problem is not likely to be the result of an event, but rather a set of intersecting trends that co-occur and co-influence each other
• The problem has embedded in it other problems—including other wicked problems
• There is no one solution, no single, one-shot effort that will eliminate the problem
• Multiple stakeholders are likely to be involved, and this fact leads to multiple formulations of what "really" is the problem and therefore what are legitimate or appropriate solutions
• Values, culture, politics, and economics are likely to be involved in the problem and in possible strategies to address the problem
• Information as a basis for action will be incomplete because of the uniqueness of the problem and the complexities of its interrelations with other problems
• The problem is likely to be unique and therefore does not easily lend itself to previously tried strategies

Note. The table draws directly from Alan E. Kazdin, Ph.D., ABPP presidential address delivered at the 2008 American Psychological Association (APA) conference in Boston, Massachusetts (Kazdin, 2009)

Assessment and Culture: The Grand Challenges

Despite its effectiveness and popularity, assessment has shared a tumultuous relationship with multiculturalism. Dana (1998a) characterizes multicultural assessment in the USA as "still art, not yet science and controversial" (p. 62). Interestingly, Dana (1998a) notes that 15 of the 849 pages in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., *DSM–IV,* American

Psychiatric Association, 1994) focus on culture, age, and gender features, accounting for <2 % of pages devoted to issues pertaining to gender and multiculturalism. This finding clearly suggests the relevance or importance the mental health fields (e.g., psychology, psychiatry, social work, and counseling) have placed on cultural issues. Unfortunately, the mental health fields' understanding of culture is often simple or circumscribed. As noted by Fuentes (2003), the concept of culture is often overlooked, misused, or misunderstood, and Hays (2008) notes that the most common associations with culture are race or ethnicity. However, over the past decade many more scholars are willing recognize that the concept of culture is significant, complex, and multifaceted and are more receptive to broadening the concept of culture to include other influences such as gender, social class, religion, or sexual orientation (Arredondo & Glauner, 1992; Hays, 2008; LaRoche & Maxie, 2003). Moreover, understanding culture becomes even more challenging when we attempt to understand the synergistic nature of these multiple dimensions in individuals. The conundrum for practitioners becomes adequately comprehending, as well as effectively assessing the synergistic derivatives of these cultural factors and deciphering their relationship to identity development and functioning. For example, staying with the focus of this book, consider a "Black, Puerto Rican, female." Theoretically, we have three distinct cultural influences—race, ethnicity, and gender. How can we, as psychologists, accurately account for and appreciate the influence of all these dimensions? Regrettably, we often focus in a singular manner on one or two of these factors (e.g., race and ethnicity) and fail to consider the impact of the others (Jones & McEwen, 2000). LaRoche and Maxie (2003) argue that cultural influences are subjective, dynamic, and complex, noting that "cultural differences may include multiple variables (e.g., gender, sexual orientation, socioeconomic status, age, educational level, language, and religion)" (p. 181). They suggest that it is vital that practitioners consider how these cultural influences intersect and define an individual's identity and experience. Similarly, Kaplan and Bennett (2003) contend that "Identity is not always fixed or easily determined; and concepts and categories are inherently imprecise" (p. 2709). While their focus was on race and ethnicity, the spirit of their comment can be easily applied to other aspects of identity, including gender.

With respect to intersectionality, the most notable contributors have been Feminist and Queer theorists (Anzaldùa, 1987; Hill Collins, 1990; Moraga & Anzaldùa, 1981; Smith, 1990). Their narrative analysis research rejects the traditional notions of human identity and embraces "an alternative view of the self, located historically in language, produced in everyday gendered and cultural experiences, and expressed everyday in writing and speaking" (Bloom, 2002, p. 291). As noted by Thing (2010), "Feminist intersectionality theories … conceptualize identities as community achievements that are inflected by, and, to a large extent, shaped by the intersection of one's position within various social hierarchies including social class, race-ethnicity, gender, and sexuality" (p. 813). Relatedly, Jones and McEwen's (2000) Multiple Dimensions of Identity Development model explores the notion of "intersecting social identities." Their model emphasizes the nonsingular nature of identities, recognizing the fluid and dynamic contributions of multiple cultural influences. Fishman (1999) examines recent philosophical developments in the areas of postmodernism and pragmatism and encourages practitioners to assess and treat clients "in all their multisystemic complexity and contextual embeddedness" (p. 2). Fortunately, there has been a proliferation of interdisciplinary journals (e.g., Social Identities, Journal of Intercultural Studies) that embrace, promote, and publish research on intersectionality. The existence of these venues not only fosters research on phenomena related to intersectionality, but also creates a critical and exciting tipping point that could significantly alter the way psychologists study, conceptualize, and discuss identity and human functioning. Recently, Nettles and Balter (2012) have begun to examine how to best consider multiple minority identities in clinical practice and provide some very helpful insights. Their work examines the interaction of race, ethnicity, gender,

and disability and utilizes a power and privilege lens to understand issues related to identity development, minority status, stigma, and oppression. Leading scholars in the field consider the applications for practice, research, and training in this newly emerging area, paying careful attention to the intersectionality that exists amongst the demographic factors that inform identity.

One clinical approach that effectively captures the complexity and synergistic nature of identity is Falicov's (1998) Multidimensional Ecosystemic Comparatives Approach (MECA). MECA includes a number of assessment strategies that when correctly applied allow practitioners to fully understand the varied identity nuances involved in assessment. While the primary focus of her work is on Latinos, one could easily extrapolate and see MECA's relevance to the intersectionality of race, ethnicity, and gender. Falicov aptly defines culture as "those sets of shared worldviews, meanings and adaptive behaviors derived from simultaneous membership and participation in a variety of contexts, such as language; rural, urban or suburban setting; race, ethnicity and socioeconomic status; age, gender, religion, nationality; employment, education, occupation, political ideology, stage of acculturation" (p. 14). Moreover, the Ecosystemic component of her model presses practitioners to assess the multiple cultural contexts (e.g., race, social class, religion, occupation, and language) in which individuals are embedded, thus facilitating a more thorough and complex understanding of identity and human functioning.

While minimal research has examined the intersectionality of race, ethnicity, and gender as it relates to diagnosis and assessment, a number of studies have examined these constructs independently. For example, with respect to race and ethnicity, Nguyen, Huang, Arganza, and Liao (2007) screened 1,189 children participating in a federally funded intervention program. After controlling for age, gender, socioeconomic status, and functional impairment, they found that Black children were more likely than White children to be diagnosed with a disruptive behavior disorder. They also found that Latino children were less likely to be diagnosed with depression or dysthymia than their White counterparts. Relatedly, Kunen, Niederhauser, Smith, Morris, and Marx (2005) found race and gender disparities in the psychiatric rates of emergency department patients. They examined the psychiatric discharge diagnoses in a national sample of 33,000 patients seen in emergency departments. They found that Whites in general have higher psychiatric rates; however, African Americans were more likely to be diagnosed with schizophrenia. With respect to gender, they found that women were more likely to be diagnosed with mood and anxiety disorders. These studies suggest that certain racial, ethnic, or gender groups are either underdiagnosed or overdiagnosed with certain disorders. While it may be that that these findings accurately reflect reality, many of these authors caution that psychologist bias or diagnostician error may be involved. This is concerning since assessment and diagnosis go hand in hand with treatment and a flawed or inept assessment process may lead to compromised treatment. To this point, regretfully, Smedley, Stith, and Nelson (2003) conclude that "A large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are White Americans" (p. 2). Hence, it is critical that practitioners maintain a culture-centered stance in their assessment approach. The following sections will examine common assessment practices across disciplines and consider how they relate to the intersectionality of race, gender, and ethnicity.

Clinical Assessment and Diagnosis

The clinical interview is often considered the cornerstone of the assessment process (Sommers-Flanagan & Sommers-Flanagan, 2009). It is a critical and central activity of most psychologists. Most clinical interview protocols include a section on culture that primarily assesses the client's racial and ethnic background. However, the intersectionality of cultural influences as discussed earlier is typically not considered. Fortunately, several clinical assessment models,

such as Hays' (2008) ADDRESSING Model and Fuentes and Adames' (2011) Socio-Cultural Profile, consider issues related to culture, including race, ethnicity, and gender. These models will be discussed in greater detail later in this chapter.

One of the widely used and accepted diagnostic taxonomy systems in the USA and beyond is the *DSM-IV-TR*. The *DSM-IV-TR* attempts to reduce a clinician's unintended bias by including three types of information: Firstly, sections for certain disorders that encourage clinicians to consider specific cultural, age, and gender features that may influence the manifestation, prevalence, or course of the disorder; secondly, a glossary of culture-bound syndromes in Appendix I, which includes the most well-known culture-bound syndromes and idioms of distress; and lastly, the Cultural Formulation model also in Appendix I, which attempts to provide a standardized approach for assessing the impact of a client's cultural context on a client's functioning.

With respect to gender features, the *DSM-IV-TR* recognizes that certain disorders are more prevalent for certain gender groups. For example, the Bipolar-I disorder section notes that this disorder is equally common in both males and females; conversely, males are more likely to have their first episode be a manic episode, while females are more likely to experience a major depressive episode. Other disorders that are highly influenced by race, ethnicity, and gender include the eating disorders—anorexia nervosa and bulimia. Both have been found to occur primarily in most industrialized countries and are most prevalent in White females. Interestingly, the *DSM-IV-TR* notes that immigrants who adopt the host culture's thin-body ideals may be at risk for developing these eating disorders as well. Also, in non-Western cultures a different meaning may be associated with the food restriction, including epigastric discomfort or a dislike for the food taste. While highlighting the cultural and gender features for every disorder is beyond the scope of this chapter, clinicians are encouraged to seriously consider these *DSM-IV-TR* sections as they consider the appropriate diagnoses for their clients.

As noted earlier, Appendix I of the *DSM-IV-TR* also includes the clinical formulation, which is intended to supplement the multiaxial diagnostic assessment (American Psychiatric Association, 2000). Essentially, the cultural formulation is meant to assist diagnosticians in systematically assessing and documenting the influence of a client's cultural context, which is critical, since Lewis-Fernandez and Diaz (2002) assert that standardizing the cultural assessment process helps reduce systematic misjudgments and hidden biases. The *DSM-IV-TR* aptly encourages practitioners to consider each client's ethnic and cultural context as they relate to each of the five axes. The five major areas explored in the clinical formulation and drawn directly from the *DSM-IV-TR* include: the cultural identity of the individual; the cultural explanations of the individual's illness; the cultural factors related to psychosocial environment and levels of functioning; the cultural elements of the relationship between the individual and the clinician; and the overall cultural assessment for diagnosis and care. For an extensive consideration and application of the clinical formulation, the reader is referred to Lewis-Fernandez and Diaz (2002) and Shea, Yang, and Leong (2010).

While the clinical formulation assesses for very important cultural factors that influence the clinical presentation, its cultural scope appears to be limited to ethnicity and related factors (e.g., language, immigration, and belief systems), preventing a comprehensive and adequate assessment and understanding of the intersectionality of salient cultural influences such as race, ethnicity, and gender. Practitioners are encouraged to supplement the clinical formulation with other models that apply an intersectionality lens in the assessment process. The next section provides such models.

Assessing Intersectionality in Clinical Assessment

A cultural assessment model that has received considerable attention is Hays' (2008) *ADDRESSING* framework. In this model, Hays

skillfully uses the acronym ADDRESSING to remind psychologists of the important cultural influences that need to be considered in assessment and treatment. Each letter represents a particular cultural influence: *A*ge and generational influences; *D*evelopmental disabilities; *D*isabilities acquired later in life; *R*eligion and spiritual orientation, *E*thnic and racial identity, *S*ocioeconomic identity; *S*exual orientation; *I*ndigenous heritage; *N*ational origin, and *G*ender. Hays suggests that the ADDRESSING factors be regularly assessed as a sixth axis of the *DSM-IV-TR's* Multiaxial Diagnostic system.

Fuentes and Adames (2011) recently published the Socio-Cultural Profile (SCP) and use a power-based model to examine the multidimensionality of identity. The SCP encourages practitioners to engage in a conversation with their clients around various aspects of their identity and to consider the levels of power, privilege, or insubordination associated with each aspect of their identity. Essentially, the SCP requires clients to identify their membership in the following sociocultural categories: race, ethnicity, class, sex/gender, religion, sexual orientation, and ability/disability (mental and physical). Once their memberships are identified the clients are asked to identify both the systemic and personal statuses (power and privilege, mixed or subordinate) associated with their memberships. The SCP also includes a few empty categories, allowing clients to identify other significant sociocultural aspects (e.g., language, appearance) that influence their identity and functioning. Through this useful tool, both clinicians and clients are able to recognize the dynamic, fluid, and synergistic nature of identity. Moreover, through the SCP, users recognize that identity can be context specific, highlighting that in certain contexts, some aspects of identity are more salient. For example, being a Black Latina may be celebrated and revered in a matriarchal household, while experienced as a significant course of pain in the workplace. This example nicely illustrates that context plays a significant role in how particular cultural influences (i.e., race, ethnicity, and gender) are regarded. Essentially, people may have numerous identity dimensions that have particular salience at different times (Fouad, 2005).

The above-referenced assessment models all allow for critical information to be ascertained and considered in the clinical formulation process. However, the ADDRRESSING framework and the SCP provide the opportunity to consider the intersectionality of cultural influences such as race, ethnicity, and gender. Key questions such as "what is it like to be a light-skin, Jamaican woman?" or "tell me about being a dark-skin Latino" create an opportunity for clients to create and possibly revise their stories, while recognizing and understanding the multidimensional and dynamic nature of their identity. As noted by Ruth (2012), "part of what makes implicit racism, sexism, and microaggression so painful is precisely the clash between perceived external attribution and self-concept" (p. 165). Through an assessment process that is sensitive to intersectionality, clients may acquire access to these intrapersonal dynamics, gain compelling insights, embrace their psychological stories with empathy, or consider creating new identity narratives.

Finally, it is important for psychologists to recognize that using a single method to assess a client can lead to monomethod bias. Meyer et al. (2001) established that "…clinicians who rely exclusively on interview data are prone to incomplete misunderstandings…" (p. 128), possibly leading to incorrect findings and improper treatment. In short, administrative, financial, or professional efforts to restrict the assessment process to brief and circumscribed evaluations must be resisted (Meyer et al., 2001). This special workgroup on assessment recommends that psychologists engage in multimethod assessment practices to ensure the greatest validity of their assessments. The following sections discuss other commonly used assessment method (e.g., projective and objective tests).

Projective Assessment

Despite the scientific controversy surrounding projective techniques, they continue to enjoy widespread popularity and usage. While projective techniques are difficult to define succinctly, Lilienfield, Wood, and Garb (2000) note that they are associated with the projective hypothesis,

suggesting that respondents "project" or reveal aspects of their personalities when disambiguating unstructured stimuli. They are historically associated with psychoanalytic frameworks. The most widely used tests include The Rorschach, The Thematic Apperception Test, and The Human Figure Drawing. For a more thorough discussion of projective techniques, the reader is directed to Lilienfield, Wood, and Garb (2000).

Again, with respect to projective assessment and the intersectionality of race, ethnicity, and gender, very little is written. However, a discussion of the relevance of race and ethnicity in projective testing is more common. For example, Dana (1998b) discusses the use of projective methods with Latinos. He notes that poorly trained practitioners can compromise the assessment practice by introducing assessor bias, engaging in improper service delivery etiquette, utilizing inappropriate measures, and misinterpreting culturally congruent data. Unlike other scholars, he does not condemn the use of projective methods with Latinos and other cultural groups. Instead, he suggests combining projective tests with other assessment tests (e.g., objective measures) when possible and relevant to the referral question. Dana argues that there are some clear advantages to using projective measures with Latinos. And while he enumerates these advantages as they pertain to Latinos, his comments also apply to the intersectionality of race, ethnicity, and gender. First, Dana suggests that due to their open-ended nature, projective methods permit practitioners to ask more direct and poignant questions. If asked appropriately, these questions permit practitioners to inquire about and more fully understand the complexities and nuances of a client's responses, as they pertain to the intersectionality of race, ethnicity, and gender. Ruth (2012) provides a compelling perspective on using contemporary psychodynamic frameworks for conceptualizing multiple identity minorities, including race, ethnicity, and gender. He recognizes that "most psychoanalytic thinking and therapy has always privileged personal freedom over normative expectations" (p. 169), a very important notion that should undergird the projective assessment process. As patients engage in the projective testing process, they may reveal aspects of themselves that they find threatening or uncomfortable. Projective tests allow psychologists to inquire more about these challenging aspects and may help clients become more aware of and appreciate the complexity of their identity. As the projective data emerges and themes related to race, ethnicity, and gender are revealed, the psychologist can inquire more about these themes. For example, if a client discusses a character in one of the projective tests, the psychologist can ask how this character feels and thinks about their race, ethnicity, or gender.

The second advantage of projective assessment that Dana highlights involves the notion of the cultural self; in that, projective assessment assists in revealing and understanding the cultural identity of clients. Ruth (2012) notes that "identity sometimes operates as an assumption based on perceptible impressions of external realities, such as race and presumed gender" (p. 165), claiming "that how we experience others and their actions determines how we construct our experience" (p. 166). In short, the projective process may help clients recognize the tension between self-concept and imposed identity (Ruth, 2012). Professionals well versed in theories of multiple minority identities can easily explore the interplay between the cultural self and an White male-dominated society. Issues related to discrimination, oppression, and sexism can be easily identified, explored, and understood within the projective assessment process. Moreover, for psychologists, one of the major tasks is not to only collect the data, but to effectively conceptualize and formulate the information. A formulation that is grounded in frameworks that are sensitive to the intersectionality of race, ethnicity, and gender (e.g., Nettles & Balter, 2012) does not pathologize or challenge these dynamics, but rather understands and respects them. The formulation should facilitate an identity reintegration process that as Hinshelwood (2003) would argue prompts "a more textured, nuanced, and balanced self-conceptualization" (p. 170) (as cited in Ruth, 2012).

Objective Assessment

Objective assessment is an informational gathering method that aspires to provide practitioners and scholars with an understanding of an individual's traits, cognitive functioning, human experience, problems of living, vocational interests, and the like. It is a model that psychologists use to draw conclusions about the varied signs, symptoms, concerns, and questions (i.e., ball of wax) that patients often present with. Objective assessment ensures consistency in the use of techniques employed to diagnose disorders, plan treatment, communicate with other providers, and evaluate the effectiveness of interventions. Overall, the goal in an objective assessment is to make sense of, organize, and mold the complex symptoms and signs that patients or clients present with. Thus, in the assessment process, we aim to narrow the presenting problem(s) or presenting phenomena to specific areas such as mood, anxiety, cognitive deficits, and the like.

Psychologists typically work in settings where objective measures are used to assess and aid in treatment planning. Camera, Nathan, and Puente (2000) found that psychologists, with whom many other mental health providers collaborate, were most likely to use objective measures of intellectual abilities, personality, and psychopathology. Specifically, they reported that the most widely used objective tests and measures of personality and psychopathology included the Minnesota Multiphasic Personality Inventory Two (MMPI-2), the Millon Clinical Multiaxial Inventory (MCMI), and the Beck Depression Inventory (BDI). For evaluating intellectual/cognitive abilities, they reported the Wechsler Scales as the most widely used measures in this domain.

Anastasi (1997), a reputable scholar who developed two classic textbooks on psychological testing, reports "the adequacy of coverage of a test depends on the number and nature of its items, whereas its predictive or diagnostic value depends on the empirical relationship between its items and the behavior [and cognitive processes] in question" (p. 2). What Anastasi is referring to here is the gold standard of standardization, which includes developing uniform procedures for administering, scoring, and interpreting test results. Standardization allows test developers to generate normative data or a sample that represents the population for which the assessment instrument is intended. Hence, the first three challenges that arise when understanding, organizing, measuring, and making meaning of a sample of behaviors and cognitive processes involve issues related to (a) reliability, or consistency of test sores, (b) validity, or the extent to which we know what the test is measuring, and (c) issues related to standardization/norming. Given the aforementioned challenges, training programs, practitioners, and test developers typically focus their efforts on addressing these challenges. However, the fourth and final challenge, the reduction or elimination of any variables extraneous to what the test is measuring, receives less attention.

Anastasi (1997) identifies and addresses four extraneous variables including testing environment, administration of the test, coaching examinees receive prior to testing, and test anxiety. However, race, ethnicity, and gender, which can theoretically be classified or understood as *extraneous variables*, certainly impact assessment, its outcome, and problem conceptualization. The purpose of this section is to highlight some of the implications of this fourth challenge, specifically when integrating race, ethnicity, and gender into the assessment process. We propose that although we cannot eliminate or reduce a patient's race, ethnicity, or gender, such variables should be central to the assessment analysis. Issues related to reliability, validity, and norming are equally important; however, readers are encouraged to make use of the existing literature on psychometric properties and test construction in order to review and facilitate their understanding of the challenges inherent in these three domains (see Anastasi, 1997; Kaplan & Saccuzzo, 2009; Ryan, Lopez, & Sumerall, 2001).

Despite its reputation for being a precise and scientific tool for measurement, objective assessment testing can be a culturally biased procedure resulting in discrimination against disenfranchised groups, particularly against racial and

ethnic minority individuals. Given the plethora of concerns regarding issues related to multiculturalism and diversity in psychology, there has been an increase of attention addressing this issue in the literature over the last 3 decades. In fact, a number of critical foundational publications such as those by Sue, Arredondo, and McDavis (1992) coupled with the approval of the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologist by the American Psychological Association (2003) have provided the field with a framework and a starting point for us to begin a dialogue which the field has avoided and neglected for decades. Although early pioneers and current scholars in the field of multicultural psychology have been influential in promoting issues of diversity, we still face challenges when applying multicultural initiatives across settings and practices within the field (Fouad & Arredondo, 2007) and in particular when integrating issues of multiculturalism into the objective assessment process.

Objective assessment assumes that all people have the same kinds of experiences that can be captured through testing. For instance, some measures of mood assume that everyone describes their symptoms through words such as "feeling sad and blue." This bias in language may not be inclusive of individuals from different cultures, who may describe depressive symptoms through somatization. Other objective tests presume that there is uniformity and similar quality of education in the USA (Manly, 2006). Such biased assumptions are compounded by other factors such as the item selection process, the content of the items, and the response(s) considered acceptable to those items (Manly, 2005). Moreover, Helms (1997) asserts that traditional objective assessments (i.e., cognitive assessments) are based on skills considered important within the dominant White, Western, middle-class group and such skills may not necessarily be salient within ethnic minority groups.

Given the concerns encountered when using objective measures to assess ethnic minorities, scholars and clinicians have suggested the use of separate norms for different groups (Heaton, Miller, Taylor, & Grant, 2004). Heaton et al. (2004) propose the use of demographically adjusted cognitive norms for African-American and Caucasian adults based on chronological age, level of education, and gender. However, demographically adjusting norms have both advantages and disadvantages. Accuracy of the assessment procedure is typically improved when norms are used with individuals who are demographically similar to the sample demographic in which tests are standardized. Hence, having separate norms for different ethnic groups that are also based on gender and education level can improve the accuracy of the objective measure. Another advantage to using demographic norms involves the promotion of research on culture and objective assessment (Manly, 2005). Manly (2005) asserts that "The responsible collection of detailed cognitive, demographic, medical, and psychiatric information among large cohorts of healthy African Americans [or other racial/ethnic minority groups] help generate additional hypotheses for the effects of culture on cognition" (p. 271).

Using demographically adjusted norms can certainly be one of the first steps to addressing the challenge of integrating race, ethnicity, and gender in the objective assessment process. However, this first step, as a solution to a complex problem, has a number of disadvantages that merit some attention. Overall, having demographically adjusted norms does not explain why ethnic differences in cognitive test performance exist (Manly, 2006). These findings can lead many clinicians and investigators to assume that the differences found between racial and ethnic groups are genetic which can lead to what Manly (2006) describes as "irresponsible biological and genetic interpretations" (p. 272). She further asserts that "It is a common practice, however, to assign race on socially defined classification of phenotypic traits such as skin color and hair features. Because of this incongruity between theory and research practice, race is a construct that lacks biologic basis. There is more genotypic variation within races than between them, it is difficult, therefore, to classify humans into discrete biologic categories with rigid boundaries" (p. S11). Although

not the perfect solution to the problem of how best to integrate and capture the demographic effects on objective assessment process, it can certainly serve as a place to begin. However, very few measures have these corrected norms; nonetheless, this fact should not preclude psychologists from integrating race, ethnicity, and gender into the assessment process.

Novel Ways of Thinking About Gender, Race, and Ethnicity in Clinical Assessment: Recommendations

In order to conduct assessments that are mindful of race, ethnicity, and gender, psychologists need to recognize that they come into the assessment process with attitudes and beliefs that may be detrimental to the testing and interpretation process (American Psychological Association, 2003). Moreover, practitioners must be willing to recognize and appreciate the intersectionality of race, ethnicity, and gender and be committed to using skills that will adequately assess this intersectionality (American Psychological Association, 2003). Hays (2008) maintains that this competence can be achieved at two levels—personal and interpersonal. At the personal level, she encourages practitioners to engage in their own self-exploration by examining their own personal belief systems and worldviews, engaging in self-questioning, as well as maintaining current in the multicultural literature and research. At the interpersonal level, she suggests practitioners engage in wide-ranging community activities, expose themselves to diverse media, and establish peer relationships that provide differing perspectives. In her book, *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy*, Hays provides numerous additional suggestions that can be easily adapted for ensuring that issues of race, ethnicity, and gender are soundly addressed in the practice of assessment.

Relatedly, Jacobsen (1988) developed an Ethnocultural assessment model for understanding the impact of the migration experience on a client's ethnocultural identity. While the model consists of five stages, the most relevant stage of this model to this chapter is stage five, where professionals are encouraged to engage in a self-exploration process and examine how their own ethnocultural backgrounds may influence the assessment process. Through this introspection, psychologists can consider how their particular race, ethnicity, and gender may impede or facilitate the assessment process. For example, professionals need to reflect on what it may mean to be of a particular racial, ethnic, or, gender identity to a client. Also, it is critical that psychologists with similar backgrounds as their clients not assume that they share comparable experiences as their clients, as this may compromise the assessment process. Psychologists may encounter comments such as "you know what it's like as a Latino." While the psychologist may feel tempted to collude with the client by not exploring the comment further, this approach could thwart the assessment process. A possible response could be "while we share similar experiences, I am curious to know more about what being a Latino means to you or what it has been like for you to be a Latino."

Once professionals have devoted some time to understanding their own sociocultural background, Ruth (2012) provides some helpful practice guidelines that have great utility in the assessment process. Ruth suggests meeting "patients with multiple minority identities [e.g., race, ethnicity, and gender] with empathy, without judgmentalism, and with even hovering attention to the diverse aspects of their experience and identity" (p. 173). He also advises us not to make assumptions about a client's understanding of herself or himself, as the "various strands of identity in a patient with multiple minority identities are, or need not be, equally clear, embraced, developed, central, or open to therapeutic exploration" (p. 175). Ruth encourages psychologists to "create space in the therapy [and assessment process] for exploring each strand of the patient's identity as a line of development, to the extent the

patient allows, with its own history and dynamics, without a priori assumptions" (p. 177).

Lastly, below are a number of other recommendations we suggest for considering race, ethnicity, and gender in the assessment process:

- Be inquisitive about the implications of the measures employed and know their limitations.
- Assess whether the task required by a test is congruent or incongruent with the patient's cultural values and whether such incongruence impacts test performance. For instance, some cultures may value quality over speed in a timed test.
- Use a qualitative process approach to describe the nuances of test performance. This method is a detailed analysis of how an individual performs on a task, in contrast to solely obtaining quantitative scores. The process approach to a patient's test results yields information about a patient's cognitive style as well as his/her strengths (Kaplan, Fein, Morris, & Delis, 1991).
- Avoid Type I errors (false positives) by being familiar with the literature on diagnoses that are commonly overused with certain populations.
- Assess the quality and cultural appropriateness of tests by completing an item analysis. This practice will help one decide whether a single item should be omitted due to the item being ambiguous or misleading.
- Model and support the practice of integrating race, ethnicity, and gender into the assessment process. Become active members in professional organizations that focus on psychological testing and introduce the complexity of cultural factors into the professional lexicon.
- Bear in mind that information derived from a measure is only one data point. Include other sources of information (e.g., behavioral observation, clinical judgment, context, third-party informant, emic and etic group differences, research) to contextualize all data points.

No Single, Definitive, or Simple Formulation of the Problem: The Case of Miguel

Reason for Referral and Background Information

Miguel was a 50-year-old, married, right-handed, heterosexual, Puerto Rican male, who was referred for a psychological evaluation due to concerns about difficulties with memory and concentration. He reported a history of cognitive difficulties that had begun prior to age 7 and have remained relatively the same throughout the years. He described difficulties "keeping up" in class, remembering segments of the lesson, and problems with concentration as early as the first grade. Miguel had long-standing difficulties following conversations, and stated, "I'm very distracted all the time." He noted that for the past 3–4 months he had noticed increased difficulties with his concentration abilities. For instance, he missed exits more frequently when driving and had problems remembering instructions (e.g., spouse asks him to do things) and felt "overall disorganized." He also described experiencing low levels of energy, increased agitation, sleep difficulties, lower interest in sex, feelings of guilt, and loss of interest in things he used to enjoy (e.g., working out). Moreover, he reported feeling afraid of the future, losing control, and not being able to relax.

Miguel reported that he had "battled" with depression "on and off" since the age of 21, when he found his mother dead at home from a heart attack. He was psychiatrically hospitalized for the first time during this period for depression and suicidal ideation. He was prescribed an antidepressant medication, which he reportedly did not take consistently at the time. Miguel sought outpatient mental health treatment again for depression 3 years ago. He reported that "a lot was going on" at the time (e.g., marital difficulties). Most recently, he was psychiatrically hospitalized for the second time (also for depression

and suicidal ideation) after his wife asked him to leave the house due to his substance use. Miguel's medical history is significant for hyperlipidemia, hypertension, asthma, and insomnia.

Miguel had a long history of substance use. His first alcohol intoxication occurred in his early teenage years (approximately 13–14 years of age). By the time he was 15 years of age, he was consuming large quantities of alcohol on a daily basis. He reported drinking "anything he got his hands on." He also started using marijuana on a daily basis. Miguel had also tried heroin, crack, cocaine, and acid from "time to time." He had been sober for 6 months from all substances at the time of the evaluation.

The Sociocultural Profile: Considering Gender, Race, and Ethnicity

An analysis of Miguel's SCP revealed that he was a dark-skinned, Puerto Rican male. With respect to race, he was most likely multiracial, as Puerto Rico has African, Spaniard, and Indigenous influences. Traditional assessment reports would simply identify these factors and not consider their intersectionality and their impact on his identity development and psychological functioning. A more culture-centered analysis would reveal that as a male (gender) he may have gained power and privilege in his personal and social contexts, while his ethnicity, multiracial background, and skin tone may have placed him in subordinate roles. Moreover, males in the USA are typically socialized to be strong and rational. When one factors race and ethnicity, these socially sanctioned male dispositions were most likely heightened, preventing Miguel, a Puerto Rican male from admitting that he had a mental illness and was in need of help. This formulation is supported by the research that asserts that Latinos tend to underutilize traditional mental health services in the USA for a number of reasons, including stigma associated with mental health, the use of alternative support systems, and inept treatment (Barrio et al., 2008; Chavez-Dueñas, Torres, & Adames, 2011). Hence the intersectionality of Miguel's gender, race, and ethnicity would all certainly influence his attitudes toward mental illness and receptiveness to treatment. Not surprisingly, Miguel used alcohol and drugs as a coping strategy for dealing with his distress, as the intersectionality of gender, race, and ethnicity would adversely influence his attitudes toward mental illness and treatment. Another factor that is associated with his race and ethnicity and may influence this formulation is his level of acculturation. If he is more acculturated, he may be more receptive to admitting that he has a problem and is in need of treatment, as the stigma may not be as pronounced; however, these dynamics may be tempered by gender, leading to or preventing the use of treatment, depending on how much he subscribes to the traditional, socially sanctioned masculine role. In this case, Miguel had a history of seeking treatment, suggesting higher levels of acculturation or cultural integration.

Projective Assessment: Considering Gender, Race, and Ethnicity

With respect to the projective assessment process, Miguel was administered the Thematic Apperception Test. An analysis of his responses revealed recurrent themes of rejection and abandonment. On one of the cards, Miguel stated that the main character was very upset because he felt unloved and unwanted. On another card, he reported that the couple were tired of fighting and were going to separate, noting that women don't stay around this man for very long. In another card, he described a little boy, who was scared and wanted to move to a safer neighborhood. Additional cards revealed similar responses. While a traditional interpretation of his responses would most likely simply identify an intrapersonal or interpersonal conflict and suggest character disturbances, a more culturally centered formulation that considers the intersectionality of his identities including gender, race, ethnicity, and the above-referenced power dynamics might provide a broader, more complex, accurate, and systemic interpretation. A culturally centered formulation might ask whether his unconscious

conflicts are primarily rooted in his early object, relational, or interpersonal history or if they are also associated with the systemic dynamics of discrimination and oppression that he may have encountered. In this case, Miguel was able to discuss how as a Puerto Rican male he had experienced considerable prejudice and unfairness. He talked about the poorly organized and funded schools he attended and the indifferent teachers he encountered. He spoke about the dilapidated neighborhood he grew up in and that he often felt unsafe. He noted that as a male, he felt compelled to be more courageous and protect his family. Appropriate prodding allowed for the psychologist to fully understand the intersectionality of his gender, race, and ethnicity and skillfully consider it in the clinical formulation.

Objective Assessment: Considering Gender, Race, and Ethnicity

In the objective assessment scoring process, demographically adjusted norms for ethnicity and gender were used to compare Miguel's test scores. Consistent with his estimated premorbid intellectual functioning, Miguel's current level of intellectual functioning fell within the low average range. Sustained attention was significantly reduced compared to premorbid estimated ability; however, simple attention was within normal expectations. Executive, working memory, processing speed, motor, memory language, and visuospatial functioning were within normal limits. Without demographically adjusted norms we would have expected Miguel's cognitive profile to appear more impaired and thus overly pathologizing the test results and his presenting problems. We postulate that the noted decline in sustained attention coupled with Miguel's reported difficulties with attention and concentration throughout his development (prior to age 7) and his depressive symptomology lends support for an attention deficit hyperactivity diagnosis and a mood disorder diagnosis. Moreover, his extensive history of poly substance abuse, his mild anxiety, and his sleep concerns may also be impacting his preexisting attentional difficulties.

Although the accuracy of the objective measures can be improved by the utilization of demographically adjusted norms, it is not as evident why ethnic, racial, or gender differences in test performance exist. As such, a qualitative process approach can assist in understanding these differences. This additional method can be employed to contextualize test data. Moreover, such an approach can guide case conceptualization and provide hypotheses regarding how Miguel's race, ethnicity, gender, and unique history contributed to test performance. For instance, in timed tasks, Miguel reported how he "wants to do the task right." During all tasks, including timed tasks, Miguel would slow down, stop, and think about his execution. From a purely quantitative approach, he would perform "poorly" on tasks that were timed. However, viewing his approach from a qualitative paradigm, Miguel approached the task in an organized and non-impulsive manner; characteristics that suggest good functioning and prognosis. The consideration of gender, race, and ethnicity in this part of the assessment process could reveal an interesting dynamic. As a male, Miguel might feel obliged to acclimate to the timed tasks and perform as quickly as possible, as his gender socialization process could have reinforced competition, efficiency, and productivity. However, his racial and socialization process could have emphasized cooperation and quality, possibly influencing his performance. In this assessment, it was clear that Miguel favored quality over speed, as his temporal orientation, perhaps informed by ethnic and racial background, compelled him to proceed thoughtfully and unhurriedly on the timed tasks despite being instructed to perform the tasks as quickly as he could. Furthermore, tasks with specific instructions for temporal sequencing (e.g., picture arrangement, projective tests) could also be impacted by his gender, race, and ethnicity. Lastly, differences in intellectual capacities between genders appear to be in patterns of ability rather than in overall intellectual functioning, so it is paramount for

psychologists to keep in mind the sociocultural defaults that are programmed in our clients by society, culture, religion, media, and family.

Novel Ways to Intervene: Treatment Recommendations

As assessment often informs treatment, we would recommend an integrative approach that incorporates standard interventions such as a psychiatric consultation to explore whether psychopharmacological interventions would be helpful with the attention difficulties and cognitive therapy to address the depression and anxiety symptomology. However, we would expect the psychologists to also consider the intersectionality of gender, race, and ethnicity and its impact in their formulation and related treatment. We would recommend that Liberation psychology and narrative therapy guide their work, examining the social issues that are at play and assisting Miguel in reconsidering his personal narrative, and, if relevant, re-authoring a narrative that is based on his own unique identity and experiences and not a prevailing narrative of oppression and injustice. Often for the underprivileged, the narrative that is imposed and internalized is fraught with deficiency, ineptness, and culpability. Narrative therapy guided by the tenets of Liberation psychology can assist Miguel in adopting a personal narrative based on strength, competence, and dignity. Our suggested integrative approach would not only lead to the resolution of debilitating symptoms, but would guide the transformation of an identity that understands and embraces its intersectionality and flourishes from it.

In closing, readers are encouraged to consider how this formulation would change, if the person's race, ethnicity, or gender were different. For example, what if the identified client was Mexican, female, or light skin? How might the intersectionality of these variables affect the person's identity development and functioning? If we simply switched the gender in this case, we might be writing about a woman, who may have been socialized to be more psychologically minded and receptive to seeking help and less likely to use substances. Considering all the potential gender, race, and ethnicity permutations is beyond the scope of this chapter, but our hope is that this case nicely illustrates how psychologists can consider gender, race, and ethnicity and their intersectionality in the assessment and formulation process.

Conclusions: Embracing the Grand Challenges

In closing, we suggest conceptualizing the dynamic and multiplicative nature of assessment as it relates to race, ethnicity, and gender, as a grand challenge, rather than a wicked problem. As noted by Hays (2008), by addressing the complexity involved in multicultural assessment, therapists can not only gain a deeper understanding of their clients, but of themselves as well. Hays implores diagnosticians and psychologists to consider assessment data "in conjunction with a thorough understanding of the client's social, cultural, historical, political and linguistic context" (p. 151). She asserts that the end result can lead not only to deeper human understandings, but to deeper human connections. We urge practitioners and scholars to consider the salient characteristics enumerated in Table 14.1, as these points can begin to provide the critical ingredients and language needed to generate hypotheses for discerning the effects of race, ethnicity, and gender on assessment. Embracing the synergy that exists between race, ethnicity, and gender in understanding human behavior and mental processes is paramount for the study and practice of sound, comprehensive, and culture-centered assessment. As noted by Margaret Mead (2001), a cultural anthropologist, "If we are to achieve a richer culture, rich in contrasting values, we must recognize the whole gamut of human potentialities [behaviors, processes, and traits] and so weave a less arbitrary social fabric, one in which each diverse human gift will find a fitting place" (p. 300). We affirm that in a sound assessment process we must employ the tools that acquaint us with the whole gamut of human potentialities, including behaviors, processes, and traits. Through this process we transform wicked problems into grand challenges and gain access

to and appreciate the richness and complexity of humankind.

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