Culturally Relevant Diagnosis and Assessment of Mental Illness

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Introduction

Psychological assessment is an important aspect in the diagnosis and treatment of psychiatric conditions. Assessment in clinical practice typically falls under the domain of psychology (McLeod, Jensen-Doss, & Ollendick, 2013) and psychological assessment is seen as a tool for mental health professionals such as a psychologist or psychotherapist. Psychological evaluations are useful to obtain information from patients to provide diagnostic clarification and to assist with intervention planning (Tiegreen, Braxton, Elbogen, & Bradford, 2012). In psychiatric settings, assessment fulfills several objectives such as differentiating typical from atypical behavior, highlighting an individual's strengths and weaknesses, and classifying a particular diagnosis to assist with treatment planning (e.g., Schroeder & Gordon, 2002). In child and adolescent mental health, the purpose of psychological assessment is to identify whether a disorder is present that is different from the behavior that would be expected in a typically developing child and that is interfering with the child's functioning (Jensen-Doss, McLeod, & Ollendick, 2013).

According to Jensen-Doss et al. (2013), psychological assessment has several important purposes: (1) to clarify a diagnosis to facilitate communication among professionals which provides a clinical picture of the patient's difficulties, (2) to assist the clinician in treatment planning and intervention selection consistent with evidence-based treatment, (3) to provide information necessary to obtain authorization for services or accommodations, and (4) to monitor treatment progress or outcomes to determine whether a child or adolescent continues to meet criteria for a diagnosis over the course of treatment. Psychological assessment may also assist with school consultation to develop appropriate school interventions and accommodations.

In order to obtain the most useful information through diagnostic assessment, multiple methods or approaches must be utilized. Conceptualization of the youth must incorporate a developmental psychopathology perspective, as well as combine the use of nomothetic and idiographic assessment tools (McLeod et al., 2013). Nomothetic assessment tools provide information about a child or adolescent compared to other youth on a similar domain. These assessment measures include parent or youth rating scales that allow the clinician to compare the child's functioning to normative data that has typically been gathered

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A.M. Breland-Noble et al. (eds.), *Handbook of Mental Health in African American Youth*,
Springer Series on Child and Family Studies, DOI 10.1007/978-3-319-25501-9_2

by the test developer. Conversely, idiographic assessment tools obtain data that is representative of the individual's difficulties and strengths. Idiographic tools allow the clinician to gather information to help conceptualize the youth within their own environment and may include direct observation methods, behavioral assessment, or unstructured clinical interviews. Specific to youth, assessment of children and adolescents requires knowledge and skills from several domains including: developmental principles, child psychopathology, psychometric theory, diversity and cultural issues, and therapy process and outcome research (McLeod et al., 2013).

The goal of this chapter is to enhance the clinician's ability to produce a valid evidence-based assessment (EBA) with African American youth and to assist mental health professionals in understanding key factors to recognize when reviewing the results of a psychological evaluation. We begin with a discussion of historical experiences that impact African Americans' utilization of mental health care. Then, we provide an overview of EBA, followed by a review of the current literature on assessment with African American youth and conclude with future directions for research and clinical practice.

EBA in Clinical Practice

EBA is described as an approach to clinical evaluation that utilizes science and theory to guide the assessment process (Jensen-Doss et al., 2013). Given the focus on providing evidence-based treatments (EBTs), EBA has been emphasized in an effort to strengthen the ability of clinicians to enhance their clinical practice and treatment effectiveness. Although both EBA and EBTs are promoted, there remains a gap between the research and clinical practice. According to the literature, clinicians are not consistently engaging in EBA practices as recommended (e.g., Jensen-Doss, 2005, 2011). For example, one study using licensed psychologists suggested that an unstructured clinical interview was the most common and often only assessment method used to provide a treatment diagnosis (Jensen-Doss & Hawley, 2010). In the age of managed mental health care, EBA should be considered integral to the treatment process. Some have noted that effective treatment depends on accurate assessment rather than solely on subjective decision making (McLeod et al., 2013). Psychological assessment could contribute to behavioral health care's capacity to provide positive payoffs such as reduced medical cost and improved treatment outcomes (Jensen-Doss et al., 2013; Quirk, Strosahl, Kreilkamp, & Erdberg, 1995). Therefore, it is highly important for the clinician to become aware of EBA and to implement these practices within their clinical work. However, psychological assessment in clinical practice has continued to decline as a result of stipulations by managed health care and the limited time of clinicians to dedicate to psychological assessment (e.g., Meyers et al., 2001).

More recently, clinically based diagnosis—unstructured assessment guided by clinical judgment—has dominated the assessment area. Clinically based diagnosis involves the clinician conducting an unstructured clinical interview to follow-up on their initial impressions by asking questions to rule-in or -out a diagnosis (Jensen-Doss, 2005). There are several reasons why clinically based diagnosis is most commonly used in practice. First, clinicians often have a limited amount of time to complete an initial diagnostic evaluation given time constraints placed on them by third party payors (i.e., insurance companies). Second, many clients/patients are anxious to initiate treatment and the likelihood of treatment dropout may increase if they feel that their needs are not being addressed. Although clinically-based diagnosis is often utilized over evidence-based diagnosis, it has been found to be less accurate and less reliable than evidence-based diagnosis. One study found that combining clinical and structured interview methods (i.e., EBA approach) appeared to improve diagnostic accuracy versus clinical methods alone (Basco et al., 2000). Accuracy of judgments can also vary as a function of the client's race, social class, or gender (Garb, 1997; Whaley, 2001). For example, numerous authors have reported that race bias occurs when judgments

made about White clients are more accurate than those made for Black clients (Garb, 1996; Whaley, 2001; Whaley & Hall, 2009). This may happen as a result of solely examining diagnostic criteria without further inquiry into possible cultural/situational explanations of the symptoms. The literature notes that some clinicians may be insensitive to cultural aspects of symptoms (e.g., paranoia) and neglect to consider how African Americans lack of trust of mental health professionals results in misdiagnosis (Whaley, 2001). Clinicians also have the tendency to overlook less severe symptoms (e.g., depression) in African Americans and over-diagnose more severe symptoms such as schizophrenia (e.g., Frank, 1992; Whaley, 2001). These errors in diagnosis are often the result of only using a clinical interview during the assessment phase of treatment. Given these concerns, it is important that evidence-based diagnosis be incorporated into clinical practice.

There are numerous reasons to address gaps in EBA with African American youth. First, with the emphasis on EBA it is necessary to determine whether the current assessment tools are equivalent across racial, ethnic, and cultural groups (Dana, 1996; Pina, Gonzales, Holly, Zerr, & Wynne, 2013). Second, the literature is full of studies that provide examples of misdiagnosis as a result of neglecting the importance of racial or cultural influences (Aklin & Turner, 2006; Dana, 1996; Pina et al., 2013). As previously noted, some clinicians over-diagnose symptoms in ethnic minorities or judge symptoms to be more serious when reported by ethnic minority patients (Aklin & Turner, 2006). Given the history of African Americans and the mental health system, it is pertinent that improvements be made to strengthen the assessment process to allow clinicians to obtain a more accurate diagnosis and subsequently improve treatment planning. McLeod et al. (2013) hypothesize that when clinicians do not follow a predetermined set of questions or procedures, assessment techniques are susceptible to bias. Therefore, having a better understanding of EBA approaches with African American youth is extremely important.

Current Status of Assessment with African Americans

According to the literature, there is a long-standing history of over- and under-diagnosis of various psychological disorders in African Americans (e.g., Garb, 1997; Kales et al., 2000; Pina et al., 2013). As noted above, a clinical interview (clinically based diagnosis) is one of the most often used tools in psychological assessments (Aklin & Turner, 2006). Proportionately far more ethnic minorities than European Americans are likely to be misdiagnosed when assessed using this method, specifically for psychiatric disorders (Garb, 1996; Whaley & Hall, 2008, 2009). This is particularly true when open-ended clinical interviews are utilized (Basco et al., 2000). Some have postulated that the reason for over- and under-diagnosis is related to how clinicians misinterpret information that is observed or reported by African Americans during psychological assessments or diagnostic interviews (Whaley & Hall, 2009). For example, some have noted that clinical psychologists often fail to identify specific aspects of their culture that are thought to influence behavior (Whaley, 2001).

In a meta-analysis of psychological assessment data published from June 1974 through 1996, it was found that African American and Latino (Puerto Rican) patients were less likely than European American patients to be diagnosed as having a psychotic or affective disorder, and more likely to be diagnosed as having schizophrenia (Garb, 1997). Findings noted that this occurred even when measures of psychopathology did not indicate that a diagnosis of schizophrenia was justified (Garb, 1997). This study also found no significant racial biases in assessment of the level of adjustment or diagnosis of personality traits; and psychiatric symptoms in African American children and adults compared to European American. This implies that if there are no biases in the assessment due to clinicians' behaviors, then the measures used to conduct the assessment may not have been clinically appropriate. Not only do clinicians need to be aware of EBA methods, but they must also evaluate and determine that that the measures used in their

evaluation are culturally and clinically appropriate. This would involve making sure that the measures are valid for use with African American patients.

In a study on differences in patterns of symptom attribution in diagnosing schizophrenia between African American and non-African American clinicians, it was found that African American clinicians were less influenced by communication barriers and dysfluencies in judging schizophrenia than were non-African American clinicians. The study also found that African American clinicians recognized differences in affect, speech, and communication as culturally acceptable, and therefore, not as negative signs indicative of schizophrenia. Normative cultural wariness of powerful institutions and individuals can make apparently suspicious and evasive communication on the part of African Americans dubious as signs of severe psychopathology (Trierweiler et al., 2006; Whaley, 1997, 2001). To effectively treat mental illness in African Americans, clinicians need to be aware of their biases and cognizant of racial and cultural variations in symptomatology.

Another way to understand cultural expressions of symptoms is to differentiate between paranoia and cultural mistrust. The central hypothesis is that clinicians' misinterpretation of cultural mistrust as clinical paranoia contributes to the misdiagnosis of African Americans as schizophrenic (Ridley, 1984; Whaley, 2001). A number of researchers suggest assessing an African American client's cultural mistrust during the assessment process (e.g., Terrell & Terrell, 1981; Whaley, 2001). Cultural mistrust is often measured using the *Cultural Mistrust Inventory* (CMI; Terrell & Terrell, 1981), which assesses African Americans' mistrust of Whites due to past experiences and contemporary forms of racism. The CMI has also been revised for use with children—*Cultural Mistrust Inventory for Children* (see Terrell & Terrell, 1996). During the evaluation, the conversation on racism/cultural mistrust should be geared toward the patient's or client's needs and not the clinicians' desire to espouse their views of racism (Whaley, 2001).

There have been many advances in understanding ethnic identity development since the creation of the CMI (e.g., Phinney, 1989; Worrell, Cross, & Vandiver, 2001). Ethnic identity is one type of group identity that is important to the self-concept of members of ethnic minority and racial group (Yasui, Dorham, & Dishion, 2004). Ethnic identity formation involves developing an understanding and acceptance of one's own groups in the face of societal stigmatization (Phinney, 1989). Whereas ethnic identity is important to consider when conceptualizing the client and their problems, cultural mistrust may result in behaviors that will impact diagnostic impressions. Therefore, it is still important to have an objective measure of the patient's cultural views and possible cultural mistrust to provide a more detailed assessment of the patient. The information can then be used therapeutically to eliminate the misdiagnosis of psychopathology. Additionally, the cultural experiences of the client can be explored in a richer context given the information provided from the objective assessment.

It is imperative that clinicians are cognizant about how race and culture can affect the data and/or results of a psychological assessment. Studies have shown that cultural mistrust impacts clinical symptoms and behaviors in both African American children and adults (e.g., Terrell & Terrell, 1983, 1996; Whaley, 2001). For example, high levels of cultural mistrust in Black students have been found to be associated with poor IQ test performance when the examiner was White versus a Black examiner (Terrell & Terrell, 1981; Terrell, Terrell, & Taylor, 1981; Whaley, 2001). Cultural mistrust in African American youth and occupational expectations has also been evaluated. Terrell, Terrell, and Miller (1993) found that high cultural mistrust scores in African American youth were associated with lower occupational expectations. Given the above information, some have suggested that assessment measures examining cultural/racial themes be incorporated in the assessment process for African Americans. Including measures such as the CMI along with diagnostic assessments may reduce the number of African Americans being misdiagnosed with paranoid schizophrenia.

In addition to diagnostic issues related to assessment methods, there are concerns about many clinicians lacking skills in cultural competence. Sue, Ivey, and Pedersen (1996) define cultural competency as a clinician having awareness of his or her beliefs and biases about a racial/cultural group, having knowledge about the client's culture, worldview, and expectations, and having the ability to intervene in a manner that is culturally sensitive and relevant. Furthermore, Whaley (2001) purports that to improve assessment and treatment with African Americans it is beneficial to incorporate the cultural mistrust construct. Cultural mistrust has been defined as paranoia in the form of mistrust of Whites that exist among Blacks due to past and contemporary experiences of racism and oppression (e.g., Whaley, 2001; Whaley & Hall, 2009). Given issues with misdiagnosis and over-diagnosis of pathology in African Americans, it appears that the concepts of cultural competency and cultural mistrust impact clinicians and clients' interactions. The lack of cultural competency and incorporation of the cultural mistrust construct may ultimately adversely influence the diagnostic and assessment process with ethnic minority clients.

Given the importance of cultural competency, several steps must be taken by clinicians to ensure they are gathering information in a manner that reduces biases, as well as, takes into account cultural and racial factors that impact diagnosis. Knowledge of the patient's culture and sensitivity to its basic premises is imperative for quality treatment (Seibert, Stridh-Igo, & Zimmerman, 2002). They note that providing culturally competent services requires that the health professional be sensitive to the differences between groups, to the differences in outward behavior, and also to the attitudes and meanings attached to emotional events (Seibert et al., 2002). To help clinicians with enhancing their cultural sensitivity and competence with providing mental health services, it may be helpful to apply specific skills (Seibert et al., 2002). They provide a checklist to assist clinicians with steps to take in order to improve their cultural sensitivity and awareness. The authors emphasized that the following areas should be considered when working with individuals from diverse backgrounds: communication method, language barriers, cultural identification, the client's understanding of the issues discussed, spiritual beliefs, the client's trust of clinician, an assessment of the client's expectations of treatment or recovery, adherence to culturally appropriate assessment practices, and provider biases. Given the historical perspective of many African American youth, it will be important for the clinician to obtain information on the client's cultural identity (e.g., does the youth have any cultural beliefs that may help the clinician understand the client's functioning), religious or spiritual belief system (e.g., does the youth have any rituals or beliefs in a higher power that contribute to recovery), and trust of the clinician (trust will be important to get the youth and their family to adhere to recommendations). Finally, the clinician must abide by ethical standards and practices. This includes the clinician addressing personal biases about African American youth, as well as being familiar with EBA practices. In order to provide culturally competent services, tests must be administered and interpreted based on recommended practices (Jensen-Doss et al., 2013; Seibert et al., 2002).

These recommendations provide general guidelines that may be helpful; however, certain aspects may not apply to African American youth or mental health care. For example, Seibert et al. (2002) note that interpreters may be needed to provide culturally sensitive services due to language barriers. Whereas this factor may be particularly important for non-English speaking individuals, an interpreter is not typically needed for working with African Americans. Although an interpreter may not be necessary for working with African American patients, it is important to recognize that there is cultural diversity within the African American communities. For instance, over the last four decades Black immigrants from the British West Indian colonies of Anguilla, the Bahamas, the British Virgin Islands and Jamaica have migrated to the USA (Forsyth, Hall, & Carter, 2014). It may be appropriate to seek consultation from a cultural liaison or interpreter—an individual with expertise in cultural differences. Cultural interpreters or a culturally

specific support team are helpful to allow the clinician insight into how the patient's culture shapes understanding and expression of symptoms (Eisenbruch & Handelman, 1990; Seibert et al., 2002).

Furthermore, clinicians should consider using the DSM-5 *Cultural Formulation Interview* [CFI; American Psychiatric Association, 2013) to help conceptualize the patients' problem and their perceived attitudes about the causes of their difficulties. Some have provided additional things to consider when applying a cultural formulation to improve implementation in clinical practice (Aggarwal, Nicasio, DeSilva, Boiler, & Lewis-Fernández, 2013). To address the ambiguity from questions on the CFI that may be unclear, it has been suggested that questions related to cultural identity should be phrased to capture aspects of the individuals' background that include community, race or ethnicity, and language (Aggarwal et al., 2013). The following prompt is recommended to reduce ambiguity in the questions on cultural identity (Aggarwal et al., 2013):

> Sometimes, aspects of people's background or identity can make their problems better or worse. By background or identity I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.

Using the prompt above allows the patient to reveal cultural factors that could potentially impact or explain the clinical presentation. Furthermore, it allows the clinician to understand the cultural contexts that are present and important to consider when conceptualizing the patient and their difficulties. The DSM-5 Outline for Cultural Formulation (OCF) is a framework to use the CFI to systematically address cultural factors: the individual's cultural identity, cultural conceptualizations of distress, psychosocial stressors and cultural features of vulnerability and illness, cultural features of the relationship between the patient and clinician, and an overall cultural assessment (American Psychiatric Association, 2013).

EBA with African American Youth

There is substantial research on EBT and EBA, but the literature on EBA with ethnic minorities is very limited. In the youth area alone, more than 30 distinct treatments have been classified as "probably efficacious" or "possibly efficacious" for ethnic minority children and adolescents (Huey, Tilley, Jones, & Smith, 2014). Additionally, in 2005 the Journal of Clinical Child & Adolescent Psychology published an entire issue on EBA with youth for both externalizing and internalizing problems (e.g., Klein, Dougherty, & Olino, 2005; Mash & Hunsley, 2005; Pelham, Fabiano, & Massetti, 2005). Although no specific evidence was provided on the use of evidenced-based assessment with ethnic minority youth, the importance of ethnicity was highlighted. For example, Kazdin (2005) states that when developing or using a measure, we ought to take into account ethnicity, race, culture, sex, age, and developmental stage of the individual. However, the literature remains sparse in terms of assessment measures that have been shown to be reliable and valid for use with ethnic minority youth (see Pina et al., 2013). Furthermore, psychometric data on psychological instruments with African American youth is an area of much needed research.

Research highlights the importance of examining ethnic difference to inform modifications to scale items and structure, as well as, how to best administer and interpret scores based on individuals from different cultures or ethnic backgrounds (e.g., Trent et al., 2012). Existing data provides basic reliability and validity estimates and a few measurement equivalence studies report on widely used clinical measures. EBA with African American youth remains in its early stage of development. Table 2.1 provides an overview of assessment instruments that identify some key findings on using these measures with African American youth. Although some findings are available on the reliability and validity of these instruments with African American youth, there is room to improve our research and clinical practice with this population.

Table 2.1 Evidence-based measures for assessing clinical problems in African American youth

Measures	References	Overall findings
Global rating scales		
ASEBA: Child Behavior Checklist (ages 6–18); Teacher's Report Form; Youth Self-Report	Lau et al. (2004)	In African Americans, Cronbach's alpha ranged from 0.87 to 0.95 which is similar to Whites/Caucasians.
Behavior Assessment System of Children (BASC-2)	Mano et al. (2009)	Cronbach's alpha ranged from 0.86 to 0.96.
Internalizing symptoms rating scales		
Center for Epidemiological Studies Depression Scale	Brown, Meadows, and Elder (2007)	Cronbach's alpha ranged from 0.76 to 0.80 across data collection points for African Americans and 0.81 for Whites.
Children's Depression Inventory	Cole, Martin, Peeke, Henderson, and Harwell (1998), Kistner, David-Ferdon, Lopez, and Dunkel (2007), and Randall and Bohnert (2009)	Across studies, alpha coefficient was 0.81–0.89 for African Americans and 0.82–0.90 for Whites.
Fear Survey Schedule for Children-Revised	Neal et al. (1993)	Cronbach's alpha was 0.96 for both African American and White youth.
Multidimensional Anxiety Scale for Children	McLaughlin, Hilt, and Nolen-Hoeksema (2007)	Alpha coefficient was 0.86 for African Americans and 0.92 for Whites.
Revised Children's Manifest Anxiety Scale	Trent, Buchanan, et al. (2012)	Cronbach's alpha was 0.83 for both African American and White youth.
Reynolds Adolescent Depression Scale	Stein et al. (2010)	Alpha coefficient was 0.91 for African Americans and 0.90 for Whites.
Social Phobia and Anxiety Inventory for Children	McLaughlin et al. (2007)	Cronbach's alpha was 0.92 for both African American and White youth.
State-Trait Anxiety Inventory for Children	Walton, Johnson, and Algina (1999)	Alpha coefficient ranged from 0.89 to 0.92 for African Americans and 0.86–0.89 for Whites.
Externalizing symptoms rating scales		
Eyberg Child Behavior Inventory	Querido, Warner, and Eyberg (2002)	Cronbach's alpha was 0.97 for African Americans.
IOWA Conners Rating Scale	Reid, Casat, Norton, Anastopoulos, and Temple (2001)	Cronbach's alpha ranged from 0.83 to 0.87 across both subscales.
Swanson, Nolan, and Pelham-IV Scale (SNAP-IV)	Bussing et al. (2008)	Cronbach's alpha ranged from 0.79 to 0.94 across scales.

ASEBA Achenbach system of empirically based assessment

The reliability and validity of these assessment measures with African American youth vary from "poor" to "superior." Between-study variability can occur for several reasons including possible variations in within-group cultural heterogeneity and the fact that reliability estimates are based on "basic" inter-item correlations, whereas invariance tests are more robust (Pina et al., 2013). Given the variability in assessment methods and the possibility of obtaining nonequivalent information across ethnic groups, it is important that the provider be aware of cross-cultural or ethnic differences in gathering information regarding clinical symptoms. Psychologists and examiners who administer psychological assessments and provide reports should include any information in their reports noting how culture or ethnicity may play a role in interpreting the data. For example, if African American youth are found to report lower scores on anxiety measures, statements should be included in the psychological report to highlight how the patient's scores compare to their normative group (Pina, Little, Wynne, & Beidel, 2014).

Psychologists have a responsibility to communicate the cultural competency of the assessments they use in the psychological assessment report (American Psychological Association, 2002). For a non-psychologist, it is important to ask the person conducting the assessment about the cultural competency of the assessment tools utilized in the psychological assessment. Information on an assessment's cultural competence is often more easily accessible for psychologists than for non-psychologists. This information (e.g., validity with African American youth) is provided in the psychometric sections of the assessment manuals, to which non-psychologists generally do not have access. Using layman's terms and non-technical jargon, the psychologist should clearly detail in the psychological assessment report the culturally relevant information for the patient being assessed. The cultural make-up of the standardization sample can be included in the report. Additionally, as detailed earlier, whether the results are being compared in a nomothetic (comparing the youth's results to a normative sample) versus idiographic fashion (comparing the youth's results to their personal strengths and weaknesses) should be detailed in the results section of the assessment report.

During the initial intake interview (i.e., prior to the testing session), it is recommended that parents of African American children ask questions regarding the assessment tools that will be utilized and the cultural relevance of the assessment tools, as well as, the clinician's experience testing African American youth. For other professionals, such as clinical social workers, psychiatrists, and special education teachers, these individuals are encouraged to ask specific questions about the psychometrics (i.e., reliability and validity) of the assessment tools used to diagnose African American youth. Sample questions may include: "What is the ethnic make-up of the standardization sample for this assessment?" and "Are the results of the assessment being compared to the youth's age-related peer group or are the results comparing the individual's personal strengths and weaknesses?"

Furthermore, mental health professionals or individuals who are reading these reports should also examine the results to determine if the psychologist or evaluator provided information demonstrating culturally competent practices. First, the summary of the report should identify how the African American client's scores differ from similar youth. By using the child's normative group (i.e., other African American children) the testing will provide a more accurate representation of the child's functioning. Second, the recommendations should be feasible for the youth and their family. If the evaluator provides recommendations that cannot be performed it does not serve the client or their family (Jensen-Doss et al., 2013).

Reliability and Validity Issues with Assessment of African American Youth

Overall, the literature notes that some of the measures most often used for assessment and diagnosis with African American youth have limited research targeted at examining their reliability and validity. Few assessment measures have been developed specifically for use with African American youth and the use of culturally nonequivalent measures pose a risk in terms of accurate diagnosis (Mano, Davies, Klein-Tasman, & Adesso, 2009). In this section, we briefly highlight a few concerns that have been expressed in the literature.

Reliability and validity of measures for use with ethnic groups has important clinical implication. Lack of invariance across ethnic groups can result in poor science, over-diagnosing, and wasted resources (Pina et al., 2014). Therefore, it is imperative that we investigate whether assessment measures developed with primarily European American/White samples provide equivalent information about ethnic minority youth, including for African Americans (Mano et al., 2009; Pina et al., 2014). Despite advances in clinical practice and EBA, few studies have examined the validity of assessment measures across different populations (McLeod

et al., 2013). When using diagnostic tools the clinician should take steps to evaluate the literature and testing manual to note whether the assessment measure supports using the tool with African American clients (e.g., Hunsley & Mash, 2007; Pina et al., 2013).

One important issue is construct validity, which consists of functional and scalar equivalence. It is important particularly when instruments are developed and normed with primarily European American youth. Construct validity is demonstrated when the variable being assessed has similar precursors, consequences, and correlates across groups (e.g., Pina et al., 2013). Some research has noted that instruments used to measure psychopathology in youth may not be conceptually equivalent with African American youth. For example, Mano et al. (2009) examined the measurement equivalence of Achenbach's Child Behavior Checklist (CBCL) in a sample of 145 African American parents and caregivers. In their study, the CBCL was found to have "poor fit" for a three-factor structure (i.e., three subscales) in African American youth (as demonstrated in the normative sample) and a two-factor structure (i.e., Internalizing and Externalizing scales) was found to be a better fit for the data. The authors do provide a caveat that this needs to be replicated in future studies to rule out the possibility that the results are due to methodological issues. Some have noted that when conceptual differences are found (e.g., scales do not capture the same information across groups), it may not be culturally sensitive in the assessment of African American youth (Pina et al., 2014). When non-psychologist and mental health providers are reviewing evaluations and psychological reports with African American youth they should note if the report discusses normative data and specifies norms for African Americans. McLeod et al. (2013) specify that if a client is different from the normative sample on characteristics, this might affect the meaning of the client's scale scores, it may invalidate the assessment tool requiring the use of another measure that is more representative.

Similarly, Neal, Lilly, and Zakis (1993) found differences in the factor structure of the Revised Fear Survey Schedule for Children (FSSC-R) among a sample of African American and European American youth. The FSSC-R is a common measure used to screen for internalizing symptoms in youth (e.g., anxiety and fears). The study (Neal et al., 1993) found that the original five-factor structure (five subscales include—Fear of the Unknown, Fear of Minor Injury and Small Animals, Fear of Danger and Death, Medical Fear, and Fear of Failure and Criticism) was not a good fit for the data for African American youth and that a three-factor structure was "superior." These subscales were Fear of the Unknown, Fear of Danger and Death, and Fear of Failure and Criticism. The authors note that some fears in youth may be a function of race or ethnicity. Overall, the studies on the CBCL and FSSC-R suggest that they may be less reliable to measure psychological functioning in African American youth. However, these measures have been identified as "well-established" in the EBA literature (Holmbeck et al., 2008), and therefore continue to be used in clinical assessment with youth. To improve utility of these assessment measures, different norms for interpreting the results may need to be established for African American youth.

Another important consideration is the reliability of psychological instruments. Both functional equivalence (i.e., the construct serves the same function on one group as in another group) and metric equivalence (i.e., do the items vary the same across groups) are important to assessment with ethnic minority youth (Leong, Leung, & Cheung, 2010; Mano et al., 2009). As previously noted, few studies provide information regarding these concepts with psychological instruments. The data from one study using the CBCL provides some information on functional and metric equivalence with African Americans (Mano et al., 2009). The findings did not support the functional equivalence of the CBCL; nor did it provide unequivocal evidence of measurement equivalence. The study did demonstrate that there was stronger support for measurement equivalence on the subscale that measures externalizing symptoms (e.g., conduct problems). This has implications for using the CBCL for screening and diagnosing African American youth. Based on limited findings, it is critical that clinicians

use multiple measures to assess psychological symptoms. Otherwise, it will preclude the ability of the provider to accurately assess the child's functioning. This is just a brief example of some of the issues related to assessment with African Americans. Mano et al. (2009) study notes that some constructs being measured may not have the same meaning across groups or that some individuals may interpret the items differently. It is possible that clinicians' judgment may be important to clarify the meaning of items prior to or during the process to strengthen the assessment process with African Americans. Some propose that the role of cultural values in the clinical assessment of ethnic minority youth needs to be examined, with consideration given to whether there should be preference for the use of self-rating scales (alone or in combination with other methods) in assessing psychopathology with this ethnic minority population (Pina et al., 2013). Additionally, some have proposed that for some assessment tools, different cutoffs may be desired for African American youth to help address health disparities. Lower cutoffs may have implications for screening to help with early intervention/prevention efforts, identifying more cases in need of diagnostic "work-ups" to better estimate program effects (Pina et al., 2014).

Given the current status, assessment research must recognize the necessity for cultural competence in assessment and focus research efforts on examining the cross-cultural construct validity of standard psychological instruments (Dana, 1996). If concerns are not addressed, the findings of ethnic minority research will remain questionable similar to when monocultural studies are seen as less stringent when reliability and validity of the measures used is not presented or adequate (Leong et al., 2010). This will subsequently further impact clinical diagnosis and treatment with African American youth.

Applying Therapeutic Assessment with African American Youth

Communication of assessment findings to clients, family members, and others (e.g., advocates, referral sources) is a necessary component of competent assessment practices (Dana, 1996). Therapeutic assessment (TA) is a method of assessment that is collaborative, guided by client's questions or interests, and uses psychological assessment as the centerpiece of a short-term intervention (Tharinger et al., 2009). Given the important of the therapeutic relationship, especially with African American clients, TA may be one way to reduce biases in assessment and improve the diagnosis process. Finn (1996, 2007) has outlined a semi-structured, six-step general model for TA which includes the following phases: (a) construction of assessment questions, (b) standardized psychological testing, (c) assessment intervention, (d) summary and discussion of findings, (e) written communication, and (f) follow-up. There is variation in the steps as applied to children, adolescents, adults, and couples. For a detailed description of the development and step-by-step application of the Therapeutic Assessment model with adolescents (TA-A), see Tharinger, Finn, and Gentry (2013). Additionally, for more on TA as used with preadolescent children and their parents, see Tharinger, Krumholz, Austin, and Matson (2011).

For the scope of this chapter, we briefly discuss applying TA with youth. Similar to TA with adults, the initial session is focused on establishing a collaborative relationship and getting the client invested in the process (in this case the child's primary caregivers). The initial session is focused on information gathering (through a clinical interview) to understand presenting concerns and the child's parents are invited to generate questions about their child, their family, and themselves to guide the assessment (Hamilton et al., 2009). The child should also be encouraged to identify questions they would like to have answered. This information should be obtained with the parent present and again when the child is alone with the clinician. Subsequent sessions should follow standardized assessment procedures to administer and score the psychological test used to assess the patient. After the tests are administered and scored, a feedback session should be held with the family to discuss the results of the evaluation. Finn (2007) recommends that the clinician use the assessment results as an empathetic window into

a client's experience and to provide the results in a way that best captures the client's personal story. Hamilton et al. (2009) note that the "feedback session should consists of a meeting with the parents to provide a summary of the assessment results, make connections between what was learned and the parents' original questions, solicit reactions and questions, and review recommendations. The final step is to send written feedback to the family." This is often done in the form of providing the family a copy of the psychological evaluation. Per TA, the clinician/evaluator sends the family a letter reviewing the major points discussed in the feedback sessions which incorporates the personal examples discussed in session.

Numerous studies have shown the benefits of TA to enhance rapport and improve psychological functioning in youth and their families (Austin, Krumholz, & Tharinger, 2012; Hamilton et al., 2009; Michel, 2002; Tharinger et al., 2009). Clinicians who are conducting assessments with African American youth could benefit from the use of TA. The aims of TA are to (a) help parents understand and become more empathetic to their child's challenges through their ongoing processing of the assessment findings from the child's testing and (b) to guide parents in shifting their attitudes toward and interactions with their child in ways that will foster positive child and family development (Tharinger et al., 2009, 2013). Many youth are not interested in participating in psychological assessments for a number of reasons. Primarily, their lack of interest is related to being referred by parents or as part of involvement with the legal system. TA has great potential to be applied to psychological assessment with African American youth. Emerging evidence is available on the use of TA with African American youth (e.g., Guerrero, Lipkind, & Rosenberg, 2011; Rosenberg, Almeida, & Macdonald, 2012). For example, Guerrero et al. (2011) published a case study of an 11-year-old African American girl, which highlighted the importance of integrating race and class in the application of TA. Their study particularly stressed the need to apply Finn's system of categorizing feedback on how readily a family can hear the results. Guerrero et al. (2011) described Finn's 3 Levels to include: Level 1 findings, those that the client can easily accept and verify themselves; Level 2 findings, those that tend to modify the client's way of thinking or amplify the ways that they think about themselves; and Level 3 findings, which is information difficult for the client to tolerate and they might reject or deny. Based on African American's historical perspective with mental health systems, TA could have a positive impact on the diagnostic process when conducting psychological assessments with African American youth.

Future Directions

Enhancing Assessment with African American Youth

It is imperative to consider cultural factors when conducting psychological assessments with African American youth. The American Psychological Association's (APA) Ethics Code includes a subsection that emphasizes that psychologists should only use assessment instruments that are valid and reliable for the population being assessed (American Psychological Association (APA), 2002). Furthermore, it is important that clinicians consider the youth's social environment and use multiple sources of information when conducting assessments with African American youth.

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) has included a section on using a Cultural Formulation during the assessment process. It includes an Outline for Cultural Formation and a CFI that can assist clinicians with the assessment and integration of cultural factors into a patient's diagnosis and treatment plan. Utilizing this information will help to decrease misdiagnosis of African Americans due to misinterpretations of cultural related information. Use of the DSM-5 Cultural Formulation section assists the clinician in incorporating culturally relevant information into their psychological assessment reports and treatment plans.

Using a non-traditional perspective (i.e., Africentric prospective) may also be beneficial. Because traditional assessment practices and clinical therapy are grounded in Western assumptions, these assumptions may not be conducive to effective clinical practice with African American youth. Morris (2001) compared an Africentric approach to clinical practice with African American clients with the more traditional Eurocentric approach. The two theoretical orientations are not mutuality exclusive and various elements of the orientations may need to be incorporated with clients. Morris (2001) compared various aspects of Eurocentric and Africentric characteristics, including values, communication style, history, status, aesthetics, and religion. Being aware of the subtle nuances in these cultural aspects of the client is essential to applying culturally competent psychological assessments when working with African American youth. There are several ways to apply an Africentric approach in clinical practice with African American youth. First, this approach may not be useful with all African Americans. It is necessary for the clinician or evaluator to have information on the client's level of cultural identity and worldview prior to conducting an evaluation (Morris, 2001). Second, the clinician should be mindful of color blindness. It has been noted that expressing color blindness may be insulting to patients. According to Morris (2001), to believe that racial color is not important and that all clients are the same is commendable in a non-race-based hierarchical society, but to assume that it is not important to the African American client is presumptuous and culturally insensitive. Applying the DSM-5 CFI is one way to capture aspects of the entire client to reduce misdiagnosis.

Clinicians should also include such factors as social environment, social stressors, and culturally relevant social supports in the assessment of African American youth. Awareness of the effects of exposure to violence is imperative when working with most African American youth. The link between violence and psychiatric symptoms and illness can be detrimental (Fitzpatrick & Boldizar, 1993; U. S. Department of Health and Human Services, 2001). Fitzpatrick and Boldizar (1993) found that over one-fourth of African American youth who had been exposed to violence had symptoms severe enough to warrant a diagnosis of PTSD. Findings also note that a number of these youth and their families may receive comfort through religion and spirituality (Boyd-Franklin, 2003). As a result, the clinician should consider incorporating the family's spiritual advisors in their treatment. This will provide the clinician with another source of data and having a trusted member of their community involved in treatment may enable the family to more freely discuss personal information. Further, using multiple sources, including self-report measures, parent measures, and teacher measures, in addition to information provided by spiritual leaders, influential family members, i.e. grandparents or individuals with "emotional family ties" but not biological kin will provide a plethora of information culminating into a dynamic assessment of the individual.

In addition to clinicians working to refine their cultural competency when working with African Americans, this population should be highlighted more in empirical research to improve assessment practices and future treatment outcomes. The barriers discussed earlier regarding the stigma of research participation and the mental health community must be overcome. Additionally, studies that include significant proportions of minority youth must report reliability estimates for measures completed by the specific ethnic group(s) being studied (Pina et al., 2013). Further, mental health practitioners must be aware of updated information regarding the treatment of their clients and must be informed of effective clinical practices during their training.

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