CHAPTER 9

Culturally Responsive Assessment and Diagnosis for Clients of Color

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Introduction

Clinical assessment and diagnosis can be characterized as the foundation of effective therapy outcomes. As clinicians, we use mental health assessments to diagnose, develop effective case conceptualizations and treatment plans, examine progress in therapy, and promote positive change in our clients. While the importance of clinical assessment and diagnosis is well understood, mental health disparities in the context of clinical assessment and diagnosis continue to jeopardize the quality of mental health care for underserved and marginalized populations.

Cultural Competency and Responsiveness

Given that cultural competency and responsiveness have become a benchmark for ethical and effective clinical practice, it is of crucial importance to consider the implementation of these throughout the different stages of the therapeutic process, including assessment and diagnosis. Cultural competence and responsiveness is described as a clinician’s commitment to gaining awareness, knowledge, and skills that can promote optimal functioning in diverse clients presenting with varied clinical presentations, with an understanding of the impact of societal and institutional systems (Sue & Sue, 2003). Sue and Sue (2003) described two different approaches to the counseling process, the *etic* and *emic* approaches, with the latter being a multicultural, culturally responsive approach. The *etic* approach, which is the manner in which assessment and diagnosis have been
American female resident in her work settings and experienced stereotype-related fears that students and faculty might view her as incompetent or unintelligent and that these fears were more intense when social encounters at work involved White males. These fears were based in a history of racial discrimination experienced by the client. The client’s exposures were then tailored to include racially salient cues, including inviting a White male colleague and supervisor to lunch and going to highly avoided areas in the hospital for specific periods of time. This case points to the importance of attending to a client’s unique and culturally based experiences in the assessment process in support of effective diagnostic and intervention strategies.

Multicultural Counseling Competencies

The multicultural counseling competencies (Arredondo et al., 1996) are a widely used model for training that consists of three developmental areas: (1) attitudes and beliefs (awareness of one’s assumptions, values, and biases); (2) knowledge (understanding the world views and values of diverse clients); and (3) skills (developing relevant and appropriate assessment, diagnostic, prevention, and intervention strategies and techniques). For the purposes of this chapter, we will focus on these skills as they relate to assessment and diagnosis and how this can contribute to the development of effective therapeutic relationships and mental health treatment retention.

Awareness

The first step in engaging in culturally responsive assessment and diagnosis is developing awareness of our own assumptions, values, attitudes, and biases as they relate to our identities and those of our clients. Hays (2008) presented an acronym, the ADDRESSING framework, that helps clinicians begin to attend to their own backgrounds and the diverse backgrounds and lived experiences of clients. Specifically, this framework focuses on nine cultural factors that merit attention in the context of assessment and diagnosis (the parenthetical additions are our own expansions): Age and generational influences; Development and acquired Disabilities; Religion and spiritual orientation; Ethnicity (and race); Socioeconomic status, which includes education; Sexual orientation; Indigenous heritage; National origin (citizenship and immigrant status); and Gender. See table 1.
Table 1. The ADDRESSING Framework.

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<tr>
<th>ADDRESSING Definitions</th>
<th>Client Information</th>
<th>Therapist Information</th>
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<td>Age and generational influences</td>
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<td>Developmental and acquired disabilities</td>
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<td>Religion and spiritual orientation</td>
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<td>Ethnicity (and race)</td>
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<td>Socioeconomic status</td>
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<td>Sexual orientation</td>
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<td>Indigenous heritage</td>
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<td>National origin and generational status</td>
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<td>Gender</td>
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Similarly, D’Andrea and Daniels (2001) present the RESPECTFUL model of interviewing. This model presents ten dimensions of identity including Religion and spirituality, Economic and social class background, Sexual identity, Personal style and education, Ethnic and racial identity, Chronic and lifespan status and challenges, Trauma and crisis, Family background and history, Unique physical characteristics, and Location of residence and language differences. See table 2.

Table 2. The RESPECTFUL Interview Model

<table>
<thead>
<tr>
<th>Ten Dimensions</th>
<th>Identify yourself as a multicultural being.</th>
<th>What personal and group strengths can you develop for each dimension?</th>
<th>How effective will you be with individuals who differ from you?</th>
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<tbody>
<tr>
<td>Religion and spirituality</td>
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<td>Economic and social class</td>
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<td>Sexual identity</td>
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<td>Personal style and education</td>
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<td>Ethnic and racial identity</td>
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<td>Chronic and lifespan status and challenges</td>
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<td>Trauma and crisis</td>
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<td>Family background and history</td>
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<td>Unique physical characteristics</td>
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<td>Location of residence, language differences</td>
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These models present a framework for clinicians to develop both self-awareness related to their identities and to understand the contexts and identities of clients. It is important for assessing clinicians to think deeply about acculturation within the context of national origin and generational status, as these can significantly impact clients’ experience of mental health symptoms and the therapeutic context.
Awareness helps guard against the imposition of clinicians’ cultural values, assumptions, or biases on clients of color. Specifically, awareness facilitates a process of recognizing each client’s cultural context as equally valuable and places importance on working within clients’ values and belief systems in the assessment and diagnostic processes. A commitment to self-reflection and valuing the diverse cultural backgrounds of our clients of color must be unrelenting and continuous to effectively develop diagnostic formulations and case conceptualizations. An example of the importance of this type of awareness can be seen in the case of a thirty-five-year-old Haitian man who came to therapy seeking counseling around his decision to attend college full-time while working sixty hours per week. Since his acceptance to an urban, commuter university one year ago, he enrolled in six courses, withdrew from two, failed two, and earned two Ds. He came to counseling to discuss ways that he can improve his academic performance while maintaining his current employment commitments. In this situation, therapists need to be aware of their own belief systems and values and not impose these beliefs on the client. The therapist, a White female, was born and raised in the United States in an individualistic culture, and her parents instilled in her the importance of prioritizing college over employment and familial obligations. However, the client, having grown up in a traditional Haitian family, values supporting his family both financially and emotionally above all, which means that he must work sixty hours per week to support his nuclear family in the United States, as well as his extended family in Haiti. In this instance, even though the therapist’s value system supports the client minimizing his work obligations and prioritizing school, she must find a way to support the client in doing what is best for him in the context of his life and family values, which might involve taking some time away from school. This process begins with assessment, as the therapist must comprehensively gather pertinent information related to the client’s identity and values system prior to development of a diagnostic formulation and case conceptualization. Culturally responsive assessment and diagnosis includes the development of awareness about one’s own background and taking care to not impose one’s particular belief system on clients, but meeting clients where they are and assessing the meaning of optimal functioning within their cultural contexts.

Throughout the process of assessment, clinicians must also attend to the therapeutic relationship with awareness of the client’s racial and ethnic identity in relation to their own, and the accompanying power dynamics (Parham, Ajamu, & White, 2011; Seller, Smith, Shelton, Rowley, & Chavous, 1998). There are several models of racial identity development that describe the process for White people and people of color, and these models are directly relevant to the trust and social distance that may be generated between dyads. One of the first racial identity models was Cross’s nigrescence model (Vandiver, Flaherty-Smith, Cokley, Cross, & Worrell, 2001), and this model was later expanded by others to include all people of color (e.g., Minority Identity Development Model; Atkinson, Morton & Sue, 1998; Racial and Cultural Identity Development Model; Sue & Sue, 2003). Minority development models may include stages referred to as Conformity, Dissonance, Resistance, Introspection, and Integrative Awareness. In the Conformity Stage, people of color accept the values of the majority culture without critical analysis. In this early stage, they may value White role models and White standards of beauty and success, and they may believe it is better to be White. There may be underlying negative emotions toward the self as person of color, and consequently they may reject a same-race therapist and view the White counselor as more desirable and competent. In the Dissonance Stage, individuals begin to acknowledge the personal impact of racism when a triggering event causes them to question and examine their own assumptions and beliefs. They become more aware of racism and experience confusion and conflict toward the dominant cultural system. In the Resistance Stage, they actively reject the dominant culture and immerse themselves in their own culture. They may feel hostility toward White people in this stage and reject a White therapist. In the Introspection Stage, the person of color starts to question the values of both his or her own ethnic group and the dominant group. The person becomes more open to connecting with White people to better learn and understand differences. In the final stage, Integrative Awareness, the person develops a cultural identity based on both minority and dominant cultural values. They feel comfortable with themselves and their own identity as a person of color in a multicultural society. As clients of color reach more advanced racial identity statuses, they become more inclined to appreciate counselors of their same race. Although those with a strong positive ethnic identity will recognize they may be able to benefit from a competent therapist of any race, and the person of color has no fears about confronting racial issues with a White therapist when needed.

This analysis does not take into account the more complex picture of what may occur between client and therapist when a therapist is also struggling with his or her own identity development. For example, a Black therapist in an early stage of racial identity development may feel hostility toward a Black client, resulting in distancing and an unsuccessful therapeutic alliance. A White therapist in an early stage may become upset and defensive when confronted with racially charged material from a client of color. Assumptions should not be made about goodness of fit based on race in advance of an assessment of racial identity development in both the client and therapist (Helms, 1984).

The models and the exercises presented above can aid the clinician in developing an effective therapeutic alliance and contribute to a more comprehensive understanding of the client’s presenting concerns and subsequent diagnoses. Conversations about a client’s many identities and their importance (or lack thereof) are encouraged early in the assessment process as part of an ongoing conversation that values these contextual frames throughout psychotherapy.

Clinicians should also attend to the contextual issues of power, privilege, and marginalization in clients’ lives. The impact of these constructs on the lived experiences of clients from diverse backgrounds, which often includes intersections of multiple marginalized identities, as well as the impact of these constructs within the therapy space, is yet another level of culturally responsive assessment. Power is described as the ability to decide who has access to resources, while privilege gives unearned advantages and benefits to members of dominant groups in society.
Culturally responsive assessment and diagnosis for clients of color begins with self-reflection and awareness of one's own cultural values and belief systems and respecting the values and belief systems of clients of color. Through self-reflection, clinicians must develop an awareness of the ways they may have benefited from individual, systemic, institutional, and cultural privilege and recognize that clients of color may not have experienced these same advantages. Through recognition of privilege, clinicians are better able to assess the ways in which marginalization and oppression of clients of color contribute to their experiences of mental health difficulties and diagnostic presentation. In addition, awareness of the power that we hold as clinicians to decide the resources our clients have access to contributes to our ability to ensure access to evidence-based, quality assessment tools, diagnostic formulations, and effective interventions. Moreover, awareness of privilege in the context of assessment and diagnosis assists us, as clinicians, in developing a therapeutic space for clients to discuss their life experiences, including racial oppression and to begin to address these inequities with clients of color (inclusive of intersecting identities) through the assessment process.

Potential cultural biases that can impact therapy with clients of color include prejudices and pathological stereotypes that clinicians may be socialized to hold in reference to any particular racial or ethnic minority group. Clinicians must work hard to gain awareness of and devalue from such stereotypes to ensure they refrain from applying inaccurate universal labels and stereotypes (e.g., intellectual inferiority, criminality, over-sexualization, laziness) onto their clients in the assessment and diagnostic process (Williams, Gooden, & Davis, 2012). These forms of stereotypes have contributed to lack of access to resources and opportunities for clients of color and have a direct, negative impact on the assessment and diagnostic processes. Research indicates that prejudice dissipates as individuals gain knowledge of diverse cultures and recognize individuals for having multiple intersecting identities and group memberships (i.e., the ADDRESSING framework; Hays, 2008). It is of crucial importance that clinicians examine their own biases related to racial and ethnic groups, and that they engage in a continuous and persistent process of disallowing these to impact their behavior in assessment, diagnosis and access to quality care for clients of color (for helpful thought and growth questions, see Miller, Williams, Wetterneck, Kanter, & Tsai, 2015).

### Knowledge

Assessment and diagnostic processes are most effective when clinicians are able to connect with clients in ways that are congruent with client cultural values and belief systems. To this end, clinicians must educate themselves about the modal experiences of clients from different cultural backgrounds, while remaining open to each client's unique experiences and life contexts, given that modal experiences do not describe the full range of varied experiences within any racial or ethnic group. This education begins with clinicians learning about the history, beliefs, values, and experiences of oppressed racial and ethnic groups in society to enable clinicians to connect with clients from diverse backgrounds and be more effective in their assessment and diagnostic approaches. In this context, clinicians also need to educate themselves about the historical views of medicine, psychology, and therapy from different cultural perspectives, which includes knowledge about institutional and systemic barriers to mental health treatment that clients of color may experience.

Part of this education includes understanding the ways that racial and ethnic minorities experience marginalization and oppression within one's societal context. These groups are often set apart and perceived negatively or “less than” in society. Marginalized populations often experience barriers to health care and jobs and experience social injustices and threats to their civil liberties. One example of a threat to the civil liberties of a marginalized group can be seen in women receiving unequal pay for doing the same work as their male counterparts, and receiving even lower pay when they are women of color. In addition, we have seen systemic efforts to disenfranchise voters of color across the United States, including closing specific polling stations and heightening regulations related to voter identification. These are just a few examples of the oppression and marginalization that clients of color may experience based on multiple marginalized statuses (intersectionality). These experiences often play a significant role in clinical presentations and must be attended to during the assessment and diagnostic phases of mental health treatment, and clinicians are advised to stay well informed of such policies and practices.

In addition, it is crucial that clinicians work to become educated about the different forms of discrimination that marginalized groups experience, including overt and covert forms of discrimination. Racial microaggressions have been described as intentional or unintentional disparaging comments, slights, or environmental indignities based on an individual's marginalized group status (Pierce, 1970). For people of color, microaggressions can occur in many different forms. For example, a racial microaggression may be a White woman clutching her purse as she walks past a Black man on the sidewalk. Additional examples are a Chinese American woman being asked what country she is from, or a White clinician making the statement “I do not see color.”

Clinicians must not adhere to ideas of colorblindness and sameness, but should acknowledge and appreciate cultural differences in the therapy room with their clients of color. While “colorblind” approaches to assessment and diagnosis are meant to reduce biases, they actually serve to ignore important lived experiences of clients (e.g., exposure to racism) and can lead to ineffective diagnostic formulations and case conceptualizations, impacting the overall success of the therapeutic process (Terwilliger, Bach, Bryan, & Williams, 2013). While subtle or covert, these microaggressions often serve to demean or invalidate certain groups and have deleterious effects on mental health and well-being (Brondolo et al., 2008; Franklin, 2004). Therefore, clinicians must gain awareness and knowledge of these types of indignities in order to both assess for their impact on mental health difficulties as well as avoid engaging in these types of behaviors with clients of color. It is important for clinicians to communicate that they value their clients and their differences.
CHAPTER 9

Discrimination and Assessing the Impact of Race-Based Discrimination

As discussed in chapter 5, an abundance of research finds that racial discrimination is experienced with frequency and persistence for people of color in the United States and that these experiences have a profoundly negative effect on the genesis, expression, and maintenance of mental health difficulties. Studies have linked both macro- and microaggressive experiences of racial discrimination to psychological distress, decreased treatment seeking, and mental health disparities in care for racial and ethnic minorities (Freimuth et al., 2001; Snowden, 2001; Williams, Printz, & DeLapp, 2018).

Given this evidence, it is of crucial importance for clinicians to address the impact of racism on clients of color during the assessment and diagnostic phases of mental health treatment. Clinicians should introduce issues of marginalization early in the assessment process, and they should assess for the experience, frequency, and perceived impact of experiences of race-based discrimination and marginalization based on the clients’ intersecting identities. When introducing experiences of marginalization with clients of color, it is important to understand that people of color often get the message that discussing race-based discrimination across difference (e.g., with folks who racially identify as White) can be dangerous, threatening, or lead to negative consequences (e.g., loss of employment, social ostracism, or isolation). Therefore, clinicians who introduce these issues early in the assessment process might think about checking in with clients of color related to their fears of discussing these issues in the context of therapy and across difference. For instance, an assessing clinician might ask the question, “What is it like for you to discuss experiences of racism with me?” Introducing these issues, as a clinician, early in the assessment process can send a message to clients of color that therapy is an appropriate and safe space to discuss experiences of race-based discrimination and their impact on mental health struggles, which contributes to effective diagnostic and case formulations.

Measures of Race-Based Discrimination

Therapists without much experience having discussions about race often wonder how they can start the conversation with clients. There are a number of scales that have been developed to assess experiences and impact of racial discrimination on mental health symptoms. The Race-Based Traumatic Stress Symptom Scale (RBTSSS; Carter et al., 2013) is a fifty-two-item self-report measure that assesses the psychological and emotional stress reactions one has to racial discrimination. Landrine and Klonoff (1996) developed an eighteen-item self-report inventory, the Schedule of Racist Events (SRE), that assesses the frequency of racist events experienced for African Americans in an individual’s past year and across their lifetime, as well as the extent to which the discrimination was perceived as stressful. The General Ethnic Discrimination Scale (GEDS; Landrine, Klonoff, Corral, Fernandez, & Roesch, 2006) is an eighteen-item measure that assesses perceived ethnic discrimination among different ethnic groups and was developed with a specific focus in health research, examining frequency and stress resulting from discriminatory experiences. The Racial and Ethnic Microaggressions Scale (REMS; Nadal, 2011) measures the frequency of which individuals experience different types of microaggressions. Similarly, the Racial Microaggressions Scale (RMAS; Torres-Harding, Andrade, & Romero-Diaz, 2012) is a thirty-two-item scale that assesses the occurrence and distress elicited by incidents of racial microaggressions. Finally, the Trauma Symptoms of Discrimination Scale (TSDS; Williams, 2018b) is a twenty-one-item questionnaire of discriminatory distress, measuring anxiety-related trauma symptoms. Therapists can administer these or similar measures before the first meeting and use the results as a springboard for further conversations.

Williams et al. (2018a) designed an instrument (UConn Racial/Ethnic Stress and Trauma Survey; UnRESTS) to explore racial stress and trauma that guides clinicians in asking clients difficult questions about their experiences surrounding race. The survey includes questions to assess ethnoracial identity development, a semi-structured interview to probe for a variety of racism-related experiences, and a checklist to help determine whether the individual’s racial trauma meets DSM-5 criteria. The format of the UnRESTS is modeled after the DSM-5 Cultural Formulation Interview (CFI; American Psychiatric Association [APA], 2013). Unfortunately, neither the CFI nor its supplementary modules examine racism or discrimination, despite the CFI having been developed as a cultural assessment. Therefore, it may be necessary for clinicians to also have access to an interview, such as the UnRESTS, specifically designed for the assessment of discrimination and its impact. The interview is available in both English and Spanish (Williams, Peña, & Mier-Chairez, 2017).

The Role of Stereotype Threat

Clinicians must also be aware of the role of stereotype threat in maintaining disparities in seeking and engaging in mental health treatment. Stereotype threat is defined as cues in the environment that make salient negative stereotypes held about one’s marginalized group status. These cues often trigger physiological and psychological processes that undermine performance and success and that contribute to mental health difficulties (Steele & Aronson, 1995). In mental health settings, stereotype threat can be described as things in the mental health setting that make salient negative stereotypes held about people of color as unintelligent or unworthy of quality care. One example can be walking in to a mental health clinic and not seeing any people of color on staff or as mental health providers. An important thing to keep in mind is that stereotype threat can occur regardless of the prejudices held by particular clinicians. Stereotype threat can affect clients of color in a number of ways, including triggering difficulties with cognitive processing, lowered self-esteem, lack self-efficacy, disengagement with the therapeutic process,
difficulties with communication, and struggles related to identity (Burgess, Warren, Phelan, Dovidio, & Van Ryn, 2010). Clinicians must be aware of the potential for stereotype threat to become a barrier to effective care for people of color. In fact, it could be helpful for clinicians to discuss with clients the ways in which stereotype threat can impact quality care and engage in discussions related to stereotype threat during the assessment process.

Role of Assessment and Diagnosis in Therapy Retention

Numerous studies have highlighted the difficulties in therapy retention for people of color (see chapter 2). For example, Freimuth et al. (2001) conducted focus groups with sixty African Americans and found that the majority of participants were aware of the Tuskegee Syphilis Study and cited this as representative of medical research and as a reason for distrusting mental health care services. In addition, racial biases contribute to misdiagnosis of psychological disorders as well as mistreatment of racial and ethnic minorities based on these biases (Snowden, 2001). For instance, historically, Black Americans have been disproportionately overdiagnosed, and misdiagnosed, with schizophrenia, which has been attributed to clinician biases as well as misinterpretation of mood disorder symptoms (Coleman & Baker, 1994; Schwartz & Blankenship, 2014). Thompson, Brazil, and Akbar (2015) used focus groups to explore perceptions of psychotherapy, psychotherapists, and barriers to treatment in a sample of Black American adults. Results indicated that participants highlighted mental health stigma (e.g., shame and embarrassment associated with seeking mental health services), cultural barriers (e.g., personal issues should be resolved within the family), lack of trust, lack of knowledge about mental health issues (e.g., symptoms or signs of mental illness; lack of knowledge about resources), lack of affordability, and impersonal services as barriers to mental health treatment engagement. In addition, study participants often believed that psychotherapists were insensitive to experiences tied to their Black American identities.

Given these findings, during the assessment process, it is essential for clinicians to assess past therapy experiences, expectations related to the therapy process, as well as ideas related to mental health stigma for clients of color. For instance, clients who have experienced racial macro- or microaggressions in the context of a previous therapeutic relationship might be reluctant to provide pertinent information during the assessment process to protect themselves from further harm. This type of reluctance can lead to misdiagnosis or ineffective case conceptualization, contributing to early termination. Clinicians might directly ask clients of color about past therapy experiences to get a sense of both positive and negative aspects of those experiences. In addition, clinicians can ask directly about experiences of racism in the context of therapy by saying, “Given how often people of color experience racism in our society, I am wondering if you have had these experiences in your past therapy experiences?” Assessing for past therapy experiences, both negative and positive, can signal to the client that you, as the clinician, care about tailoring the assessment, diagnostic, and intervention experience to their individual needs.

The Effects of Mental Health Stigma

Clinicians should determine the impact of mental health stigma for clients of color to aid in case conceptualization. Sources of this stigma are widespread, including media and societal messages as well as cultural and familial influence (Corrigan, 2004; Rao, Feinglass, & Corrigan, 2007). Among some communities of color, mental illness can be perceived as contagious, chronic, genetic, a personal weakness, curse, or sin (Mishra, Luckstead, Gioia, Barnet, & Baquet, 2009). Mental health stigma is higher among racial and ethnic minority groups compared to White Americans (Rao et al., 2007), and this is a significant barrier to treatment engagement and retention for individuals of color. It is important for clinicians to understand clients’ views of others who experience mental illness as well as clients’ perceptions of their own experience with mental illness. Through the assessment process, clinicians must ask direct questions related to clients’ perception of their struggles generally (e.g., “How did you learn about mental health struggles?” “How are mental health struggles viewed by family members, friends, community?”) The DSM-5 Cultural Formulation Interview (APA, 2013) is a good guide for asking these questions. In addition, there are other mental health stigma assessment measures that may assist in the assessment effort (e.g., the Endorsed and Anticipated Stigma Inventory; Vogt et al., 2014).

Culturally Responsive Diagnostic Process

Diagnosis is a fundamental piece of effective mental health treatment. For this reason, many clinicians adhere to evidence-based treatments that have been shown to be effective for specific mental health disorders (Proctor, 2002), which suggest that diagnosis is of crucial importance in the context of utilizing appropriate evidence-based strategies.

To that end, mental health practitioners have a responsibility to inform themselves as to whether or not the measures they use to assess clients are culturally appropriate and normed and validated in those specific populations. There is now a wealth of evidence that indicates strong cultural biases in many of our “gold standard” assessment tools. This includes popular IQ tests (e.g., Thaler, Thames, Cagigas, & Norman, 2015), diagnostic interviews (e.g., Chasson, Williams, Davis, & Combs, 2017), and self-report measures (e.g., Williams, Davis, Thibodeau, & Bach, 2013). The potential for lasting harm based on improper diagnoses is great. For example, incorrect intellectual assessment could result in improper educational placement, a wrong psychotic disorder diagnosis could result in inappropriate medications, and a misplaced personality disorder diagnosis could lead to long-lasting stigma and barriers to care. To ensure the measures chosen for
the purpose of assessment are appropriate for clients of color, it is important to consult the literature outlining research related to the validity and reliability of a particular measure and whether or not a given assessment tool has been used and validated with clients of color specifically. Validation on a “representative US sample” is not adequate to ascertain if a given measure is appropriate for any specific ethnic group unless subgroup analyses have been conducted.

Culturally Responsive Diagnostic Formulation

The process by which clinicians develop a diagnostic formulation is directly tied to cultural responsiveness. Specifically, given the history of cultural mistrust of medical providers among people of color stemming from past and current exploitative practices (e.g., Tuskegee Syphilis Study, eugenics), clinicians must think deeply about the development of a collaborative diagnostic formulation in which the client feels part of the diagnostic process as well as the outcome. For clients of color, it can be helpful for clinicians to be transparent about the diagnostic process. For instance, clinicians should have an open conversation with clients about the diagnostic criteria related to their mental health struggles and check in with clients to make sure that diagnostic conclusions match with their perspectives related to their struggles. Culturally responsive assessment also includes openness and transparency on the clinician’s part about how diagnoses will be portrayed in the client’s chart and who will have access to it. Specifically, in many clinics, other physical and mental health providers may have access to clients mental health diagnoses, and it is important for clients to be aware of this. Finally, clinicians must be willing to process and discuss client’s reactions to and responses to their diagnosis. The basis of culturally responsive diagnosis is collaboration and trust.

Conclusion

Culturally responsive assessment and diagnosis have become a top priority for the governing bodies of psychology. While the research, training, and application of culturally responsive assessment and diagnosis has increased over the last several decades, there is a continued need for a focus on training culturally responsive clinicians. For clinicians working to enhance their cultural responsiveness, Hays (2008) noted that the skills of a culturally responsive clinician are similar to those of an effective clinician more broadly—developing cultural humility (to avoid mistaking difference for inferiority), compassion (for self and others), and critical thinking skills (the process of continually questioning one’s assumptions and biases). Clinicians who attend to these principles achieve the overarching goal of every clinician: client well-being.

KEY POINTS FOR CLINICIANS

- Cultural competency and responsiveness have become a benchmark for ethical and effective assessment and diagnostic processes.
- The first step is to develop awareness of our own assumptions, values, attitudes, and biases as they relate to our identities and those of our clients.
- Each client’s cultural context is equally valuable, and it is important to work within clients’ values and belief systems in the assessment and diagnostic processes.
- Clinicians should attend to the contextual issues of power, privilege and marginalization in clients’ lives.
- Use properly validated measures to help assess cultural constructs for diverse clients.

References


