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Multicultural Assessment: Research, Training, and Practice

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Multicultural Assessment:

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pp 17-20~~

Abstract

The credibility of standard assessment has been questioned by intra-professional debate, diminished by training deficits, redefined as semi-skilled technology by managed care, and compromised for multicultural populations by research bias. Scientific psychology has been responsible for perpetuation of bias and the limited generality of published ethnic minority research. A constructive response to these issues includes more coherent scientific preparation for assessment practice, particularly with ethnic minority populations. Adequate preparation entails careful reformulation of assumptions, redefinition of variables, informed selection of research methodologies, understanding deficiencies in normative data, and using culturally responsible interpretive strategies with standard test data in addition to employment of new measures. Currently available guidelines for culturally-relevant research, training, and practice are precursors to empirically-derived consensual standards for responsible and ethical multicultural assessment.

Multicultural Assessment: Research, Training, and Practice.

Introduction

Psychological assessment – a defining practice of professional psychology- has diminished in professional importance within psychology during the last 20 years. Decrements in quality, intensity, and scope of assessment training now coexist with intra-professional controversy concerning the scientific status of standard instruments, particularly projective methods, while managed care imposes restrictions on assessment practice. In response to these anti-science allegations, recent research has led to positive changes in the contemporary assessment climate regarding usage of standard instruments, their scientific status has been clarified, and appreciation of their clinical utilities has increased.

However, the assessment establishment has failed to establish the legitimacy of multicultural assessment practice. Culturally sensitive assessment practice is dependent upon modifying interpretations of standard instruments, accepting acculturation and racial identity measures as bona fide test battery components as well as advocacy for new culture-specific instruments. By the same token, there is a dearth of the specialized multicultural training and practice necessary for constructive services to ethnic minority populations now comprising approximately one-third of mental health clients. As a consequence, despite the sustained efforts of a small number of dedicated psychologists, the necessity for teaching multicultural assessment in addition to standard assessment has not been adequately addressed. Similarly, there is no general acknowledgement within professional psychology of the limited adequacy and generality of published ethnic minority research now required to sustain informed multicultural assessment training and

practice. Disagreement concerning the prevalence of bias in current ethnic minority research as well as the extent of deficiencies in standard assessment instruments and their available normative data for ethnic minority populations undergird the lack of professional consensus on these issues.

In this paper, standard assessment training is contrasted with multicultural training origins, examples, and ingredients. Selective reinforcement of scientific principles during all phases of research result in biased and incomplete empirically-derived knowledge of ethnic minority populations. Remediation for bias can only occur by application of current research guidelines and compilation of more adequate knowledge as a basis for multicultural assessment training and practice.

Multicultural competency interest during the 1980s by counseling psychology resulted in constructs operationalized by a number of instruments applied during counselor training and/or for evaluation of training. Although the effectiveness of multicultural competence training has not been unequivocally demonstrated, this training gradually incorporated assessment issues, instrumentation, and advocacy for research designed to increase multicultural competency. There is now sufficient knowledge of relevant cultural issues to foster graduate multicultural assessment course exemplars as well as research and practice guidelines applicable to ethnic minority populations. However, multicultural assessment training is affected by selection of measures, the quality cross-cultural equivalence research, the adequacy of definitions for group identification variables used in group comparisons and normative data, and a number of issues pertinent to particular research designs and strategies. Confrontation with the nature and extent of bias as well as the limited generality of published ethnic minority

research provides another incentive for the assessment establishment to recognize that multicultural assessment training is necessary to supplement and complement standard assessment instruction and experience. Multicultural assessment training and practice can contribute to the development of assessment practice standards that responsible for more adequate ethical codes and non-discriminatory mental health policy.

Standard Assessment in the United States

External Influences on Practice

Assessment practice in managed care settings shows an increasing preference for brief, symptom-focused instruments (Piotrowski, 1999). Administration, scoring, interpretation, and report preparation within approximately 2 hours of compensated time is required although a minimum of 4 hours is necessary using a standard test battery (Camara, Nathan, & Puente, 2000). The most recent review of managed care practices affecting professional psychology acknowledges assessment restrictions and suggests that more direct approaches to assessment may ultimately replace standard tests and test batteries (Sanchez & Turner, 2003). If this interpretation is correct, applications of standard psychological tests in public sector mental health settings will occur with decreasing frequency leading to dramatic alterations of the prevailing assessment model and training contents.

Internal Debate on Tests/Methods

Within professional psychology, a major event in this new millennium has been an attempt to restrict traditional assessment training and practice because of the mistaken belief that projective methods constitute pseudoscience, are devoid of legitimate scientific support, potentially harmful to clients (e.g., Lilienfeld, Lynn, & Lohr, 2003;

Lilienfeld, Wood, & Garb, 2001; Lohr, Fowler, & Lilienfeld, 2002), and of unclear status for appropriate usage with ethnic minorities and non-Americans (Wood, Garb, Lilienfeld, & Nezworski, 2002). Refutation of these allegations provides new evidence that these assessment methods are not only legitimate scientific products (e.g., Hibbard, 2003; Smith, 2002; Lerner, 2002; Weiner, Spielberger, & Abeles, 2002), but document the present usage of time-intensive, clinician-administered tests and methods with mainstream U. S. populations (Meyer et al. 2001). Documentation from this landmark meta-analysis has not stifled allegations, but a long, positive history of using empirically grounded projective assessment methods is reaffirmed by psychological test validities comparable to medical test validities. However, the passion and professional energy consumed by this controversy suggests an essential ingredient is a continuing absence of consensus among professional psychologists concerning the nature of science as applied to understanding human beings.

Standard Assessment Training

In describing training needs for the twenty-first century, Fox (1994) concluded that "the continued growth and development of professional psychology may ultimately stand or fall on the integrity of the educational system that prepares future generations of practitioners" (p. 200). Fox was concerned with a narrowing focus on diagnosis of mental illness that curtailed employment of a full array of diagnostic and assessment instruments necessary for comprehensive mental health services.

It has been my observation that psychological assessment training has decreased in quality, intensity, and scope over the last 20 years (Dana, 1992). Several sources of converging survey evidence provide support for this assertion. First, a limited number of

tests of intelligence, psychopathology, and personality have been consistently employed, including the Rorschach, TAT, and MMPI-2 (Camara, Nathan, & Puente, 1998; Piotrowski & Belter, 1999). Second, training in psychometrics, statistics, and research methodology once considered a prerequisite for competent assessment practice, is no longer required in most programs. Third, there has been insufficient investigation of how assessment training is conducted (Childs & Eyde, 2002). Fourth, the median number of required reports using these instruments is grossly insufficient to demonstrate competence (Stedman, Hatch, & Schoenfeld, 2001). Fifth, most internship programs attempt to augment perceived deficiencies in their expectations for standard assessment knowledge and skills (Clemence & Handler, 2001). Meyer et al (2001) suggested expanding competence training to include a wider variety of assessment methods, focusing on clinical judgment to move beyond instrument-based technological efficiency, and legitimizing a role for assessment consultation. These considerations for improving standard assessment require supplementation for multicultural assessment training.

Multicultural Competency Training

Origins

Professional psychology in the United States has a long history of relative disinterest in mental health needs and services for ethnic minority populations (e.g., Dana, 2002a) in spite of explicit inclusion of these populations in the National Conference on Levels and Patterns of Professional Training endorsed by the American Psychological Association in 1973 (Korman, 1976). Culturally relevant training for professional psychologists has been incorporated within programs by specific courses or areas of specialization, availability of relevant courses in other disciplines, and less

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frequently by integration of cultural issues within the total program involving faculty, students, and practitioners (Copeland, 1982). Despite early APA endorsement of Vail model aspirations, a majority of professional psychology programs have not explicitly included ethnic minority populations in their professional training agendas (Dana, 1993; Dana & May, 1987). Integumentation of cultural issues in cultural competency training is now perceived as “the central core of the counseling profession’s identity“ (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002, p. 153), although this perception has not been implemented in many professional psychology programs..

This recognition was fostered initially by development of a multicultural counseling competency model specifying attitudes/beliefs, knowledge, and skills constructs (D. W. Sue et al., 1982) and later by construction of a number of instruments operationalizing these constructs (for review, see Ponterotto, Fuertes & Chen, 2000). A single, improved psychometric instrument, the California Brief Multicultural Competence Scale (CBMCS), developed from 157 items in earlier instruments, contained 21 items and 4 factors labeled as knowledge, awareness, sensitivity, and non-ethnic ability (Gamst et al., submitted). An accompanying user’s guide presented normative data described self-perceived levels of multicultural competency levels of 1,244 California public mental health clinicians (Der-Karabetian et al., 2002).

The contents of the CMBCS items were used to create the preliminary version of a manual for multicultural competency training with modules representing each factor (Dana, 2002b). The manual contains a range of contents representing each item using handouts for presentation to trainees. The manual was deliberately designed to be open-ended to facilitate inclusion of new item-relevant contents and additional instructional

modalities to augment or replace handouts in the preliminary version. This preliminary version was subsequently adapted for training of trainers and clinical staff at various CMBCS levels, initially in one California agency (Arrellano, Huff-Musgrove, & Morrow, 2003), and endorsed by the State Department of Mental Health for piloting and statewide application. A revised version of this manual (Dana, 2003a) incorporates a more complete scenario for multicultural competency training that includes evaluation of training effectiveness and contains additional references from the adaptation augmenting the range of relevant item contents composing an empirical basis for training.

Multicultural Assessment Training Examples

Contemporary national surveys do not address the extent to which ethnic minority populations have unique assessment needs relevant to increased utilization and positive outcomes of standard and/or culture-specific mental health interventions. These surveys also omit information concerning varieties, prevalence, availability, and outcomes of multicultural assessment training. Restricted training opportunities and self-reported feelings of inadequacy among professional psychologists in providing competent services to various ethnic and racial populations were suggested by an early survey (e.g., Allison, Crawford, Echemendia, Robinson, & Knepp, 1994). However, graduates of counseling psychology programs, especially ethnic minority counselors, report multicultural awareness and skills competency in spite of dissatisfaction with the extent of their cultural knowledge (Holcomb-McCoy & Myers, 1999).

One published symposium described culturally sensitive courses in four different university psychology programs (Dana, 2002c). Communalities in these courses include (a) instructor responsibilities for teaching students to understand and respect cultural

differences and understand cultural competence as a multifaceted construct; (b) increasing awareness of bias sources, strategies for bias reduction, and familiarity with psychometric issues relevant to tests/methods studied; (c) exposure to standard and multicultural assessment simultaneously and (d) supervised practice with multicultural assessment data.

Multicultural Assessment Training Ingredients

These published examples of assessment courses provide evidence that multicultural assessment training is now feasible. A continued development of multicultural assessment training was encouraged by an organized overview beginning with premises that multicultural assessment and cultural identity assessment are synonymous and both quantitative and qualitative tools are required for implementation (Ponterotto, Gretchen, & Chauhan, 2001). Quantitative tools include standard nomothetic instruments and approximately 100 self-report measures of cultural identity. Standardized tests were examined using guidelines for selection and use including construct clarity and definition, construct dimensionality, psychometric properties, construct validity, criterion-related validity, reliability, and test validity and reliability. Qualitative idiographic cultural identity stage assessment models were presented using the DSM-IV cultural formulation outline (American Psychiatric Association, 1994) as an anchor for five additional semi-structured interview protocols, including the Multicultural Assessment-Intervention Process model (MAIP) (Dana, 1997). The contents, order, and numbers of stages in these formulations for multicultural assessment practice vary considerably with regard to conceptual origins, level of abstraction, degree of comprehensiveness, breadth, and inclusiveness.

Ponterotto et al (2001) integrated these models into a descriptive context of provider responsibilities and awareness of power differentials as a consequence of self-exploration and self-scrutiny consistent with the multicultural counseling competency model described earlier. This holistic idiographic framework can also be used for a culturally relevant diagnostic interview process with subheadings and relevant questions organized within major areas of client worldview/perception of problem, client's family background, cultural explanations of the presenting illness, and cultural elements of the provider-client relationship.

A number and variety of general guidelines for multicultural competence (for review, see Dana, 2003b, Chapter 4) provide a general context for multicultural assessment training and practice. However, more specific assessment guidelines for training and practice can supplement the Ponterorro et al (2001) conceptual framework by providing the beginnings of consensus for the process of multicultural assessment.

Two independent sources of contrasting assessment-specific guidelines are now available (Dana, 2003b, Chapter 5; Ridley, Hill, Thompson & Ormerod, 2001).

Ridley

The Ridley et al guidelines were preceded by a philosophy of assessment practice- the Multicultural Assessment Procedure (MAP) (Ridley, Li, & Hill, 1998)- published with commentaries (Arbona, 1998; Constantine, 1998). History taking and multiple data collection methods are used to identify cultural data in MAP phase one. Phase two- interpreting cultural data- requires differentiation of cultural and idiosyncratic data, application of base rate information, differentiation of dispositional from environmental stressors, and recognition of clinically significant data. Phase three incorporates cultural data by ruling out medical implications, employing psychological testing, and comparing

data with DSM-IV criteria. Phase four concludes with a viable assessment decision. These guidelines for assessment practice were presented in a descriptive context of good guideline characteristics including validity, reliability-reproducibility, clinical applicability, clinical flexibility, clarity, multidisciplinary process, scheduled review, and documentation.

Dana's multicultural assessment training desiderata (2003b) begin with employment of the MAIP practice model for an overall description of how and when to embed culturally relevant issues in the assessment-intervention process. These desiderata also contain relevant contents for this process, including (a) early evaluation of client-clinician language skills; (b) specification of multicultural competency components of clinician attitudes/knowledge/ skills and self-appraisal/understanding as well as knowledge of multicultural research standards and culture-specific service delivery etiquette; (c) use of moderators to evaluate cultural identity/racial identity status to determine adequacy of standard tests for client; (d) use of standard and/or emic instruments with recognition of test construction, standardization, and norms for specific multicultural populations; (e) familiarity with the process of preparing cultural formulations for DSM-IV diagnoses; (f) increasing the applicability of standard tests by specific guidelines for interpretation; (g) recognizing assessment reports as the primary vehicles for communication; and (h) learning to provide culture-specific feedback to the client entity.

Students and practitioners now have recourse to abundant cultural knowledge relevant for multicultural assessment training and practice. The necessity for compiling and organizing this knowledge omits the important question of how much knowledge can

responsibly be incorporated during assessment training. S. Sue (1998) suggested that providers have sufficient cultural knowledge to avoid stereotypes of consumers and understand when valid generalizations are permissible, or the ability to employ *dynamic sizing* to recognize “when to generalize and be inclusive and when to individualize and be exclusive” (p.446). Such an outcome as a training objective may require substantially more exposure to cultural issues than multicultural assessment training per se.

Nonetheless, multicultural assessment training has not thrived in spite of sustained attention by many authors for at least 20 years. In a comprehensive evaluation of multicultural literature, Ridley et al. (1998) suggested we have no coherent conceptual framework, the existing literature is biased, identification of issues has occurred in the absence of remedial activities, and a scientific basis consisting of adequate empirical data and scientific attitudes regarding cultural issues is lacking. The remainder of this paper responds to these conclusions by suggestions for research that informs a more inclusive science of assessment.

Remediation for Bias

Bias in assessment instruments developed in one culture and exported internationally is minimized by assumptions that measured constructs are universal and cultural differences are minimal, particularly if translations are accomplished systematically. These potential sources of bias are magnified by flawed empirically-derived knowledge due to continued insufficiency of research operations. Prior to multicultural assessment training, students need information concerning contamination of research by selective enforcement of scientific principles and insufficient awareness of the influence of cultural issues during each phase of research (S. Sue & L. Sue, 2003).

These phases include planning, definition of variables, selection of measures, equivalence levels, selection of subjects/sampling, cooperation, research designs/strategies, and interpretation of data. Students also require practice in applying consensual guidelines to published research (Council of National Psychological Association for the Advancement of Ethnic Minority Interests, 2000).

This section describes a number of major assessment-specific issues including (a) selection of measures; (b) levels of equivalence; (c) definition of variables; (d) reformulation of assumptions; (e) group comparisons; (f) normative data; and (g) selective and limited usage of the full array of relevant research designs and strategies.

Selecting Measures: Etics, Emics, and Imposed Etics

Cross-cultural psychologists employ the terms etic and emic to specify the locus of investigation and origin of measuring instruments. These terms originated with Pike (1967) to describe different but overlapping and symbiotic non-dichotomous perspectives of equivalent value and importance (Berry, 1999). Etic implies a broad structure for description and comparison of cultures using instrumentation that is developed externally from a given culture. Emic pertains to discovery and understanding emerging within a particular language and culture pertinent to understanding individuals in their life contexts.

Standard tests or emics constructed in the United States are typically translated and exported internationally because they are presumed to be universally applicable perhaps because cultural differences are minimized and general laws of human behavior are the abiding focus of interest. "Employing a construct as if it has the same meaning in the target or nonoriginating culture" (Lonner, 1985, p. 601) refers to "imposing an etic"

hence an imposed ethic. While these distinctions may be inherently ephemeral, Lonner reminds us that the “processes, procedures, and assumptions underlying psychological assessment are likely not to be absolute and that relativism or contextualism should be granted the upper hand until indicated otherwise” (p. 602).

Levels of Equivalence

Cross-cultural equivalence, or discovery of systematic variation among groups must be established to avoid measurement error or chance statistical relationships. Brislin (1993) described translation, metric, and conceptual equivalence. Translation or item equivalence also referred to linguistic equivalence. Metric or scalar equivalence requires that a scale measure the same behavioral properties. Conceptual or construct equivalence refers to identity of meaning of an underlying psychological construct across groups. A fourth type, functional equivalence as a special case of construct equivalence, recognizes that specific overt behaviors may be measured by different scales in different cultures (Berry, 1980). While necessary, it is never sufficient to demonstrate linguistic or translation equivalence without attention to other types of equivalence, although it has proven more difficult to examine constructs and metric issues have only infrequently been explored.

Definition of Variables

S. Sue and Zane (1987) proposed clear distinctions between distal and proximal variables. Distal variables such as “culture”, “race”, and “ethnicity” are complex, burdened with surplus meaning, and lack consensual definition (APA, 2003; see also, Mio, Trimble, Arredondo, Cheatham, & D. Sue, 1999). Proximal variables provide linkages within the research process that transform these vague referents into concrete

operations that clarify research-based conclusions. Whenever race or ethnicity is operationalized as a demographic variable, culture is rendered distally and functions as a proxy variable for unknown underlying culturally-based personality processes potentially mediated and correlated with other variables (S. Sue and L. Sue (2003); Okazaki & S. Sue, 1995). These authors prefer direct measures of personality processes affecting test performances coupled and more adequate description of samples. Hibbard (2003) reiterated concern with the methodological flaw of obscuring research conclusions by unsystematically introducing many demographic and cultural variables potentially mediating observed relationships and differences. Professional psychology has failed to consistently incorporate culture as a proximal variable in research, training, and practice.

Reformulation of Assumptions

Resolution of the proximal/distal issue can begin with Malgady's (1996) recommendation to reverse the null hypothesis of no cultural bias to specify bias and alter the practical implications of Type I and 2 errors. The Multicultural Assessment-Intervention Process model (MAIP) incorporates Malgady's recommendation by specifying opportunities for employment of cultural information not only within the assessment process per se but ultimately an incorporation of assessment procedures within the entire mental health system of care (Dana, Aragon & Kramer, 2002).

Additional assessment examples include use of moderator variables as sources of cultural information affecting test interpretation, client language proficiency evaluation to specify language usage during service delivery, and culture-specific interpretation strategies for standard tests (Dana, 2003b; S. Sue, 1998).

Group Comparisons

Group comparisons predicated on inaccurate and incomplete group identification as a distal variable have been criticized for many years (e.g., Azibo, 1988). The finding of a group difference on assessment measures may not permit valid conclusions concerning the meaning of these differences whenever groups are described by overinclusive, misleading, and stereotypic “ethnic glosses” serving to separate groups without providing sufficient detail for responsible identification (Trimble, Helms, & Root, 2003). Moreover, the groups are frequently be too small, unrepresentative, or inadequately and incompletely matched. Furthermore, it is unknown what magnitude of difference is required for interpretation of scores (e.g., 5 points on the MMPI/MMPI-2). An Index of Correction for Culture (ICC), suggested by Cuellar (2000), derived from comparing acculturation status scores with normative data can provide evidence of the magnitude of difference occurring as a function of culture. Allen and Walsh (2000) noted that nonequivalence in instrument metric qualities or underlying construct definitions, in addition to a genuine difference between groups, also serves to confound the meaning of obtained group differences.

Normative Data

In spite of the limitations of available normative data described earlier for standard tests, these data serve as comparative criteria for comparing ethnic minority populations with White populations on personality and psychopathology constructs. Norms for separate ethnic minority populations are infeasible due to the equivalence of within-group and between-group differences. Local norms for some isolated, local, and unacculturated groups within larger societies (e.g., First Nations people and American Indians/Alaska Natives) had limited historic utility as practical markers of the extent of

potential worldview and behavior differences. With the emergence of a global society mediated by English language usage, the Internet, and normative biculturalism, local norms can provide independent, emic sources of personality and psychopathology information, no longer necessary exclusively for comparative purposes, but as a powerful means of distinguishing between universal and local standards (Dana, 2003c) as well as sources of information to modify existing instruments (see Lee & S. Sue, 2001).

Lonner and Ibrahim (2002) suggest that normative data collected in the United States describe a sophisticated, privileged, primarily middle-class group. This observation is supported by samples and normative studies from other countries, including relatively larger numbers of lower class persons, in which there are significant cross-cultural score differences from domestic Rorschach normative studies. Nonetheless, these quickly outdated, normative studies conducted in the United States have become the comparative standard, although methodologies exploring the relation of group-specific test variables to a cross-culturally equivalent criterion variable as well as to the underlying nomological net through tests of convergent and divergent validity are less prone to bias (Allen & Dana, in press).

Another and alternative source for normative data can be provided by corrections for acculturation or racial identity status applied to scores from standard assessment instruments. Acculturation refers to changes in traditional cultural patterns as a result of continuous, first-hand contact and acculturation status describes outcomes to changes in individuals during this process described by traditional, bicultural, marginal, and assimilated cultural orientations (Dana, 1993). Acculturation status has received documentation as a major source of heterogeneity within ethnic groups, a performance

correlate for Hispanics as well as a source of confounding with psychopathology, and remains a specific variable of interest underlying ethnic group membership. For example, pathologizing effects of acculturation and racial identity status data on MMPI/MMPI-2 scores are consistent for the four major ethnic/racial minority groups (Dana, 2000a; Whatley, Allen, & Dana, in press). Acculturation status norms can describe individuals who are either traditional or in process of developing racial identities for whom existing test norms are often inappropriate.

Research Designs and Strategies

Too much reliance on comparative methodology coupled with employment of distal rather than proximal variables and selective utilization of methodologies limits opportunities for introduction of other methods. For example, selective enforcement of scientific principles overemphasizes the importance of internal validity research, or causal effects of one variable upon another and has been accompanied by relative neglect of external validity, or the generality of findings to specific settings and populations (S. Sue, 1999). Similarly, whenever linguistic equivalence is used as the sole cross-cultural equivalence exemplar, generalizations to construct and scalar equivalence without research-based demonstrations are unwarranted. Finally, the fact that construct validation designs are difficult to design and implement is not a legitimate excuse for failure to employ them. Underutilization of confirmatory factor analysis, tests of differential item functioning, particularly item response theory, and regression analyses of cultural identity measures is also apparent in published assessment research (Allen & Dana, in press).

Preference for quantitative methodology in professional psychology has minimized the credibility of qualitative strategies. These strategies, including case

studies, ethnographic research, focus groups, participative inquiry, and phenomenological research (Mertens, 1998) are useful for understanding the behaviors, meanings, patterns, and rules in culture-specific communities (S. Sue & L. Sue, 2003). Combined emic-etic designs can provide feasible multiple quantitative and qualitative sources of data, although these designs are underutilized (e.g., Franchi, V., & Andronikof-Sanglade, 1999).

The above examples illustrate relevant assessment-specific issues. In addition, relevant methodological issues are also germane for application with each standard instrument. For the Rorschach Comprehensive System (CS) (Allen & Dana, in press), explicit recommendations include linguistic equivalence, setting/instructional set equivalence, interrater coding reliability, normative data including acculturation status norms, predictor bias, screen for construct equivalence, and construct validation research. Clearly, a substantive body of knowledge developed from culturally-relevant research strategies is necessary for development of consensual multicultural training and practice standards. Subsequently, this knowledge can compromise research ingredients for a viable global assessment science.

New Tests/Methods

Surveys document assessment training and practice with a limited number of tests/methods for description of personality and psychopathology. This paper focuses on the consistent selection of Rorschach CS, the TAT, and the MMPI/MMPI-2 as standard and multicultural exemplars. These tests/methods share a common antiquity with psychometric difficulties for standard assessment that provide some general limitations (Dana, 1993) as well as specific instrument deficits for multicultural applications (Dana,

2003d; Allen & Dana, in press; Allen & Dana, unpublished paper). These instrument-specific methodology reviews suggest that standard instruments can be employed with ethnic minority populations in the United States and cross-culturally provisionally pending development of research literature demonstrating equivalency. Moreover, a variety of objective tests with fewer psychometric issues than the MMPI/MMPI-2 also have potential multicultural utilities pending substantive new research demonstrations of equivalency (see Holden, 2000), despite the fact that these instruments were not explicitly designed and constructed for use with multicultural populations and share deficiencies in normative data and other assessment-specific issues described earlier in this paper.

Regardless of the empirical outcomes of new research with standard instruments, there is also compelling need for incorporation of new emic instruments in assessment batteries to provide general culture-specific information as well as cultural/racial identity information for acculturation and racial identity status. Many relevant instruments are already available for African Americans (Jones, 1996) and a review of emic resources is already dated (Dana, 1998b). These new instruments contribute to available culture-specific information sources concerning ethnic minority populations.

Instruments designed to be applicable across several population are also important for ethnic identity (e.g., Phinney, 1992; Stephenson, 2000). Personality/psychopathology assessment can be accomplished using instruments designed conceptually to be universal, or etic, (e.g., Big Five measures), although these instruments omit emic traits and have not been applied in extremely divergent cultures (Triandis & Suh, 2002).

Of more immediate promise are instruments designed conceptually and constructed empirically for applicability to several emic populations such as the Tell-Me-A-Story Test (TEMAS) (Costantino, Malgady, & Rogler, 1988). TEMAS treats culture as a proximal variable, presents an active research presence that can potentially demonstrate assessment relevance to treatment outcomes to a greater extent than projective methods. TEMAS meets Dana's 1993 criteria for culturally-relevant projective methods (i.e., stimuli, scores, norms, context, and theory) in a more substantive manner than other projective methods.

Discussion

This paper acknowledges the legitimacy of multicultural assessment training in addition to standard assessment training by presenting evidence documenting the availability of sufficient knowledge in the form of guidelines to sustain courses and other training modalities. These guidelines for training and practice presented earlier in this paper antedate more recent and comprehensive American Psychological Association guidelines (APA, 2003). This landmark APA document clarifies usage of the terms *culture*, *race*, *ethnicity*, *multiculturalism*, *diversity*, and *culture-centered*, articulates principles endorsing knowledge of racial/ethnic group differences and identity dimensions as well as legitimizing a professional role promoting racial equity and social justice, and presents six overarching guidelines. This APA document focuses psychologists' behavior on the centrality of culture as a context emphasizing general research issues relevant to acquisition of an adequate and sufficient ethnic minority knowledge basis as well the more specific assessment research and practice issues. Multicultural assessment practice standards, however, are ultimately dependent upon

increasing empirical knowledge of ethnic minority populations using available research guidelines and utilizing research guidelines to examine sources of bias and avenues for bias remediation.