of the test improve the success of the decision making process?" by making it either more efficient, less costly, more accurate, more rational, or more relevant. (p. 292)

All of these concerns are consistent with the emphasis on an examiner fulfilling the role of an expert clinician performing psychological assessment rather than a psychometrist acting as a technician.

ETHICAL PRACTICE OF ASSESSMENT

Ethical guidelines reflect values that professional psychology endorses. These include client safety, confidentiality, the reduction of suffering, fairness, and advancing science. These guidelines have largely evolved through careful considerations of how these values are expressed in ideal practice. Unfortunately, many of the ethical codes have been refined due to conflicts and criticisms related to assessment procedures. Criticism has been directed at the use of tests in inappropriate contexts, confidentiality, cultural bias, invasion of privacy, release of test data, and the continued use of tests that are inadequately validated. These criticisms have resulted in restrictions on the use of certain tests, greater clarification within the profession regarding ethical standards, and increased skepticism from the public. To deal with these potential difficulties as well as conduct useful and accurate assessments, clinicians need to be aware of the ethical use of assessment tools. The American Educational Research Association (AERA) and other professional groups have published guidelines for examiners in their Standards for Educational and Psychological Tests (1999) and the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002). A special series in the Journal of Personality Assessment (Russ, 2001) also elaborates on ethical dilemmas found in training, medical, school, and forensic settings. The next section outlines the most important of these guidelines along with additional related issues. It is roughly organized in the chronological sequence psychologists are likely to encounter as they work their way through the beginning and on to the final stages of assessment.

Developing a Professional Relationship

Assessment should be conducted only in the context of a clearly defined professional relationship. This means that the nature, purpose, and conditions of the relationship are discussed and agreed on. Usually the clinician provides relevant information, followed by the client's signed consent. Information conveyed to the client usually relates to the type and length of assessment, alternative procedures, details relating to appointments, the nature and limits of confidentiality, financial requirements, and additional general information that might be relevant to the unique context of an assessment (see Pope, 2007a,b and Zuckerman’s [2003] Paper Office for specific guidelines, formats, and forms for informed consent).

An important area to be aware of is the impact the quality of the relationship can have on both assessment results and the overall working relationship. It is the examiner’s responsibility to recognize the possible influences he or she may exert on the client and to optimize the level of rapport. For example, enhanced rapport with older children (but not younger ones) involving verbal reinforcement and friendly conversation has been shown to increase WISC-R scores by an average of 13 IQ points compared with an administration involving more neutral interactions (Feldman & Sullivan, 1971). This is a difference of nearly 1 full standard deviation. It has also been found that mildly disapproving comments such as "I thought you could do better than that" resulted in significantly lowered
performance when compared with either neutral or approving ones (Witmer, Bornstein, & Dunham, 1971). In a review of 22 studies, Fuchs and Fuchs (1986) concluded that, on the average, IQ scores were 4 points higher when the examiner was familiar with the child being examined than when he or she was unfamiliar with the child. This trend was particularly pronounced for lower socioeconomic status children. Whereas there is little evidence (Lefkowitz & Fraser, 1980; Sattler, 1973a, 1973b; Sattler & Gwynne, 1982) to support the belief that African American students have lower performance when tested by European American examiners, it has been suggested that African American students are more responsive to tangible reinforcers (money, candy) than are European American students, who generally respond better to verbal reinforcement (Schultz & Sherman, 1976). However, in a later study, Terrell, Taylor, and Terrell (1978) demonstrated that the main factor was the cultural relevance of the response. They found a remarkable 17.6-point increase in IQ scores when African American students were encouraged by African American examiners with culturally relevant comments such as “nice job, blood” or “good work, little brother.” Thus, the rapport and feedback, especially if that feedback is culturally relevant, can significantly improve test performance. As a result, the feedback, and level of rapport should, as much as possible, be held constant from one test administration to the next.

A variable extensively investigated by Rosenthal and his colleagues is that a researcher/examiner’s expectations can influence another person’s level of performance (R. Rosenthal, 1966). This has been demonstrated with humans as well as laboratory rats. For example, when an experimenter was told to expect better performances from rats that were randomly selected from the same litter as “maze bright” (compared with “maze dull”), the descriptions of the rats’ performance given by the experimenter conformed to the experimenter’s expectations (R. Rosenthal & Fode, 1963). Despite criticisms that have been leveled at his studies and the finding that the magnitude of the effect was not as large as originally believed (Barber & Silver, 1968; Elashoff & Snow, 1971), Rosenthal maintains that an expectancy effect exists in some situations and suggests that the mechanisms are through minute nonverbal behaviors (H. Cooper & Rosenthal, 1980). He maintains that the typical effects on an individual’s performance are usually small and subtle, and occur in some situations but not in others. The obvious implication for clinicians is that they should continually question themselves regarding their expectations of clients and check to see whether they may in some way be communicating these expectations to their clients in a manner that confounds the results.

An additional factor that may affect the nature of the relationship between the client and the examiner is the client’s relative emotional state. It is particularly important to assess the degree of the client’s motivation and his or her overall level of anxiety. There may be times in which it would be advisable to discontinue testing because situational emotional states may significantly influence the results of the tests. At the very least, examiners should consider the possible effects of emotional factors and incorporate these into their interpretations. For example, it might be necessary to increase the estimate of a client’s optimal intellectual functioning if the client was extremely anxious during administration of an intelligence test.

A final consideration, which can potentially confound both the administration and, more commonly, the scoring of responses, is the degree to which the examiner likes the client and perceives him or her as warm and friendly. Several studies (Sattler, Hillix, & Neher, 1970; Sattler & Winget, 1970) have indicated that the more the examiner likes the client, the more likely he or she will be to score an ambiguous response in a direction favorable to the client. Higher scores can occur even on items in which the responses are not ambiguous (Egeland, 1969; Simon, 1969). Thus, “hard” scoring, as opposed to more lenient scoring, can occur at least in part because of the degree of subjective liking the examiner feels
Ethical Practice of Assessment 45

Again, examiners should continually check themselves to assess whether their relationship with the client is interfering with the objectivity of the test administration and scoring.

Issues Related to Informed Consent

Psychologists should obtain informed consent for assessment procedures. Any consent involves a clear explanation of what procedures will occur, the relevance of the testing, and how the results will be used (see Pope, 2007a; kspope.com/consent/index.php?). This means that examiners should always have a clear conception of the specific reasons for giving a test. It should be stressed that the information is usually considered to be confidential. However, exceptions to confidentiality may occur in situations involving child/elder abuse, danger to self or others, and information that has been requested based on a subpoena. The information should be provided in clear, straightforward language that can be understood by the client. Unfortunately, many formal consent forms are written at a level far above the reading comprehension level of a large proportion of clients.

Informed consent involves communicating not only the rationale for testing but also the kinds of data obtained and the possible uses of the data. This fact does not mean the client should be shown the specific test subscales beforehand but rather that the nature and intent of the test should be described in a general way. For example, if a client is told that a scale measures "sociability," this foreknowledge might alter the test's validity in that the client may answer questions based on popular, but quite possibly erroneous, stereotypes. Introducing the test format and intent in a simple, respectful, and forthright manner significantly reduces the chance that the client will perceive the testing situation as an invasion of privacy.

Sometimes clinicians will have provided clear information and the client has agreed to the procedures, but unforeseen events not covered in the information may occur. This might occur when the examiner discovers aspects of the client that he or she would rather keep secret. Thus assessment may entail an invasion of privacy. The Office of Science and Technology (1967), in a report entitled "Privacy and Behavioral Research," has defined privacy as "the right of the individual to decide for him/herself how much he will share with others his thoughts, feelings, and facts of his personal life" (p. 2). This right is considered to be "essential to insure dignity and freedom of self determination" (p. 2). The invasion of privacy issue usually becomes most controversial with personality tests because items relating to motivational, emotional, and attitudinal traits are sometimes disguised. Thus, persons may unknowingly reveal characteristics about themselves that they would rather keep private. Similarly, many persons consider their IQ scores to be highly personal. Public concern over this issue culminated in an investigation by the Senate Subcommittee on Constitutional Rights and the House Subcommittee on Invasion of Privacy. Neither of these investigations found evidence of deliberate or widespread misuse of psychological tests (Brayfield, 1965).

Dahlstrom (1969) has argued that public concern over the invasion of privacy is based on two basic issues. The first is that tests have been oversold to the public, with a resulting exaggeration of their scope and accuracy. The public is usually not aware of the limitations of test data and may often feel that tests are more capable of discovering hidden information than they actually are. The second misconception is that it is not necessarily wrong to obtain information about persons that they either are unaware of themselves or would rather keep private. The more important issue is how the information is used. Furthermore, the person who controls where or how this information is used is generally the client. The ethical code of the American Psychological Association (2002) specifically
states that information derived by a psychologist from any source can be released only with the permission of the client. Although there may be exceptions regarding the rights of minors, or when clients are a danger to themselves or others, the ability to control the information is usually clearly defined as being held by the client. Thus, the public is often uneducated regarding its rights and typically underestimates the power the public has in determining how the test data will be used.

Whereas concerns about invasion of privacy relate to the discovery and misuse of information that clients would rather keep secret, *inviolacy* involves the actual negative feelings created when clients are confronted with the test or test situation. Inviolacy is particularly relevant when clients are asked to discuss information they would rather not think about. For example, the MMPI contains questions about many ordinarily taboo topics relating to sexual practices, toilet behavior, bodily functions, and personal beliefs about human nature. Such questions may produce anxiety by making the examinees more aware of deviant thoughts or repressed unpleasant memories. Many individuals obtain a certain degree of security and comfort by staying within familiar realms of thought. Even to be asked questions that may indicate the existence of unusual alternatives can serve as an anxiety-provoking challenge to personal rules and norms. This problem is somewhat related to the issue of invasion of privacy and it, too, requires one-to-one sensitivity as well as clear and accurate information about the assessment procedure.

Another issue is that during personnel evaluations, participants might feel pressured to reveal personal information on tests because they aspire to a certain position. Also, applicants may unknowingly reveal information because of subtle, nonobvious test questions, and, perhaps more important, they have no control over the inferences that examiners make about the test data. However, if a position requires careful screening and if serious negative consequences may result from poor selection, it is necessary to evaluate an individual as closely as possible. Thus, the use of testing for personnel in the police, delicate military positions, or important public duty overseas may warrant careful testing.

In a clinical setting, obtaining personal information regarding clients usually does not present problems. The agreement that the information be used to help clients develop new insights and change their behavior is generally clear and straightforward. However, should legal difficulties arise relating to areas such as child abuse, involuntary confinement, or situations in which clients may be a danger to themselves or others, ethical questions often arise. Usually there are general guidelines regarding the manner and extent to which information should be disclosed. These are included in the American Psychological Association’s *Ethical Principles of Psychologists and Code of Conduct* (2002), and test users are encouraged to familiarize themselves with these guidelines. Professional psychologists can also consult with colleagues, their insurance companies, or the APA ethics office (apa.org/ethics).

**Labeling and Restriction of Freedom**

When individuals are given a medical diagnosis for physical ailments, the social stigmata are usually relatively mild. In contrast are the potentially damaging consequences of many psychiatric diagnoses. A major danger is the possibility of creating a self-fulfilling prophecy based on the expected roles associated with a specific label. Many of these expectations are communicated nonverbally and are typically beyond a person’s immediate awareness (H. Cooper & Rosenthal, 1980; R. Rosenthal, 1966). Other self-fulfilling prophecies may be less subtle; for example, a juvenile with minor but poor sexual boundaries might be labeled as a “sex offender,” which would then result in quite restrictive treatment along with quite public distribution of the label.
Just as labels imposed by others can have negative consequences, self-acceptance of labels can likewise be detrimental. Clients may use their labels to excuse or deny responsibility for their behavior. This is congruent with the medical model, which usually assumes that a "sick" person is the victim of an "invading disorder." Thus, in our society, "sick" persons are not considered to be responsible for their disorders. However, the acceptance of this model for behavioral problems may perpetuate behavioral disorders because persons see themselves as helpless, passive victims under the power of mental health "helpers" (Szasz, 1987). This sense of helplessness may serve to lower their ability to deal effectively with new stress. In contrast to this sense of helplessness is the belief that clients require an increased sense of responsibility for their lives and actions to effectively change their behavior.

A final difficulty associated with labeling is that it may unnecessarily impose limitations on either an individual or a system by restricting progress and creativity. For example, an organization may conduct a study to determine the type of person who has been successful at a particular type of job and may then develop future selection criteria based on this study. This can result in the future selection of relatively homogeneous employees, which in turn could prevent the organization from changing and progressing. There may be a narrowing of the "talent pool," in which people with new and different ideas are never given a chance. In other words, what has been labeled as adaptive in the past may not be adaptive in the future. One alternative to this predicament is to look at future trends and develop selection criteria based on these trends. Furthermore, diversity might be incorporated into an organization so that different but compatible types can be selected to work on similar projects. Thus, clinicians should be sensitive to the potential negative impact resulting from labeling by outside sources or by self-labeling, as well as to the possible limiting effects that labeling might have.

**Competent Use of Assessment Instruments**

To correctly administer and interpret psychological tests, an examiner must have proper training, which generally includes adequate graduate course work combined with lengthy supervised experience (Turner et al., 2001). Clinicians should have a knowledge of tests and test limitations, and should be willing to accept responsibility for competent test use. Intensive training is particularly important for individually administered intelligence tests and for the majority of personality tests. Students who are taking or administering tests as part of a class requirement are not adequately trained to administer and interpret tests professionally. Thus, test results obtained by students have questionable validity, and they should clearly inform their subjects that the purpose of their testing is for training purposes only.

In addition to the preceding general guidelines for training, examiners should also acquire a number of specific skills (Moreland, Eyde, Robertson, Primoff, & Most, 1995; Turner et al., 2001). These include the ability to evaluate the technical strengths and limitations of a test, the selection of appropriate tests, knowledge of issues relating to the test's reliability and validity, and interpretation with diverse populations. Examiners need to be aware of the material in the test manual as well as relevant research both on the variable the test is measuring and the status of the test since its publication. This is particularly important with regard to newly developed subgroup norms and possible changes in the meaning of scales resulting from further research. After examiners evaluate the test itself, they must also be able to evaluate whether the purpose and context for which they would like to use it are appropriate. Sometimes an otherwise valid test can be used for purposes it was not intended for, resulting in either invalid or useless inferences based on...
the test data. Examiners must also be continually aware of, and sensitive to, conditions affecting the examinee's performance. These conditions may include expectations on the part of the examiner, minor variations from the standardized instructions, degree of rapport, mood of the examinee, or timing of the test administration in relation to an examinee's life changes. To help develop accurate conclusions, examiners should have a general knowledge of the diversity of human behavior. Different considerations and interpretive strategies may be necessary for various ethnic groups, sex, sexual orientation, or persons from different countries (see Dana 2005; Nguyen, Huang, Arganza, & Liao, 2007). A final consideration is that, if interns or technicians are administering the tests, an adequately trained psychologist should be available as a consultant or supervisor.

Specific data-based guidelines for test user qualifications have been developed by relevant professional organizations (APA, 1988; Turner et al., 2001) and these guidelines have been incorporated by most organizations selling psychological tests. Qualification forms request information regarding the purpose for using tests (counseling, research, personnel selection), area of professional expertise (marriage and family, social work, school), level of training (degrees, licenses), specific courses taken (descriptive statistics, career assessment), and quality control over test use (test security, appropriate tailoring of interpretations). Persons completing the forms certify that they possess appropriate training and competencies and agree to adhere to ethical guidelines and legal regulations regarding test use.

In addition to being appropriately trained to use tests themselves, psychologists should not promote the use of psychological techniques by persons who are not qualified. This does not mean that all psychological tests should be used exclusively by psychologists because many tests are available to other professionals. However, psychologists should be generally aware of which tests require a high level of training (i.e., individually administered IQ tests) and those that are more generally available.

One of the important aspects of competent test use is that the tests should be used only for the purposes they were designed for. Typically, tests being extended beyond what they were designed for have been done in good faith and with good intentions. For example, an examiner might use a TAT or Rorschach as the primary means of inferring an individual's IQ. Similarly, the MMPI-2 or MCMI-III, which was designed to assess the extent of psychopathology in an individual, might be inappropriately used to assess a normal person's level of functioning. Although some conclusions can be drawn from the MMPI-2 relating to certain aspects of a normal person's functioning, or although IQ estimates based on projectives can be made, they should be considered extremely tentative. These tests were not designed for these purposes, and, as a result, such inferences do not represent the strengths of the tests. A somewhat more serious misuse can occur when a test such as the MMPI-2 is used to screen applicants for some types of personnel selection. Results from MMPI-2-type tests are likely to be irrelevant for assessing most job-related skills. Of equal importance is that the information derived from the MMPI-2 is typically of a highly personal nature and, if used in many types of personnel selection, is likely to represent an invasion of privacy.

**Interpretation and Use of Test Results**

Interpreting test results should never be considered a simple, mechanical procedure. Accurate interpretation means not simply using norms and cutoff scores but also taking into consideration unique characteristics of the person combined with relevant aspects of the test itself. Whereas tests themselves can be validated, the integration of information from a test battery is far more difficult to validate. It is not infrequent, for example, to have contradictions among different sources of data. It is up to the clinician to evaluate
these contradictions to develop the most appropriate, accurate, and useful interpretations. If there are significant reservations regarding the test interpretation, these should be communicated, usually in the psychological report itself.

A further issue is that test norms and stimulus materials eventually become outdated. As a result, interpretations based on these tests may become inaccurate. For this reason, clinicians need to stay current on emerging research and new versions of tests. A rule of thumb is that if a clinician has not updated his or her test knowledge in the past 10 years, he or she is probably not practicing competently.

Part of remaining current means that psychologists should select their testing instruments, as well as any scoring and interpretation services, based on evidence related to the validity of the programs or tests. Part of this requires knowledge of the context of the situation (Turner et al., 2001). A well-validated test might have been found to be quite valid in one context or population but not for another. Another issue that might have ethical considerations is conversion to or use of computerized or Internet-assisted technology (McMinn, Buchanan, Ellens, & Ryan, 1999; McMinn, Ellens, & Soref, 1999). Ultimately, any interpretations and recommendations regarding a client are the responsibility of the clinician. Placing a signature on a report means that the clinician is taking responsibility for the contents of the report. Indeed, an important difference between an actuarial formula or automated report and a practitioner is that the practitioner ultimately will be held accountable.

Communicating Test Results

Psychologists should ordinarily give feedback to the client and referral source regarding the results of assessment (Lewak & Hogan, 2003; see Pope, 1992, 2007b, and on http://kspope.com/assess/feedabs1.php for forms and guidelines). This should be done using clear, everyday language. If the psychologist is not the person giving the feedback, this should be agreed on in advance and the psychologist should ensure that the person providing the feedback presents the information in a clear, competent manner. Unless the results are communicated effectively, the purpose of the assessment is not likely to be achieved. This effective feedback involves understanding the needs and vocabulary of the referral source, client, and other persons, such as parents or teachers, who may be affected by the test results. Initially, there should be a clear explanation of the rationale for testing and the nature of the tests being administered. This explanation may include the general type of conclusions that are drawn, the limitations of the test, and common misconceptions surrounding the test or test variable. If a child is being tested in an educational setting, a meeting should be arranged with the school psychologist, parents, teacher, and other relevant persons. Such an approach is crucial for IQ tests, which are more likely to be misinterpreted, than for achievement tests. Feedback of test results should be given in terms that are clear and understandable to the receiver. Descriptions are generally most meaningful when performance levels are clearly indicated along with behavioral references. For example, in giving IQ results to parents, it is only minimally relevant to say that their child has an IQ of 130 with relative strengths in spatial organization, even though this may be appropriate language for a formal psychological evaluation. A more effective description might be that their child is “currently functioning in the top 2% when compared with his or her peers and is particularly good at organizing nonverbal material such as piecing together puzzles, putting together a bicycle, or building a playhouse.”

In providing effective feedback, the clinician should also consider the personal characteristics of the receiver, such as his or her general educational level, relative knowledge regarding psychological testing, and possible emotional response to the information.
(Finn, 2007). The emotional reaction is especially important when a client is learning about his or her personal strengths or shortcomings. Facilities should be available for additional counseling, if needed. If properly given, feedback is not merely informative but can actually serve to reduce symptomatic distress and enhance self-esteem (Armengol, Moes, Penney, & Sapienza, 2001; Finn & Tonsager, 1992; Lewak & Hogan, 2003). Thus, providing feedback can actually be part of the intervention process itself. Because psychological assessment is often requested as an aid in making important life decisions, the potential impact of the information should not be underestimated. Clinicians are usually in positions of power, and with that power comes responsibility in that the information clients receive and the decisions they make based on this information is often with them for many years.

**Maintenance of Test Security and Release of Test Data**

If test materials were widely available, it would be easy for persons to review the tests, learn the answers, and respond according to the impression they would like to make. Thus, the materials would lose their validity. Not only is maintaining test security an ethical obligation, but it is a legal requirement related to trade secrets and agreements made with the test publisher when materials are purchased. Psychologists should make all reasonable efforts to ensure that test materials are secure. Specifically, all tests should be kept locked in a secure place and no untrained persons should be allowed to review them. Any copyrighted material should not be duplicated (see Zuckerman [2003] for forms and guidelines).

The security of assessment results should also be maintained. This usually means that only persons designated by the client (usually the referral source and client) should see the results. In reality, however, this ethical principal may sometimes be difficult to achieve. For example, many medical contexts expect most relevant treatment information (including psychological assessment results) to be kept in clients’ charts. Typically, all members of the treatment team have access to the charts (Claassen & Lovitt, 2001). On one level, this access represents a conflict between psychological and medical guidelines. On another level, it represents a conflict between benefit to the patient (that may be enhanced by the treatment team having access to his or her records) and patient autonomy (patient control over who and where information should go). Security of assessment results can also be compromised when a large number of organizations (insurance company, interacting rehabilitation provider, referral source) all want access to patient records. This issue arises frequently in the managed health care environment. The security of client records also becomes more tenuous when large interconnected databases potentially have access to patient data (McMinn, Buchanan, et al., 1999; McMinn, Ellens, et al., 1999).

In some clinical and legal contexts, the court or the opposing counsel may wish to see actual client data. This data can be released if the client authorizes it or if the material has been subpoenaed. Ideally, however, the examiner should recommend that a qualified person be present to explain the results. This recommendation is consistent with the principle that the examiner protect the client from potential harm. If the examiner feels that releasing the test data may result in “substantial harm” to the client or “misuse or misrepresentation of the data;” (APA, 2002, p. 14), he or she may have the option of refraining from releasing the data. This situation has the potential of resulting in a conflict between legal and ethical requirements.

One important distinction is between “test data” and “test materials.” Test data refers to raw and scaled scores, such as subscale scores and test profiles. In contrast, test materials refers to “manuals, instruments, protocols, and test questions and stimuli” (APA, 2002, p. 14).
Interestingly, test material turns into test data when a psychologist places the client's name on it. Since actual items should not be released, it would thus be important for clinicians to make sure they do not place client-identifying information on what might be copyrighted or restricted material. This is crucial since psychologists can release test data, but they cannot release test materials, such as actual test items. As stated, the release of test materials would constitute a breach of trade secrets, copyright, and the conditions of purchase (Behnke, 2004). One exception to this point is that the material may be released to persons who are properly qualified (Tranel, 1994). Another exception is when a subpoena specifically squashes these terms of purchase, copyright, and trade secrets.

ASSESSING DIVERSE GROUPS

Competence in assessing diverse groups is an essential part of professional practice. This fact is highlighted by increased globalization, extensive immigration, controversies over potential test bias when used with diverse groups, cross-national adaptation of common instruments, and the American Psychological Association's requirement that professional psychologists be trained to work with diverse groups. In the United States, the minority population now comprises a third of the population (100 million people; United States Census Bureau, 2007). Hispanics make up the largest minority (44.3 million), and there are an estimated 40 million African Americans, and approximately 15 million Asian Americans. Additional data indicate that nearly 21 million minorities live in California with the result that 57% of California is comprised of "minorities" (and 75% of Hawaii). Many minority populations in the United States are underrepresented and underserved (Levine, 2007). Thus, developing guidelines for competent assessment is crucial. The guidelines are centered on language skills, cultural competency, assessing cultural/racial identity, appropriate use of instruments, diagnostic issues, and interpretation guidelines (see Dana, 2005).

Language Skills

Evaluating a client's language proficiency is a first step in assessing diverse clients. Based on this evaluation, it may be necessary, or at least advisable, to conduct the assessment in the client's native language. The sufficiently knowledgeable clinician can conduct the assessment him- or herself. Sometimes a translator or referral to another clinician who speaks the language may be required. If the client is reasonably proficient in English, then it may be possible to conduct the assessment in English. However, clinicians should be aware of how this might alter the interaction. For example, a client who is struggling with English may appear to be uncooperative or to have flat affect when in reality this impression is created primarily due to language difficulties. It may also be advisable to use assessment instruments that have been translated into the client's native language.

Cultural Competency

Cultural competency on the part of clinicians begins with self-exploration of personal histories, attitudes, and knowledge. This involves understanding their exposure to various cultures as well as the degree of comfort with these cultures. It is natural to feel more resonant with some cultures as opposed to others. Often attitudes can be subtle and unconscious; for example, clinicians might have a sense of white privilege yet may have difficulty acknowledging these feelings. These attitudes are typically transmitted through nonverbal rather than verbal means.
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