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Abstract:

Despite practice guidelines and ethical standards that provide imperatives for clinicians to utilize multicultural assessment (MCA), little is known about how the average psychologist actually conducts MCA. The current mixed-method study was designed to investigate clinicians' training and use of MCA practice strategies. Participants were 239 (107 male, 131 female, 1 other gender) licensed psychologists residing in the United States and Canada who were recruited from the American Psychological Association practice directory to complete an online survey. Quantitative items on the survey included questions about the number and utility of MCA-related graduate courses and

supervision experiences, and strategies and frameworks used when conducting MCA. Open-ended questions provided expansion about factors that were helpful and not helpful in graduate training experiences. Findings suggested that only 75% of participants had taken a course that included MCA-related content, but almost all of those participants found the material they learned to be helpful. Graduate courses with MCA-related content were perceived as more helpful than graduate supervision, and the most helpful aspects of courses and supervision were related to increasing knowledge and awareness about MCA. Almost 40% of the sample reported using no theory or framework for conducting MCA, and participants differed in their use of MCA strategies. Findings are discussed in relation to the training and continuing education of clinicians and future directions for research.

Keywords:

multicultural, assessment, strategies, survey, training

Acknowledgement:

Over the past several decades a growing body of research has examined the numerous ways culture influences psychological assessment and practice. Many authors have written about multicultural assessment (MCA), providing a rationale for the importance of attending to culture within assessment, providing descriptions of frameworks to be used by clinicians, and describing the potential detrimental consequences of not addressing culture in assessment (Dana, 2005; Hays, 2008; Ridley, Li, & Hill, 1998; Ridley, Tracy, Pruitt-Stephens, Wimsatt, & Beard, 2008; Suzuki & Ponterotto, 2008a). Additionally, ethical and practice guidelines and standards (e.g., American Educational Research Association, American Psychological Association [APA], & National Council on Measurement in Education, 2014; APA, 2003, 2010) have provided suggestions for the practice of assessment with culturally diverse populations. It is clear that making accurate and comprehensive assessments of clients is the foremost goal of working with clients (McKitrick, Edwards, & Sola, 2007), and that attending to culture is related to important clinical outcomes such as client satisfaction and the counseling alliance (Burkard, Knox, Groen, Perez, & Hess, 2006; Wade & Bernstein, 1991; Zhang & Burkard, 2008). While recommendations for how to conduct MCA are numerous, little is known about how, if at all, the average clinician actually conducts MCA. Specifically, questions about the training that psychologists receive and the strategies that they employ remain unknown. The current study was designed to address these gaps in the literature through a mixed-method survey of practicing psychologists.

Training and Education in Multicultural Assessment

It has been suggested that culture is always relevant to understanding an individual, and as such clinicians should be engaged in MCA with every client (Padilla & Borsato, 2008; Ridley et al., 2008). MCA, similar to psychological assessment, can be considered the process of collecting, organizing, and interpreting psychological data about clients (Ridley et al., 1998). While this process may include the use of formal tests and instruments, MCA is considered to be a broader practice that includes gathering both formal and informal data during intake, diagnosis, treatment planning, the development of a working alliance, and all other interactions with the client over the course of psychotherapy (McKitrick et al., 2007; Spengler, 1998). In addition to a broad view of assessment,

authors also have emphasized that *culture* includes more than just race and ethnicity (Ridley et al., 1998). Indeed, clients' identities are usually at the intersection of various identity facets, including gender, age, disability status, immigration history, and others (Hays, 2008).

Training in the area of multicultural counseling and assessment has increased immensely over the past years, driven in part by the adoption of documents such as the "Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists" (APA, 2003), as well as the growth in research and theory about multiculturalism (Grieger, 2008; Suzuki & Ponterotto, 2008b). Accredited programs are expected to include a course on multicultural counseling, and ideally infuse opportunities to learn about and apply multicultural knowledge and skills throughout the curriculum, as well as during supervision. The extent to which content related to multicultural assessment is covered in either coursework or supervision, however, is unknown. In addition, the perceived utility of these courses and supervision experiences for the eventual practicing clinician is unclear.

Multicultural Assessment Frameworks and Strategies

Several models of MCA have been proposed within psychology, some of which are frameworks that can be used to understand the influence of culture, while others serve as models to guide clinicians through the process of MCA. Examples of popular frameworks for integrating culture into conceptualization and diagnosis include Personal Dimensions of Identity (Arredondo & Glauner, 1992), the Cultural Assessment Interview Protocol (Grieger, 2008), the Personal Cultural Perspective Profile (Ramsey, 1995), the Person in Culture Interview (Berg-Cross & Chinen, 1995), Sinacore-Guinn's (1995) diagnostic window, *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition) Cultural Formulation Interview (American Psychiatric Association, 2013), and the ADDRESSING model (Age and Generational Differences, Disability-acquired, Disability-developmental, Religion and Spiritual Orientation, Ethnic and Racial Identity, Sexual orientation, Socioeconomic status, Indigenous heritage, National Origin, Gender; Hays, 2008). In each of these frameworks, suggestions for aspects of cultural background to attend to are provided, such as experiences of discrimination, acculturation level, disability status, and family influences, among others. Additionally, several authors provide suggestions for practice strategies, including the use of interpreters, working with members of clients' communities, and utilizing debiasing strategies.

Two prominent models exist that provide an actual process/procedure for conducting MCA. The Multicultural Assessment Procedure (Ridley et al., 1998), is considered a scientist-practitioner model of assessment that includes four phases (gathering data through multiple methods, organizing data as either idiosyncratic or culture-specific, hypothesis testing, and arriving at a sound assessment decision), as well as debiasing strategies that are implemented throughout the process. The Multicultural Assessment Intervention Process (MAIP; Dana, 1998) provides procedures in the form of a flowchart for clinicians to conduct intervention and assessment by asking relevant questions about cultural orientation, type of instrument (e.g., etic or emic), formulation and intervention (e.g., universal, culture specific, etc.). The MAIP has been refined and applied to specific populations, as well as individual and community levels of care (Gamst, Dana, Meyers, Der-Karabetian, & Guarino, 2009).

While studies have explored clinicians' diagnostic formulations of minority client case studies (e.g., Lee & Tracey, 2008; Lopez & Hernandez, 1986; Ramirez, Wassef, Paniagua, & Linskey, 1996), as well as the

trends and practice challenges for neuropsychologists who conduct ethnic/racial assessment (Elbulok-Charcape, Rabin, Spadaccini, & Barr, 2014), no surveys exist that have reported broadly on the training and strategies used by the average clinician to conduct MCA. The current mixed method study was designed to fill notable gaps in the literature about how clinicians conduct MCA. Specifically, information was sought about (a) graduate training experiences (e.g., graduate courses and supervision), which included MCA-related content, and (b) frameworks and strategies used to conduct MCA. Using a mixed-method approach allowed for *expansion* of data (Greene, Caracelli, & Graham, 1989), such that the qualitative responses about the helpful aspects of training added breadth to the quantitative data. The study was conceptualized as a dominantly quantitative, concurrent design, which is indicated by the following procedural notation (Morse, 1991): QUANT + qual. That is, both quantitative and qualitative data were collected at the same time, and the primary methodology was quantitative, with a lesser emphasis on the qualitative portion (Tashakkori & Teddlie, 1998).

Method

Participants

Participants included 239 (107 male, 131 female, 1 other gender) adult, licensed psychologists residing in the United States and Canada. The average age of participants was 50 (SD = 13.0). In terms of racial/ethnic background, there were 78% White participants, 8% Latino, 4% Asian, 2% African American, 2% mixed race, and 6% were other or did not report their background. The majority (N = 229, or 96%) of the participants had earned a doctorate, and the majority (N = 153, or 64%) had studied clinical psychology. The remaining participants had studied counseling psychology (N = 44, or 18%), counseling (N = 6, or 3%), counselor education (N = 6, or 3%), or another field (N = 26, or 11%), which included programs such as health psychology and neuropsychology. Almost half the participants (N = 119, or 48%) had over 16 years of clinical experience. The most common setting for the participants' current practice was independent practice (N = 100, or 41%), and the most common clientele was adults (N = 124, or 50%). Additional demographic information can be seen in Table 1.

Table 1. Participants' Experience, Work Settings, and Multicultural Assessment (MCA) Theories/Frameworks

Characteristic	*N*	%
Years of experience		
16+	119	48.0
12–15	26	11.0
8–11	34	14.0
4–7	39	16.0
0–3	22	9.0
Type of work		
Private practice	100	41.0
Hospital	28	11.0
Community counseling center	19	8.0
K–12 schools	11	5.0
College counseling center	10	4.0
Residential treatment center	4	2.0
Other[a]	60	24.0
Primary clientele		
Adults	124	50.0

Youth	47	19.0
College students	20	8.0
Families	15	6.0
Older adults	9	4.0
Couples	2	1.0
Other[b]	17	7.0
MCA theories/frameworks used[c]		
No theory/framework	115	38.1
DSM-IV-TR	51	16.9
Other	34	11.3
ADDRESSING model (Hays, 2008)	26	8.6
Person-in-culture (Berg-Cross & Chinen, 1995)	17	5.6
Personal Dimensions of Identity (Arredondo & Glaunen, 1992)	17	5.6
MAP (Ridley et al., 1998)	14	4.6
MAIP (Dana, 1998)	14	4.6
Cultural Assessment Interview (Grieger, 2008)	8	2.6
Personal Cultural Perspective (Ramsey, 1995)	6	2.0

Note. K = kindergarten; *DSM*-IV-TR = *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, text revision); ADDRESSING = Age and Generational Differences, Disability-acquired, Disability- developmental, Religion and Spiritual Orientation, Ethnic and Racial Identity, Sexual orientation, Socioeconomic status, Indigenous heritage, National Origin, Gender; MAP = Multicultural Assessment Procedure; MAIP = Multicultural Assessment Intervention Process. [a]Included academia, business, correctional work, community rehabilitation, faith based counseling, federal government. [b]Comprised all ages. [c]more than one.

Materials and Procedure

The primary research team developed the survey collaboratively after reviewing literature about MCA. Several drafts of the survey were developed including a pilot version that was administered to three licensed psychologists who provided feedback about the items, clarity of presentation, overall purpose, length, and other aspects. After incorporating the pilot reviewers' feedback the final version was posted utilizing Opinio software (ObjectPlanet, 2010). Invitations were sent via e-mail to approximately 1,200 licensed psychologists identified from the APA directory with a brief letter describing the study, informed consent details, and a link to the survey. The survey was posted for 6 weeks and was closed once the desired sample size was achieved. While 597 members completed portions of the survey, only 239 surveys had most sections complete and were therefore usable (20% completion rate). Participants were offered the opportunity to provide their contact information to be entered into a drawing for one of three gift certificates after finishing the survey. All procedures for the study were approved by the institutional review board.

The online survey included quantitative and qualitative questions about MCA. Quantitative items included questions about the number of MCA courses taken in graduate school, how helpful graduate course and supervision experiences were in learning about MCA, and MCA frameworks and strategies. The list of strategies was compiled from several different articles and chapters regarding MCA (e.g., Dana, 1998; Ridley et al., 1998; Suzuki & Ponterotto, 2008a). Qualitative questions included helpful and unhelpful aspects of graduate training experiences.

Results

Survey data was downloaded to SPSS (Version 21) for analysis, and descriptive data was calculated for the quantitative questions. For questions with missing data, percentages were calculated based on the sample size of those who responded to the question. The open-ended questions were analyzed utilizing strategies from grounded theory (Strauss & Corbin, 1998). A team of three individuals worked individually to categorize each meaning unit for the responses for every question and then came together to discuss the categorizations until consensus was reached. Categories were given titles and, where possible, grouped together into themes. Following guidelines from other qualitative studies (e.g., Gomez et al., 2001), words such as *generally*, *typically*, *most* and *the majority* were used to indicate the characteristic response of 70% or more of respondents. Words such as *some*, *several* and *a number* indicated responses from 30–65%, and *a few* indicated responses from 25% of respondents or less.

Graduate Training Contexts

Graduate courses

The majority of participants reported having three or fewer graduate courses that addressed MCA topics, with about one quarter having had two to three classes (*N* = 63, or 26.3%), followed by another quarter who reported having zero courses with MCA content (*N* = 62, or 25.9%), and those who reported having one course (*N* = 57, or 23.8%). The remaining participants reported having four or more graduate courses with MCA content (*N* = 57; 23.8%). Of the participants who had taken at least one course that included MCA content, most indicated that the courses "helped a little" (*N* = 86, or 48.6%), followed by those who felt the coursework "helped a lot" (*N* = 86, or 48.6%). The remainder of participants who took these courses reported them to have had "no effect on learning/neither helped or detracted" (*N* = 4, or 2.2%), or felt the MCA related coursework "detracted from learning" (*N* = 1, or 0.6%).

When identifying helpful aspects of their graduate courses with MCA-related content, most themes focused on how courses increased their sensitivity to the role of culture and privilege, increased their knowledge about aspects of MCA and counseling, and helped them explore their worldview, especially cultural identity and biases. As one participant noted, "it [graduate course] helped to broaden my understanding and perspective about cultures, orientations and variables that contribute to the problems." In addition, a few participants found it helpful that their instructors were knowledgeable of and experienced with diverse cultures.

With regards to aspects of graduate courses that were not helpful, participants' primary theme was that course content lacked complexity, detail or was dated. As an example, a participant indicated, "not much detail, aside from 'it's important to consider culture.'" Four additional themes also emerged that were endorsed by fewer participants: MCA was barely mentioned, the instructor teaching style was ineffective, the professors lacked knowledge or experience, or classes lacked clinical application.

Supervision experiences

When asked about how helpful graduate supervision was in learning about MCA, over one third of participants (*N* = 85, or 36.8%) found that graduate supervision "helped a little," with another third finding it "helped a lot" (*N* = 75, or 32.5%), followed by those who felt graduate supervision had "no

effect on learning/neither helped nor detracted" (*N* = 63, or 27.3%). Less than 4% of the sample found graduate supervision as unhelpful to learning about MCA, with 2.2% (*N* = 5) reporting supervision "detracted a little" from learning about conducting MCA and 1.3% (*N* = 3) reporting supervision "detracted a lot" from learning about MCA.

Several participants indicated that working with graduate supervisors experienced and knowledgeable of cultural and assessment was important, specifically when supervisors actively addressed culture and challenged participants' assumptions regarding clients' cultural backgrounds. As an example, a participant stated, "supervisors did not shy away from discussions around culture in supervision." Additionally, many participants felt that supervision helped them increase their awareness and knowledge of working with culturally diverse clients. A few participants felt it was important that they learned caution in the interpretation of test data. Finally, a few participants noted the importance of working with supervisors from different cultural backgrounds.

Participants also identified several areas of graduate supervision that were not helpful to learning about MCA. A theme endorsed by several participants was that supervisors ignored or had a limited focus on MCA practices, with many supervisors suggesting that culture was irrelevant to client care. As one participant stated, "I learned a very traditional way of assessment. Culture was a 'noise' variable." In a few cases, participants indicated that supervisors lacked cultural knowledge or experience. A few participants also acknowledged that some supervisors showed bias during supervision. A final theme that some participants endorsed was that client populations at practicum sites were culturally homogeneous.

Frameworks and Strategies

In response to a quantitative question about the theory or framework used to conduct MCA (see Table 1), the majority of participants reported using *no theory or framework* (*N* = 115, or 38.1%), followed by the next largest group of participants who reported using the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, text revision; *N* = 51, or 16.9%), with the third largest group of participants who report using "other" (*N* = 34, or 11.3%). Within this "other" category, most responses were related to using the clinician's own experiences or success with clients, and treating each client as an individual.

Participants were asked to use a 4-point Likert scale ranging from not at all to all the time, to describe the frequency with which they used certain MCA strategies in their work with clients. As can be seen in Table 2, the strategy that most clinicians endorsed as using all the time was asking about clients' backgrounds, followed by examining clients' cultural belief systems. The strategies that clinicians most commonly indicated that they did not use at all were culture specific tests, interpreters, and professionals from the clients' communities.

Table 2. Strategies Used When Conducting Multicultural Assessment

	Not at all	A little	Quite a bit	All the time
Item	*N* (%)	*N* (%)	*N* (%)	*N* (%)
Examine literature on the client's cultural background	23 (9.3)	120 (48.8)	71 (28.9)	19 (7.7)
Use emic criteria[a]	27 (11.0)	72 (29.3)	99 (40.2)	36 (14.6)
Ask about client's cultural background	2 (.8)	21 (8.5)	79 (32.1)	134 (54.5)
Explore cultural explanations for presenting concerns with client	4 (1.6)	42 (17.1)	109 (44.3)	81 (32.9)
Examine client's cultural belief system	6 (2.4)	38 (15.4)	95 (38.6)	95 (38.6)
Examine culturally related defenses	29 (11.8)	72 (29.3)	82 (33.3)	49 (19.9)
Consider psychocultural factors[b]	12 (4.9)	52 (21.1)	92 (37.4)	77 (31.3)
Seek consultation/supervision about cultural topics	19 (7.7)	124 (50.4)	74 (30.1)	18 (7.3)
Examine knowledge of culture bound syndromes	50 (20.3)	111 (45.1)	60 (24.4)	15 (6.1)
Integrate cultural information into standardized tests/measures	60 (24.4)	72 (29.3)	61 (24.8)	41 (16.7)
Utilize nonstandardized methods[c]	83 (33.7)	67 (27.2)	56 (22.8)	28 (11.4)
Use culture specific tests/measures[d]	155 (63.0)	53 (21.5)	13 (5.3)	9 (3.9)
Explain purpose/goals of multicultural assessment to client(s)	90 (38.6)	58 (23.6)	51 (20.7)	34 (13.8)
Conduct culturally sensitive behavioral analysis	81 (32.9)	67 (27.2)	57 (23.2)	27 (11.0)
Use interpreters/translators	97 (39.4)	89 (36.2)	38 (15.4)	12 (4.9)
Interview family or other significant people	27 (11.0)	75 (30.5)	82 (33.3)	49 (19.9)
Work with professionals from clients' communities[e]	93 (37.8)	92 (37.4)	35 (14.2)	13 (5.3)
Integrate theories/models of multicultural assessment	54 (22.0)	94 (38.2)	63 (25.6)	20 (8.1)
Assess ethnic identity level	37 (15.0)	74 (30.1)	84 (34.1)	38 (15.4)
Assess acculturation level	29 (11.8)	62 (25.2)	99 (40.2)	43 (17.5)
Assess the influence of culture on the working alliance	24 (9.8)	56 (22.8)	102 (41.5)	52 (21.1)
Assess oppression and discrimination	24 (9.8)	78 (31.7)	83 (33.7)	49 (19.9)
Address cultural differences between client and counselor	15 (6.1)	64 (26.0)	90 (36.6)	65 (26.4)

Note. Percentage values do not total 100% because some respondents did not answer every item.

[a] That is, culture-specific/knowledge about client's background. [b] For example, racial identity development. [c] For example, postassessment narratives, idiographic assessment, ethnographies, etc. [d] For example, TEMAS (Tell-Me-A-Story-Test). [e] For example, priest, curandera, shaman.

Post Hoc Explorations of Training and Practice

While the purpose of this study was to provide a broad description about how clinicians utilize MCA, a few specific questions were explored regarding participants who reported no graduate courses with MCA-related content and participants who used no theory/framework (the largest group of respondents). First, we explored differences in the percentage of participants who reported having zero graduate courses as a function of field (e.g., clinical or counseling psychology) and number of years of experience (0–3 or 16+). We picked clinical and counseling psychology because they were the largest groups represented in the sample, and we focused on the extremes of years of experience to see if there were differences. Results indicated that 26.1% of clinical psychology students and 27.3% of counseling psychology students had never had a graduate course with MCA-related content. Results also indicated that 9.1% of participants with 0–3 years of experience had never taken a course, while 42% of participants with 16+ years of experience had never taken a course.

Next, we explored differences in the percentage of participants who reported no theory/framework as a function of field and years of experience. We found that 46.4% of clinical psychologists and 47.7% of counseling psychologists reported no theory/framework. Results also indicated that 36.4% of participants with 0–3 years of experience had no theory/framework, as compared to 56.3% of participants with 16+ years of experience.

Finally, we calculated the frequency of number of graduate courses for those participants with no theory/framework (*N* = 115). The highest percentage was the group with zero graduate courses (32.2%), followed by those who had taken one course (27.8%), those who had taken two to three courses (17.4%), those who had taken four to five courses (12.2%), and those who had taken six or more courses (10.4%).

Discussion

This study sought to provide an overview of practicing psychologists' training and use of MCA strategies. In the sections below we summarize the major findings regarding training and practice strategies, noting areas for future research. We conclude with implications and limitations.

MCA Graduate Training Experiences

Findings revealed that 25% of participants had never taken a course with MCA-related content. Post hoc explorations further revealed that while the percentages of participants who had never had a graduate courses were similar for clinical and counseling psychologists, there were differences based on years of experience, such that those with more years of experience (i.e., years since graduation) were more likely to have never had a course. These findings are likely a result of MC counseling courses not being required by accreditation during some of these participants' early training experiences, as well as a lack of attention given to MCA concepts more generally in the past (Suzuki & Ponterotto, 2008b). Alternatively, it is also possible that while participants received training in multicultural counseling more broadly, their graduate courses did not focus on MCA content specifically. Regardless of the reason it is important to consider that a sizable number of practicing clinicians had not received any graduate training in this area, particularly those who have been in the field for a longer amount of time, suggesting important areas for continuing education intervention with respect to specific models and training.

Of the remaining 177 (75%) participants who had taken courses that included MCA-related content, about 97% indicated that these courses either helped *a little* or *a lot* in learning about MCA. These are positive findings, and the qualitative data provided expansion about the factors that helped. Participants reported that graduate courses increased their sensitivity to the role of culture, helped them explore their worldview, and were taught by instructors who were knowledgeable about diverse cultures. In contrast, participants noted that the most unhelpful aspect of their courses were that they lacked complexity or were outdated. Taken together, these findings suggest that participants generally evaluated their graduate courses and instructors as helpful in promoting some of the same competencies that have been described in guidelines (e.g., APA, 2003) related to cultural awareness and knowledge of self and others.

Within the area of graduate supervision, participants evaluated their experiences less favorably. Only about 69% of participants reported that supervision helped *a little* or *a lot*, and about 27% noted that supervision had *no effect* on their learning. Qualitative findings paralleled those of graduate courses, with participants indicating that supervisors who were knowledgeable about culture and assessment were helpful, and that supervision helped participants increase their awareness and knowledge in the area. Participants also noted that supervisors who challenged participants' assumptions were helpful, suggesting that supervisors are in a unique position to help supervisees become aware of and challenge their biases which may influence MCA. Given the prominent role of supervision in professional psychology (Bernard & Goodyear, 2013), as well as research that suggests that avoiding discussions about racial issues detrimentally affects supervisees (Burkard, Johnson, et al., 2006), it is important for supervisees and supervisors to engage in some of the same conversations about MCA that might take place in graduate courses. Supervision might allow for even more depth to these discussions, with opportunities for further self-understanding for the trainee/supervisee in the context of working with clients.

MCA Frameworks and Strategies

Surprisingly, almost 40% (115) of participants reported using no MCA theory or framework. Post hoc explorations revealed that there were similar percentages of clinical and counseling psychology participants who reported using no theory/framework, but there was a larger percentage of people with 16+ years of experience with no theory/framework as compared to those with 0–3 years. Similar to the findings about those who have never taken a graduate course with MCA-related content, it appears that the years of experience (i.e., years since graduation) is more likely a reason for the lack of theory/framework rather than the field of study. Again, this finding suggests that more recent students may be receiving some of this training, perhaps as a result of required courses (likely due to accreditation) or more attention to MCA in the field of psychology. It was also of note that very few participants utilized either the Multicultural Assessment Procedure (Ridley et al., 1998) or MAIP (Dana, 1998), both of which are considered well-developed models for how to conduct MCA. Questions remain about the actual content that is included in graduate courses, and within which courses (e.g., multicultural counseling, assessment) this content is covered. Future studies could explore the content of syllabi throughout the curriculum, as well as program assessment plans, to gain a better understanding of topics being taught to trainees.

It is important to note that the largest percentage of participants who reported using no theory/framework was those who had never had a graduate course with MCA-related content, and the percentages for each group (e.g., one course, two to three courses) decreased, such that those who had taken the most courses were the smallest percentage of the group who had never had a class. These findings are positive, suggesting that those who have had more MCA-related coursework are more likely to have a MCA theory/framework. Clearly, more research is needed to explore this, however, and to ascertain how information about these frameworks is taught and later implemented into practice.

The responses regarding the various MCA strategies used by clinicians suggests that practitioners are not fully attending to the strategies indicated as important by researchers (e.g., Dana, 1998; Ridley et al., 1998; Suzuki & Ponterotto, 2008a). For example, only about half of clinicians *always* employ procedures such as asking about clients' cultural backgrounds, examining clients' cultural belief systems and exploring cultural explanations for presenting concerns with clients, and less than half engage in basic practices such as considering psychocultural factors such as racial identity development. Also of note is that many clinicians are not using certain strategies from the list at all. While some clinicians might not use culture-specific tests/measures because of their practice context, it is unsettling that many other basic strategies such as examining literature on clients' cultural backgrounds or considering psychocultural factors are not used or only used a little. Taken together, it appears that clinicians are generally not utilizing the basic MCA strategies suggested in the literature to fully understand clients' experience and context (APA, 2003; Padilla & Borsato, 2008; Ridley et al., 2008). It may be that they were not exposed to these strategies and frameworks in their training, that they have not sought additional training in this area, or that they have chosen to not utilize them in their practice. Qualitative questions regarding the reasons for not employing specific strategies and frameworks would be helpful to include in future studies.

Limitations and Implications

The current findings should be considered in light of certain study limitations. While a relatively large number of psychologists (*N* = 597) started the survey, only 239 surveys were usable. It is likely that our survey was too long, particularly with the open-ended options. Given the prevalence of Internet surveys and the busy nature of practice in the field of psychology, it is likely that some respondents started the survey yet became fatigued by the length and discontinued early. A higher response rate would have been ideal, and future studies should attempt to recruit a larger sample and consider editing the survey for brevity. Similarly, this survey is likely to have been affected by selection bias, such that participants who responded were more open to MCA and perhaps more likely to engage in MCA. Though variability still existed within the strategies utilized, it is possible that the responses may have differed had the participants been randomly sampled or had more completed the survey.

The findings from this survey suggest that the training (both graduate and postgraduate) related to MCA concepts within the professional psychology curriculum could be improved, particularly in the area of frameworks and strategies. Given that there are several MCA theories and frameworks in the field and authors have argued that having a comprehensive approach to conducting MCA can avoid diagnostic and conceptualization errors (Ridley et al., 1998; Ridley et al., 2008). Including more than one multicultural course would be one solution, as researchers have found that trainees who had

completed two multicultural courses demonstrated greater multicultural case conceptualization skills with fictitious cases (Lee & Tracey, 2008). Alternatively (or additionally), MCA concepts could be more purposefully integrated into several courses (e.g., counseling skills, assessment, multicultural counseling), including practicum experiences and supervision. While specific assessment issues related to translation of instruments and bias are included in standards (American Educational Research Association, APA, & National Council on Measurement in Education, 2014), specific MCA frameworks as well as more broad MCA strategies such as those proposed by Ridley et al. (1998) and others should also be included. Integrating these "best practices" in both training and supervision may require the development of a standard set of competencies for the average clinician.

The current results suggest that supervision regarding MCA topics can also be improved. It is likely that supervisors with exposure and knowledge about this area will be better equipped to serve as supervisors and will more frequently integrate this knowledge into their work; therefore, improving education about MCA topics will benefit practitioners and supervisors alike. Academic programs might consider requiring evidence of supervisor MCA training before placing students at certain practicum sites, and programs might take responsibility for providing such training to supervisors as part of a larger module or workshop about supervision. Supervision agreements can delineate MCA skills that need to be discussed at some point during the semester or year, and supervision evaluations (of both student and supervisor) can include sections about MCA.

Respondents in the current survey also indicated that they found it helpful when supervisors challenged them about their biases and assumptions. These results, along with research suggesting that avoiding discussions of multiculturalism can have detrimental effects on supervisees (Burkard, Johnson, et al., 2006), suggest that supervision must go beyond acknowledgment of culture and must also involve supervisors' deliberate (and sometimes difficult) efforts to challenge supervisees about their worldviews and how those can influence their clients.

Given that many practicing psychologists have not received extensive MCA training and are not utilizing many MCA strategies, it seems warranted to suggest that clinicians seek opportunities to engage in continuing education about MCA, and for researchers and practitioners with expertise in this area to consider developing CE workshops and trainings. Helping clinicians to see both the importance (e.g., Ridley et al., 2008) and applicability of MCA to their work can be a first step, and state licensing boards could consider requiring continuing education in this specific area as well. Clearly recruiting MCA experts to engage in CE workshops and trainings is critical, and conference (e.g., APA and state association) program chairs might consider plenary sessions and workshops about these topics. As mentioned above regarding training, CE opportunities should include theory/frameworks as well as strategies. This might be even more important to highlight within CE contexts as it appears that more recent graduates are more likely to be getting this information.

MCA is relevant for every client throughout the therapeutic process (McKitrick et al., 2007; Ridley et al., 2008). As such, it is important to understand the type of training clinicians receive and how that may relate to eventual MCA practice and outcomes. Future research can extend the field by exploring how expert MCA practitioners, or exemplars (e.g., Bronk, 2012) conduct MCA, or by studying client and supervisee outcomes as a result of MCA use. The current findings serve as a first step toward these

longer term investigations. Readers with interest in MCA resources are directed toward Dana (2005), Hays (2008), McKitrick et al. (2007), Ridley et al. (1998), and Suzuki and Ponterotto (2008a).

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