Cross-cultural neuropsychology: Training and practice considerations

Society for Clinical Neuropsychology’s Ethnic Minority Affairs (SCN-EMA)
Association of Neuropsychology Students in Training (SCN-ANST)

A webinar hosted by

Preeti Sunderaraman, M.S., EMA Student Rep.
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Drexel University

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Clinical Psychology Ph.D. Student
University of Wisconsin-Milwaukee
1. Introduction to SCN-EMA & ASNT Webinar series
2. Multicultural neuropsychology clinical training
3. Multicultural neuropsychology practice considerations
4. Questions and answers
5. Webinar’s materials and brief survey
April Thames, Ph.D.

- Assistant Professor at UCLA’s Semel Institute for Neuroscience & Human Behavior
- Research: 1) factors impacting test performance in minorities; 2) the impact of infectious disease, substance abuse & aging on cognitive functioning; 3) genetic predictors of cognitive outcomes
- Clinical: neurodegenerative disease, neuromedical illness & comorbid psychiatric disorders
- Chair for the SCN-EMA Committee
Tedd Judd, PhD., ABPP/CN

- Clinical/forensic neuropsychologist & cultural generalist in private practice
- Adjunct faculty at University of Washington, Antioch University & Seattle Pacific University
- Research: competence-to-stand-trial assessments of immigrants
- National Academy of Neuropsychology Fellow & Past president of the Hispanic Neuropsychological Society
From Afghanistan to Zimbabwe: Teaching and Learning Multicultural Neuropsychology

Tedd Judd, PhD, ABPP-CN
Certified Hispanic Mental Health Specialist

A Webinar Sponsored by:
Society for Clinical Neuropsychology (APA Div. 40)
Ethnic Minority Affairs Committee and Association of Neuropsychology Students in Training
February 25, 2015
Outline

- **Justification**
- Judd’s Cross-Cultural Practicum
- NP Cultural Competence
- Practicalities of a training program
Justification for Multicultural Neuropsychological Training

The Stick

The Carrot

and . . .
Justification
For Multicultural NP Training

THE STICK

- demographics
- ethics
- health disparities
- fairness
- Legal mandates
Why are non-native English speakers not seen in our practices in proportion to their representation in the population?

(The following are my impressions and opinions, but they are all empirical statements and testable. I just haven’t gone digging for the data yet.)
Justification: Non-native English speakers are more likely to:

- Have neuropsychological disorders
- Seek out alternative approaches (family, religious, traditional healers, alternative healers)  
  (Thanks to Preeti Sunderaraman for adding this one)
Justification: Non-native English speakers are less likely to:

1. Be aware of neuropsychological problems
2. Have access to professionals who would refer them to our services
3. Seek out professionals for such problems
4. Complain to professionals of neuropsychological problems when they have them
5. Understand that such problems may be treatable
6. Ask and push for evaluation and treatment of those problems
7. Know about our services
8. Get referred
9. Be referred in a timely manner
10. Have an administratively smooth referral and funding process
11. Follow through on the referral
12. Get accepted for services
13. Have payment for our services
14. Have transportation and childcare for the appointment
15. Feel comfortable with the process
16. Feel satisfied with the result
17. Follow through on recommendations
Justification
For Multicultural NP Training

THE CARROT

It makes us better NPs!

- You get to do a lot of differential diagnosis work.
- You get to see a lot of disorders that are rare in North America: malnutrition, pesticide poisoning, cysticercosis, cerebral malaria.
- You get a broader understanding of the variations and invariance in the manifestations of brain disorders.
- You get to learn about illiteracy and the cognition of literacy in different writing systems.
- You get a much deeper understanding of the principles of testing and measurement.
- Improves our research
Justification
For Multicultural NP Training

THE ICE CREAM
It’s really rewarding!

For those with a 2\textsuperscript{nd} language and/or minority cultural/ethnic identity it is an opportunity to use one’s knowledge and skills professionally and serve one’s community.

Personally, I find this work very rewarding because:

- There is great satisfaction in meeting the academic, clinical, and emotional challenges
- The clients are often exceptionally grateful to feel both culturally and clinically understood.
- The professional camaraderie is exceptional.
- An excuse to learn about other cultures (travel, movies, novels, festivals, restaurants, music, friendships; [generally not billable or tax deductible])
Definitions:

- **Translators** translate written language.
- **Interpreters** interpret spoken language.
- They are separate professions and skills (although some people do both).
- “*Translating is like chess; interpreting is like volleyball*”.
- When we confuse them, we sound naïve to them, like someone who confuses “psychologist” with “psychiatrist.”
- **Sight translation** is the process of reading a document (or test) aloud in a language other than the language it is written in.
Judd’s Cross-Cultural (Neuro) Psychology Practicum

(with a few how-tos included)
Judd’s Cross-Cultural Practicum

General Description

Solo practitioner, community-based, part-time clinical psychology practicum in administrative and forensic assessment of non-English speaking clients
Students: 3rd year and later doctoral students in clinical psychology from 8 universities

Most are themselves ethnic minorities and/or immigrants

Many have a second language and/or international experience

Career dedication to ethnic diversity
Judd’s Cross-Cultural Practicum
Needs, Populations

**Needs:** Determined by word-of-mouth demand for both clients and students

**Clients:** Both consistent and rare populations and interpreters:

**Consistent:** Mexicans, Central Americans, both Latino and indigenous; Somalis, Ukrainians, Russians, Ethiopians, Eritreans, Punjabis, Iraqis, Vietnamese, Meskhetian Turks.

**Occasional:** Other Latin Americans, Belarusians, Moldovans, Bulgarians, Iranians, Bhutanese, Armenians, Pakistanis, Albanians, other former Soviet Union, Liberians, Congolese, Burundians, Sudanese, Hmong, Native Americans, Afghans, Koreans, Chinese, other Indians, Fijians, Samoans, Marshall Islanders, Cambodians, Thais, Bosnians
Judd’s Cross-Cultural Practicum

Issues

- medical exclusion from the English and U.S. history and civics exam requirement for U.S. citizenship (N648)
- refugee status
- worker compensation
- disability (Voc rehab, DD, SSI, accommodations, etc)
- competence to stand trial, Miranda comprehension
- mitigating and aggravating circumstances to a crime
- sentencing recommendations
- parenting capacity for child welfare
Judd’s Cross-Cultural Practicum
Locations

- Lutheran Refugee Services
- Ukrainian Community Center
- Farmworkers’ Clinic
- Tribal Clinics
- Northwest Immigrant Rights Project (legal services)
- Private attorneys’ offices
- Public defenders’ offices
- Federal Detention Center, immigration detention, and regional jails and juvenile halls
- State Children and Family Services
- Nursing homes
- Private homes
- Restaurants (especially ethnic)
- Dr. Judd’s office
Judd’s Cross-Cultural Practicum

Finances

- Pro bono (non-profits)
- Reduced rate (private pay)
- Medicaid/Medicare
- Health insurance
- State agencies (child welfare, Voc Rehab, Developmental Disabilities, workers’ comp)
- Courts via public defender/state psychiatric hospital
- Personal injury lawsuits
- IME companies
Judd’s Cross-Cultural Practicum

Format

- Apprenticeship model (students observe professor, gradually take over portions of the process when ready).
- Advanced students teach beginners
- Students are cultural/linguistic resources
- Each case discussed among all
- Resources shared in Google Drive folder
- Schedules coordinated via Google Calendar
- Collective development of specialized tools
- Focused interest groups
- International consultation
Judd’s Cross-Cultural Practicum Skills (see handouts)

- Researching client's ethnic, linguistic, migration, acculturation background
- Interpreter use skills: https://www.youtube.com/watch?v=9JLytaKjceU
- Taking an ethnic, linguistic, migration, acculturation history
- Diagnostic history
- Adaptive behavior
- Cross-cultural testing
- Incorporating culture and language in conclusions and recommendations
Cultural Profile: Nepali-speaking Bhutanese (Lhotsampa)

Author(s): Maya Maxym, MD, PhD
Reviewer(s): Pradeepa Upadhyay; Mitra Dhital
Date Authored: March 01, 2010

Contents

- Methods
- Country of Origin, History, & Politics
- Language
- Interpersonal Relationships
- Marriage, Family, Kinship
- Sexuality, Reproduction, and Pregnancy
- Nutrition and Food
- Religious Beliefs and Practices
- Death and Dying

- Traditional Medical Practices
- Concepts of Health and Disease
- Experience with Western Medicine
- Common Health Concerns
- Transition to Life in the USA and Common Acculturation Issues
- Recommendations for Assisting Refugees
- Other Resources
- Photos, map, video

Lacking for Neuropsychology:

- Education system
- Legal system
Judd’s Cross-Cultural Practicum

Tools

- Ethnicity Profiles
- Semi-structured Interview
- Specialized/translated consent forms, etc.
- Report templates
- Test collection (Fuld, animal naming, Scenery Picture Memory Test, sensory-perceptual, San Diego Odor ID, coin rotation, Bilingual Aphasia, BVAT, Woodcock-Johnson, 5-Digit, MoCA, WHO-DAS-II, IQCODE, PHQ9, GAD7, Harvard Trauma Questionnaire, acculturation scales)
Judd’s Cross-Cultural Practicum
Specialized Tool Development

- **Name Memory Test** (for second language learning potential)
- Two-alternative, forced-choice recognition memory for Fuld Object Memory Evaluation
- Home country history and civics questions (for fund of knowledge for learning US history and civics)
- **US citizenship English literacy test**
Judd’s Cross-Cultural Practicum
Focus Groups

**Spanish speakers**—work directly in Spanish, learn Spanish interviewing and tests, supervision in Spanish, connections with HNS and Latin American NPs, case reviews in Spanish, serve as cultural consultants.

**Meskhetian Turks**—deeper background research, organizing colloquium of local providers serving Meskhetian Turks, local Turkish NPs, and Turkish-specialized psychologists.

**South Asian focus group**—students of South Asian backgrounds serve as cultural consultants, research focus interest groups, develop language skills, accumulate and develop tests and semistructured interview, network, develop handouts.
Judd’s Cross-Cultural Practicum

Future

- Train-the-trainers
- “Franchises”
Neuropsychological Cultural Competence
NP Cultural Competence
General learning objectives for all NP students:

Cross-cultural clinical psychology competencies 1:

- Cultural self-awareness and awareness of power dynamics
- Interpreter use skills
- Ethics awareness
- Cultural background research skills
NP Cultural Competence
General learning objectives for all NP students:

Cross-cultural clinical psychology competencies 2:

- Accessing community cultural resources
- Cross-cultural rapport skills
- Culturally-appropriate psychotherapy
- Cultural bridge skills (communicating cultural findings to others)
NP Cultural Competence
General learning objectives for all NP students:

- Cross-cultural cognitive/neuropsychology competencies 1 :
- International epidemiology (e.g., malaria, cysticercosis, malnutrition, pesticides)
- Linguistic/cognitive diversity
- Educational systems
- Illiteracy
NP Cultural Competence
General learning objectives for all NP students:

Cross-cultural cognitive/neuropsychology competencies 2:

- Interview skills for education, immigration, acculturation, medical and mental health history, symptoms, current cultural context, aspirations, motivations

- Culturally-appropriate rehabilitation and other interventions
NP Cultural Competence
General learning objectives for all NP students:

Cross-cultural cognitive/neuropsychology competencies 3: Test skills

- Test translation and adaptation principles (e.g., ITC Guidelines)
- Testing skills for test-naïve clients and clients with diverse test expectations
- Background assumptions of assessment and their variants
Cultural dimensions of the testing situation (Ardila, 2005)

- One-to-one relationship
- Background authority
- Best performance
- Isolated environment
- Special type of communication
- Speed
- Privacy
- Familiarity of test materials
- Standardized instructions vs understanding the test expectations
NP Cultural Competence
Distinctive learning objectives for monolingual, mono-cultural students:

- Interpreter use skills
- Cross-cultural communication
NP Cultural Competence

Distinctive learning objectives for monolingual, bicultural students:

- Interpreter use skills
NP Cultural Competence
Distinctive learning objectives for bilingual, bicultural, L1*-dominant students:

- Clinical and academic proficiency in L2**
- Accessing L2 professional literature
- Option: develop skills as interpreter

*L1 refers to the language in which neuropsychology is being practiced. In the case of mainland US, this is usually English.

**L2 refers to the “other” language of psychologist
NP Cultural Competence
Distinctive learning objectives for bilingual, bicultural, L2-dominant students:

- L1 and L2 academic proficiency
- Accessing L2 professional literature
- Option: US academic acculturation (Thanks, April)
- Option: interpreter/translator skills
NP Cultural Competence
Training Modalities for the monolingual, mono-cultural student

- **Monolingual, not culturally competent supervisor:**
  With culturally competent consultant working with both; using interpreters

- **Monolingual, culturally competent supervisor:**
  With interpreters and sometimes cultural consultants

- **Bilingual, culturally competent supervisor:**
  With interpreters and sometimes cultural consultants
NP Cultural Competence
Training Modalities for the monolingual, bicultural student

- **Monolingual, not culturally competent supervisor:**
  With culturally competent consultant working with both; using interpreters

- **Monolingual, culturally competent supervisor:**
  With interpreters

- **Bilingual, culturally competent supervisor:**
  With interpreters
NP Cultural Competence
Training Modalities for the bilingual, bicultural student

• Monolingual, not culturally competent supervisor:

With culturally competent consultant working with both. Student does clinical work in L2; Supervisor uses interpreter. Option: student becomes interpreter

• Monolingual, culturally competent supervisor:

Student does clinical work in L2; Supervisor uses interpreter. Option: student becomes interpreter

• Bilingual, culturally competent supervisor:

Clinical work in L2; supervision in L2
NP Cultural Competence
Training for the the bilingual NP or student without background in bilingual assessment and culture and diversity needs:

- Training in culture and language principles
- Training in test translation/adaptation principles
- Training in the neuropsychology of the target population (epidemiology, tests, idioms of distress, etc.)
- May need to learn neuropsychology and related vocabulary in L2.
- Training/experience in communicating their language and cultural insights in L1.
- Mentoring
Practicalities of a training program
Practicalities of a training program

- Based in the community
- Services where immigrants congregate: immigration evaluations, special education, criminal, worker’s comp, ethnic specialty clinics
- Network, network, network
- Collaborative learning
Practicalities of a training program

- Using, not abusing, student cultural expertise
- International literature and in-language literature
- International rotations
- Triage
Acknowledgements

Thanks to April Thames, Octavio Santos, Preeti Sunderaraman, and Melissa Castro for organizing this webinar and assisting me with this presentation.

Thanks to my students for the collaborative development of this practicum: Heidi Montoya (now co-supervisor), Dellanira Garcia, Heather Romero, Jesus Luna, Alesya Radosteva, Orlando Sanchez, Andrew Paves, Gurjeet Sidhu, Ari Natinsky, Danee Ta, Diomaris Safi, Jennifer Bloomgarden, Jessa Carlisle, Kim Huynh, Liz Dykhouse, Luís Ramos, Maureen Nickerson, Monique Brown, Rebekah Foreman, Rodrigo Reyes, Sharon Hsu, Rebecca Shacht, Mike Warren, and apologies to any I may have forgotten.

Thanks to my scheduler, Roosmiwati Reynolds, who coordinates students, clients, families, interpreters, locations, paperwork, attorneys, physicians, agencies, and, most difficult, me.

Thanks to the agencies who host us, and especially to the many clients and families who are so kind as to trust us with their life stories.
Consultation

- I am happy to consult by email, phone, and teleconference with webinar participants who have follow-up questions and concerns, especially when it regards developing multicultural training.

- However, in consideration of the large number of people who participated in this webinar, before you contact me, please review the handout materials and slides to be certain that the answers you seek are not to be found in those sources.
Melissa Castro, Psy.D.

- Neuropsychologist at Dean Clinic in Madison, WI
- Clinical: bilingual clinical services (English/Spanish) & cross-cultural neuropsychological assessments
- Research: cognitive rehabilitation for MCI & early dementia
- Advocate for improving culturally competent assessment practices with minorities
How to set up a Neuropsychology Service for Hispanics sin tener un ‘ataque de nervios’

Cross-cultural neuropsychology:
Training and practice considerations
February 25, 2015

Melissa Castro, PsyD
Department of Neurology
Dean Clinic, Madison, WI
Email: melissa.castro@deancare.com
 Feeling unprepared? 
You are not alone

- In a recent survey, less than 10% of neuropsychologists identified as ethnic minorities; 3% of whom were Hispanic (Elbulok-Charcape, et al, 2014)

- 83% of US Neuropsychologists who offered service to Hispanics self-reported inadequate preparation to work with this population (Echemendia, et al, 1997)

- Only 1% believed themselves to be “extremely competent”

- As self-rated competence increases, so do the numbers of Hispanics treated.
My experience

No Good Deed Goes Unpunished
No Good Deed Goes Unpunished
No Good Deed Goes Unpunished
No Good Deed Goes Unpunished
No Good Deed Goes Unpunished
No Good Deed Goes Unpunished
Step 1: Build a support system

- Seek out experienced mentors willing to train / consult with you on a case by case basis, at least initially

- Join professional list serves of the Society for Clinical Neuropsychology (SCN) at lists.apa.org
  - Ethnic Minority Affairs Committee (EMA)
  - Association for Neuropsychology Students in Training (ANST)

- Join the Hispanic Neuropsychological Society (HNS) http://hnps.org

- INS-ILC cross-cultural database: http://www.ilc-ins.org/language.cfm
Step 2 : Make a Plan

- Have a business plan to submit to the decision makers in your institution
- Have a training contract in place with your supervisor /training site
- Establishes realistic expectations and increases understanding on the specialty nature of this service for all parties involved
Monitor how many referrals you or your department get for Spanish speakers over the past year

1997 survey of neuropsychologists reported approximately 15 Hispanic evaluations /year (range 0-480) (Puente et al. 1997)

Interpreter services usually can provide these numbers

Include Hispanics seen without an interpreter, bilingual, highly acculturated folks as they often go under the radar

Anticipate increasing need
- Greater access to medical care with Obamacare.
- Aging population
- Increase in Hispanic population
Determine Potential Need

Figure 5.
Percent Hispanic for the Older Population by Selected Age Groups for the United States: 2010 to 2050

Source: U.S. Census Bureau, 2008.
Scope out your area

Figure 2. Foreign Born From Latin American and the Caribbean by State: 2010
(Data based on sample. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/acs/www)

Distribution of the Latin American and Caribbean Foreign Born by State: 2010
(Percent distribution. Data based on sample. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/acs/www)

Source: U.S. Census Bureau, 2010 American Community Survey.

All other states 28.9
California 25.8
Illinois 4.0
New Jersey 4.0
New York 10.2
Florida 13.0
Texas 14.2

Source: U.S. Census Bureau, 2010 American Community Survey.
## Hispanic Subgroups

### Table 3

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Centers for Disease Control and Prevention (CDC, 2012)
Percent of Population 1980
Hispanic or Latino

Hispanic or Latino population as a percent of total population by county

U.S. percent is 6.4

25.0 to 100
10.0 to 24.9
5.0 to 9.9
2.5 to 4.9
0 to 2.4

Source: U.S. Census Bureau, Decennial Census, 1980
Figure 5.
Hispanic or Latino Population as a Percent of Total Population by County: 2010

(For information on confidentiality protection, nonsampling error, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)

Source: U.S. Census Bureau, 2010 Census Summary File 1.
Figure 6. Percent Change in Hispanic or Latino Population by County: 2000 to 2010

(For information on confidentiality protection, nonsampling error, and definitions, see www.census.gov/prod/cen2010/doc/sf1.pdf)

Sources: U.S. Census Bureau, Census 2000 Summary File 1 and 2010 Census Summary File 1.
Step 3: Gather materials

- Position and Education papers

- National Academy of Neuropsychology
  - Professional Considerations for Improving the Neuropsychological Evaluation of Hispanics: A National Academy of Neuropsychology Education Paper
  - The Use, Education, Training and Supervision of Neuropsychological Test Technicians (Psychometrists) in Clinical Practice
  - Culture & Diversity Committee links

- AACN
  - Challenges in the Neuropsychological Assessment of Ethnic Minorities: Summit Proceedings
  - Multicultural References 2007

- Increasing culturally competent neuropsychological services for ethnic minority populations: A CALL TO ACTION (Rivera-Mindt et al. 2010)

- Interpreter-Mediated Neuropsychological Testing of Monolingual Spanish Speakers (Casa et al., 2012)
Build a reference library


- Handbook of Cross-Cultural Neuropsychology - Critical Issues in Neuropsychology (Fletcher-Janzen, Stricklan, Reynolds, 2012)

- Principles of Neuropsychological Assessment with Hispanics: Theoretical Foundations and Clinical Practice - Issues of Diversity in Clinical Neuropsychology (Edited by Llorente, 2007)


- Guide to Psychological Assessment with Hispanics (Edited by Benuto, 2012)

- Assessing Hispanic Clients Using the MMPI-2 and MMPI-A (Butcher, Cabiya, Lucio, & Garrido, 2007)

- The Bilingual Brain (Hernandez, 2013)
Tests and Norms

- HNS Test Database – 175 tests/inventories
- Make a Norms Binder
- **Handbook of Normative Data for Neuropsychological Assessment** (Mitrushina, Boone, Razani, D’Elia, 2005)
- **A Compendium of Neuropsychological Tests: Administration, Norms, and Commentary** (Strauss, Sherman, & Spreen, 2006)
- **Spanish Multicenter Normative Studies The NEURONORMA Project** (Pena-Casanova et al., 2009-2014) [www.oxfordjournals.org/our_journals/acn/neuronorma_collection.html](http://www.oxfordjournals.org/our_journals/acn/neuronorma_collection.html)
Juan Carlos Arango and Paul Perrin - NAN 2014

Culturally-Sensitive Neuropsychological Evaluation of Spanish-Speaking Adults: What Every Neuropsychologist Should Know

N=5841 equally spread across Latin America (12 countries)

18-90

70 minute battery of 11 tests (Rey, Stroop, WCST, TMT, BTA, Verbal Fluencies, BNT, HVLT, SDMT, TOMM)
Step 4: Setting up the Clinic

- **Staffing**
  - Bilingual Psychometrist  www.napnet.org
  - Bilingual Administrative Staff (scheduling, etc)
  - Language Line

- **Setting**
  - Test Batteries and materials
  - Office Space
First Impressions

- Does your practice contain brochures, websites, or fliers in different languages? images of diverse people?

- Is your waiting area/office a welcoming place for ethnic and/or linguistic minorities (i.e., written signs, symbols, magazines, art, decorations, play materials, greetings, staff)?

- Seating
  - Can you accommodate patient and several family members at a time times including children?
  - What about the Interpreter, WC Case Manager?
Step 5 - Got referrals?

- Advertise at your institution and in the general community at large
- What kind of referrals will you accept? How many can you accept?
- If there are many providers at your institution, discuss with your department beforehand how these referrals will be distributed to ensure patients get equal and best standard of care regardless of provider.

Common referrals
- Legal/Workmen’s Comp (WC)
- Disability
- Medical
- Academic
- Citizenship examination waivers (N-648)
Citizenship & Naturalization
Exemptions & Accommodations

- **English Test (read, write, speak)**
  - 50/20 Exemption: if 50+, permanent resident for 20 years
  - 55/15 Exemption: if 55+, permanent resident for 15 years
  - Still have to take Civics Test

- **Civics Test (knowledge of understanding of US History and government)**
  - 6/10 to pass; pool of 100 questions [www.uscis.gov](http://www.uscis.gov)
  - If language exempt, can take in native language, but must bring qualified interpreter with you

- 1 Retest only. If fail, application denied.
Medical Disability

- Exemption to both English and Civics naturalization requirements if you are unable to comply with these requirements because of a physical or developmental disability or a mental impairment even with reasonable accommodations.

- Must be “medically determinable”
  - Illiteracy and age are not valid reasons.

- Reasonable accommodations include, but are not limited to, sign language interpreters, extended time for testing, and off-site testing.
Step 6 – Translators / Interpreters

- What is your institution’s policy on Certified Medical Interpreters (CMIs)
  - Mental health certification

- If using a bilingual psychometrist are they qualified to interpret? ensure their training in language/culture is adequate and they are familiar with Spanish versions of tests

- Translate necessary informed consent documents / protocol sheets/test materials
Step 7 – Scheduling and interviewing

- Set up schedule for consults, tests, and feedback session
  - Pros and cons of doing components of evaluation on separate days
    - More preparation/scoring time
    - More no shows and scheduling conflicts/issues

- Depending on the volume of patients you see, consider setting up a day just for Spanish speaking assessments each week or month

- Keep in mind that these evaluations take much longer than typical
  - Anticipate longer interviews (60-90 min), testing, scoring, and data interpretation/background research
TIME – why does it take so long?

- More time must be spent establishing trust and rapport
  - Lack of familiarity and understating of medical process
  - Distrust of the medical establishment and psychologists
  - Evaluation of IQ can be considered disrespectful

- *Personalismo*: Many Latinos have a distaste for situations which are impersonal, (Echemendia 1997).

- Cultural Difference in Perspective of Time (*Que sera, sera, cuando sera, y solo si Dios quiere*)

- Cultural Values: Best performance ≠ Fastest performance

- Opportunity to communicate their health concerns to a provider that FINALLY understands them

- Opportunity to voice their previous negative experiences or insensitivity of previous providers to their needs
I keep getting sudden overwhelming feelings that I'm Mexican.

You're having Hispanic attacks.
Informed Consent

- Informed consent should be explained in writing and explained verbally

- Consent for Interpreter services
  - Patients may refuse interpreters provided by the facility; such refusal will be documented in the medical record.
  - Inform patient they do not have to pay for interpreter services

- Consent for audio/video recordings (with patient’s permission)
Step 8 – Testing & Scoring
Testing Considerations

- Choose language of administration depending on patient's level of language proficiency and purpose of evaluation and document this in the report.
- Don't forget to document ALL languages spoken and level of acculturation to the English culture/language.
- Rule of thumb: preferable to test in individual's language of study in high school.
- When to test in Spanish:
  - Monolingual patients
  - Medical diagnostics
  - To evaluate personality or emotional functioning
- When to test in English:
  - To evaluate academic abilities for pursuing studied in English
  - Ability to participate in work where knowledge of English is required
  - Ability to participate in court proceedings
  - Ability to participate in treatment or cognitive rehabilitation
- When to do Bilingual Evaluations:
  - When assessing for language disorders
  - When assessing language proficiency
Test Selection

- Tests – not all adaptations/translations were made equally

- Choose tests based
  - Purpose of evaluation
  - Patient characteristics (language, ed, age)
  - Availability of tests
  - Availability of norms
    - Flexible vs. fixed battery
    - Education corrections
    - Demographic corrections (foreign vs USA)
  - Time
Technology

Computerized testing

- Pros:
  - Ease of administration
  - Automatically scored
  - Many languages

- Cons:
  - Low computer literacy/mouse
  - Elicits less effort/engagement
Test Batteries

- Effort Testing (Greens WMT/NVMST, TOMM, Rey 15, Dot Counting) [wordmemorytest.com/languages/]
- IQ – EIWA or Woodcock-Johnson Cognitive Battery - Brief IQ subtests [Pearson / Riverside Publishing]
- ST-DRS-2 (ages 50-80), 15-30 min [PAR by special request - Vicki McFadden: vmark@parinc.co]
- Neuropsi Screener (16-86, education 0-10+, 20-30 min) [Pearson]
- Batería neuropsicológica en español (BNE) (18-65, education 0-16, 2.5 hours) [www.lartiola.com]
- Meyers Battery (mean age 32, high ed, 2.5 hours) [meyersneuropsychological.com]
- Neuronorma Battery (ages 18-90, education 0-20, 4 hours) [www.oxfordjournals.org/our_journals/acn/neuronorma_collection.html]

Mood/Personality Measures
- GDS [web.stanford.edu/~yesavage/GDS.html]
- BDI/BAI [Pearson]
- MMPI [Pearson]

Informant Questionnaires
Scoring

- Don’t get caught up in a number-centric approach to interpreting the data
- Process Oriented approach
- Qualitative information also telling
Step 9 – Report writing & Billing

- Important things to document in report
  - Whether tests were administered in a standardized format or not
  - If appropriate norms were available
  - Use of interpreters
  - Other linguistic and cultural factors that may have interfered with the evaluation process

- Should reports be written in Spanish or English?

- Translating full vs. summary report for patient and family

- Make recommendations that are easy to read and actually accessible to patient and family

- Provide psychoeducational info in Spanish

- Be inclusive of traditional and culturally specific approaches to healing (herbs, household remedies)
Billing

- Time = $
- Insurance providers consider 4-6 hours is typical for testing
- Supportive documentation is needed when testing surpasses 8 hours
- Reduce costs by using psychometrists to test
- Billing for literature review/background research?
  - Only if so specific that can only be used for this specific case and not likely to be used for other cases
- Pro-bono work
- Patient Payment Plans
Step 10 – Self Evaluation

- Patient Feedback
  - satisfaction surveys
  - Comments/Suggestions Box

- Encourage patient and family to voice their complaints to the institutional Patient Relations Department or equivalent – provide a name not just an office number

- Develop a contact list for local resources/referral and get your patient’s input on their experiences with these services
Strive to be competent & ethical

- Culturally competency is a goal never attained but continuously strived for.
- Aim to be “culturally responsive” by considering the impact of cultural factors on your clients.
- Never stop learning.
- Advocate for your patient’s rights and access to services.
- Educate others (patients, peers, co-workers, trainees).
- Stay ethical “The Patient’s needs come first”
Summary

- Step 1 – Build a support system
- Step 2 – Make a plan
- Step 3 – Gather materials
- Step 4 – Setting up the Clinic
- Step 5 – Get referrals
- Step 6 – Translators and Interpreters
- Step 7 – Scheduling & interviewing
- Step 8 – Testing & Scoring
- Step 9 – Report Writing & Billing
- Step 10 – Self Evaluation
Gracias

Melissa.castro@deancare.com
Questions & Answers
Thank you for your attendance and support!

Please give us feedback by filling out our brief survey (<5mins): https://www.surveymonkey.com/s/32WZ9LR

This webinar will be available on Youtube: http://www.youtube.com/watch?v=9dWSvu2Rhic

Materials will be available at: http://www.div40-anst.com


Multicultural Clinical Neuropsychology Learning Objectives

Tedd Judd, PhD, ABPP-CN

The following is a menu of learning objectives that students and supervisors may want to choose from for clinical training in multicultural neuropsychology. Note that objectives may vary depending upon the clinical opportunities and the language skills and cultural knowledge of the student and the supervisor. See the powerpoint for more details.
The student who completes this practicum will:

1. Know and follow the major professional ethics, laws, and guidance concerning cross-cultural psychological work.
2. Be skilled at researching a client’s culture, language, and background, especially with respect to (neuro)psychological dimensions.
3. Be skilled at working with an interpreter.
4. Be skilled at establishing rapport across cultures.
5. Be skilled at taking a cultural, language, acculturation, and migration history.
6. Be skilled at taking a diagnostic history with few or no pertinent medical records available, and from evaluatees and their family members with limited or no education and knowledge of medicine.
7. Understand and be able to take into account cultural and educational considerations in testing, including how to test individuals who are test-naïve.
8. Develop professional competence in evaluating test translation/adaptation according to ITC guidelines.
9. Understand and be able to take into account cultural considerations in mental health, symptoms, perceptions, and presentation, including culturally distinct mental health disorders, idioms of distress, and cultural limitations of the DSM-5.
10. Be able to take culture into account in planning interventions.
11. Be aware of his/her own cultural perspectives and background in approaching cross-cultural work and its impact on the encounter and on their judgment and be able to take steps to adjust for that to achieve an ethical and responsible outcome.
12. Be skilled at communicating findings and recommendations to diverse clients/families.
13. Be skilled at communicating cultural considerations to other professionals in written and oral formats.
14. Understand international neuroepidemiology and public health pertinent to immigrant neuropsychological populations.
15. Develop skills as an interpreter of _________ language.
16. Develop skills as a translator of _________ language.
17. Develop clinical and academic vocabulary and competence in _________ language.
18. Develop skills in accessing professional literature in _________ language.
19. Acculturate to US academia and medicine.
20. Learn to teach cultural competence to others.

Cross-Cultural Psychological Evaluation Checklist

Tedd Judd, PhD, ABPP-CN

Should I take the case?

What is the referral question?_________________________

Other likely questions/issues:_______________

Language(s) of evaluation:
Interpreter available

Do I know what I need to know about this culture?

Possible cultural consultation available from:_____________

Is the funding feasible/acceptable?

Is there anyone more appropriate to refer to?

Do I have the clinical skills for these questions?

Should I take the case?

**Pre-Appointment**

Records

Do I have the cultural knowledge I need regarding:

- Worldview; Values; Religion and Beliefs; Family Structures; Social Roles; Recent History; Epidemiology; Communication and Interpersonal Style; Attitudes towards Health, Mental Health, Disease, and Disability; Traditional Healing; Educational System; Legal System
- Professional literature on this population
- Tests available in this language and their appropriateness

Do I have the tests I need?

Certified or otherwise qualified interpreter secured

Consent and other forms adapted and/or translated as needed?

Evaluee and informant(s) well-informed about the appointment, directions, duration, expectations, etc?

Ancillary staff (psychometrist, receptionist, student) prepared as needed?

**Appointment**

Prep the interpreter for interview

- Write down the interpreter’s name and qualifications

Attend to evaluee and informant(s) orientation, comfort, needs, expectations,

Attend to cultural expectations regarding disclosure, talking with different family members, etc

Focus on rapport
Consent, including interpreter role and instruction in interpreter use, if needed

History:

Languages (when began, current preferences and use)

Education: years, quality, problems, language(s), specializations

Culture: identity, affiliations, aspirations

Migration: who, why, when, where, how, stressors, past and future return trips and other travels

Attend to cultural idioms of distress

Inquire non-judgmentally about alternative, traditional, spiritual beliefs about health, illness, and healing, and about use of traditional healing

Note unusual behaviors and possible cultural or other explanations

Testing

Refine plans for language(s) of interviews and testing

Review original and emergent questions and hypotheses along with time and test availability to refine test selection

Prep the interpreter for testing

Rough review of test results for any further testing, probing limits, confirmation, etc.

Debriefing with interpreter to clarify and confirm/disconfirm hypotheses about cultural aspects of interview responses and behavior

After the appointment

Need to research any cultural features?

Need to consult?

Need any more records or interviews?

Address the referral and ancillary questions

Writing the Report

General

Language(s) of evaluation
Interpreter name, qualifications, quality of interpretation

Document cultural consultation, if used

General cultural information that readers of the report will need

Special considerations regarding consent that were used if these need to be documented in the report.

Interviews

History:

Languages (when began, current preferences and use)

Education: years, quality, problems, language(s), specializations

Culture: identity, affiliations, aspirations

Migration: who, why, when, where, how, stressors, past and future return trips and other travels

Cultural idioms of distress

Alternative, traditional, spiritual beliefs about health, illness, and healing, and about use of traditional healing

Unusual behaviors and possible cultural or other explanations.

Testing

Testing adaptations that were used.

Specify and justify which versions (and translations) of which tests and norms were used.

Conclusions

Cautions and limits of interpretation

Summary of the evaluatee’s linguistic, cultural, and acculturation status and aspirations. Also family and community contexts.

DSM-V Cultural analysis, if needed

The perspective of the evaluatee (and family and others from their social context, when relevant) regarding the nature of the problems and possible solutions

Recommendations:
Language needs (in own language, interpreter, English, etc.) in health care, social services, court, education, etc.

Ways to frame the problems, diagnoses, and recommended interventions to the evaluatee and their social network

Cultural considerations in professional services (rapport, gender, goals, etc.)

Cultural appropriateness of professional services (referral to named local providers and agencies with the specified cultural competence, when known)

Coordination with cultural resources (respected family members, community and spiritual leaders and healers, complementary medicine, etc.)

The evaluatee’s cultural aspirations are taken into account (intentions to return to their country of origin vs learn better English and acculturate into the mainstream workforce, etc.)

The Psychologist's Second Language Skills

Tedd Judd, PhD, ABPP-CN

This is a rough guide for neuropsychologists who may want to use their second language skills in neuropsychological assessment.

Monolingual, infrequent use of target language: Have interpreter-use skills, research characteristics of the target language.

Monolingual, frequent use of target language: Select and use the same interpreter(s) consistently. Consider bilingual psychometrist model. Learn some social phrases in the target language. Learn some testing terms (examples, “good,” “correct,” “incorrect,” “next,” “here,” the item names from the Fuld Object Memory Evaluation (a selective reminding memory test)). Deepen knowledge of the characteristics of the language.

Basic Interpersonal Communication Skills (BICS): (learned some from grandma as a child; studied it in high school): Use interpreter, but explain to interpreter what you will be doing. Use the target language in small talk to establish rapport, but then explain that you will be using the interpreter for everything of importance. Listen directly to the client but then listen to the interpretation, as well. Speak the target language in interview only for brief, responsive phrases (“I understand,” “Oh, how terrible” “Wow!”). Jumping back and forth between using the interpreter and not can be confusing.

In testing you may administer selected tests directly if your pronunciation is good and where there is a restricted vocabulary. For example, you may be able to do a better job yourself than
through an interpreter of reading or reciting the instructions for predominantly non-verbal tests while simultaneously demonstrating the expectations, such as with Wechsler performance subtests. You may also be able to administer tests like Digit Span, word list memory tests, and Stroop tests. You may be able to administer many of the Woodcock tests, which are available in many languages. Keep the interpreter in the room, available when needed. You will probably need the interpreter or bilingual psychometrist for tests with open-ended verbal responses and will need to strategize your approach test by test. Be careful about checking with interpreter and evaluatee that your use of the language is quite clear and understandable (being certain that the interpreter and evaluatee are not being acquiescent and that they feel free to criticize).

**Intermediate skill:** Take on more structured parts of interviews and verbal tests, with interpreter available in the room. You can probably carry out verbal testing when your language skills exceed those of the evaluatee (e.g., evaluating a child or the language skills of a bilingual with less skill in the language than you). However, evaluating aphasia or developmental language disorders may be more challenging because it may be more difficult to recognize language errors or to infer what was intended.

**Cognitive-Academic Language Proficiency (CALP):** Carry out most testing and interview. Use interpreter or consultation as needed, especially for language evaluation, dialects, colloquial expressions, informal language. Record, take notes on, or get clarification of unfamiliar idiomatic expressions. Work on pertinent neuropsych vocabulary, idiomatic expressions of distress, and language for culture-typical conceptualizations of illness, healing, disability, etc. May still use more formal language with evaluatee and family than a native speaker. May write feedback letter, reports, therapy notes, etc. in target language.

**Fluent/native speaker:** May use familiar and colloquial language with evaluatee and family. May need to learn technical vocabulary and formal writing in target language if not schooled in that language. May need consultation for dialects and colloquial expressions.

**Learning professional second language skills:** Second language learners who intend to use that language professionally can focus their learning efforts by various means: there are courses, workshops, books, etc. available that focus on medical or mental health aspects of second language learning. There are also immersion language-learning programs in foreign countries that include clinic volunteer work. One can also study abroad or on line with courses in the target language. Reading textbooks and research literature in the target language helps not only with vocabulary but also with understanding subtle differences in the culture of neuropsychology in different countries. Of course, as with any new test, one should practice with a test in a second language before using it. It can also be helpful to carry out supervision/consultation in the target language (for both the supervisor and supervised). As language skills improve, our learning moves beyond the purely linguistic vocabulary to the more cultural manifestations of neuropsychological phenomena—the “idioms of distress,” the forms of presentation of various phenomena, the culturally-typical and distinctive ways of conceptualizing and dealing with those
phenomena, cultural differences in approaches to test-taking, etc. Of course, we are continually learning this in English, as well, as part of our professional skills.

**How do you judge your own linguistic competence or the competence of your student or psychometrist?** As with our evaluation of competencies in our clients, professional linguistic competence is relative to the intended domain of application. A cognitive screening in acute in-patient rehabilitation is very different from a death penalty Atkins (intellectual disability) evaluation. BICS uses (as described above) are very different from fluent uses. Commercial language competence tests are available and may be useful for screening job applicants. But no fixed standards exist (to my knowledge) for language competence relative to neuropsychological applications. Interpreter certification programs are available in some jurisdictions. These may be specialized as legal and medical/social, and there is some limited mental health interpreter certification available. To my knowledge, there is no systematic training or certification available for interpretation in psychological testing. Given these limitations, we are currently mostly left to clinical judgment in evaluating professional linguistic competence. This can be through our own observation, observation by others with clear competence in the target language (such as certified interpreters), customer satisfaction, recording and reviewing of sessions, etc. Care must be taken with respect to the demand characteristics of such evaluation procedures (customers, students, psychometrists, and interpreters may be reluctant to criticize the language skills of neuropsychologists). At the same time, customer satisfaction may be genuinely higher with the less-than-perfect language skills of a professional as compared to work through an interpreter. Possible future endeavors would be to create a peer-review system online by bilingual neuropsychologists to gauge student/psychometrist work with non-English speaking patients, use bilingual psychometrists to train others at national conferences, and include a subtest of non-English related language tests offered with the Certified Specialist in Psychometry by the Board of Certified Psychometrists.

**Bilinguals evaluating bilinguals:** Unbalanced bilingualism is common; balanced bilingualism is rare. When the evaluator and evaluee share a best language then evaluation in that language is generally not very problematic (except for dialect differences). Evaluation of their shared second language is more complex and depends upon the needs of the context. Generally, the evaluator should be better in the second language than the evaluee, at least in the domains of evaluation. For example, if they are both native Mandarin speakers and the evaluee is a child in the US school system being evaluated with respect to academic skills in English, the evaluator should be at least as good in academic English (or at least in the English of the tests), as the child, (even though the child may have better pronunciation and be better able to communicate on the playground). In such a situation the bilingual evaluator with somewhat limited English may be preferable for evaluation of intelligence, fund of academic knowledge (e.g., science, social studies) and some academic skills (math, computers, narrative) because the child would have the option of responding in either language (bilingual evaluation, content testing). Ideally, a native English speaker would evaluate more specific English language skills.
The choice of language(s) of evaluation in bilinguals is complex. Ideally, it is driven primarily by the intended uses of the results and secondarily by the language skills of the evaluator and available tests, norms, etc. Language use during interview and testing may vary according to who is present and test-by-test, sometimes in L1 only, sometimes in L2 only, and sometimes bilingually. For example, an examiner and child may both speak English better than Vietnamese but the father speaks mostly Vietnamese with very limited English so the joint interview is mostly in Vietnamese, the interview with the father only in Vietnamese, and the interview with the child mostly in English. An injured worker who is a crew boss and informally interprets Spanish-English between the supervisor and workers may be tested in Spanish to determine the extent of brain injury, in English to determine ability to communicate with the boss and potential for retraining in English, and informal testing of interpreting skills to determine if she can still handle the attention load of interpreting to return to her former work.

Sample Language for Cross-Cultural Reports
from Tedd Judd, PhD

**INTERVIEWS:** ______ and ________ were interviewed together and separately on __________ by __________ with the assistance of ________, certified medical interpreter. The quality of the interpretation was judged to be ________________________.

______ and ________ were interviewed together and separately in Spanish and English on __________ by __________.

**History of Traumatic Experiences:** _____________________ denied any history of physical, emotional, or sexual abuse or other major traumatic experiences. On inquiry, _____________________ specifically denied major traumatic experiences resulting from immigration experiences.

**BEHAVIORAL OBSERVATIONS:**

**Speech, Language:** Her speech was normal in articulation, tone, rate, word finding, and coherence, as best as could be determined through the interpreter. Her comprehension of test instructions was normal. Her handwriting was legible, coherent, and organized on the page, and correct in spelling, grammar, and punctuation consistent with her education, as judged by the interpreter.

**Effort, Validity:** ________________ gave a good effort on the tests and tolerated frustration well. This was a valid testing in the sense that it reflects her abilities at this time, but no directly applicable norms or validations are available, and test interpretation requires considerable inference.

**TESTING:** Testing was carried out in accordance with the 1990 “Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations” of the American Psychological Association; the International Test Commission’s 2000 Test Adaptation Guidelines; The Department of Health and Human Services 2002 Guidance to Federal Financial
Wechsler Adult Intelligence Scale—3—Spanish

The WAIS-3 is a standard, individually-administered intelligence test with 14 subtests. These subtests can be administered alone or in combination to evaluate different aspects of cognitive functioning. Norms are by age. IQs are not reported here because they are of limited usefulness in neuropsychology and can be misleading, but properly trained professionals who may have use for them can derive such scores.

The WAIS-3 has translations/adaptations/renormings from Spain, Puerto Rico, and Mexico, among other versions. The Mexico version has unacceptable reliability and therefore I do not use it. The version from Spain has perceptual organization subtests that are essentially identical to the English perceptual organization subtests, and so the raw scores can be used to derive equivalent scores in English for comparison to a US population. The young population from the Spain norm group has a high education level, while the old group has low education. The Puerto Rican version of the perceptual organization subtests differs in item content and order and cannot be compared directly. The processing speed subtests are essentially equivalent across all 3 versions. Digit Span is the same for the Spain and Puerto Rico versions, but cannot be compared to the English version even though the same digits are used because the digit words are longer in Spanish than in English. The Puerto Rican version of the verbal comprehension subtests is linguistically and culturally more appropriate for Latin Americans than the Spain version. Item 5 of Similarities has to be changed for non-Puerto Ricans because of the use of local Puerto Rican words. For all of these reasons, there is no “best test” to give to Latin Americans, and this administration uses some subtests from each version according to their clinical appropriateness.

Batería Neuropsicológica en Español (Neuropsychological Battery in Spanish):

The BNE consists of 8 tests adapted from neuropsychological tests in English. The Visual Memory Test consists of presentation of the 3 cards from the Visual Reproduction Subtest of the Wechsler Memory Scale I for 10 seconds each, followed by an immediate recall of all of the drawings. There are up to 5 successive presentations and recalls, to a criterion of accuracy of reproduction. The Verbal Prose Memory Test consists of up to 5 successive presentations and recalls of a story to a criterion of recall. Both of these tests have a 1 hour delayed recall and a recognition memory trial.

On Letter Oral Fluency the person is asked to say all the words s/he can think of beginning with the letters P, M, and R for one minute each. On the Wisconsin Card Sorting Test (WCST) the person must sort cards according to various abstract categories, and discover what those categories are by feedback from the examiner regarding whether or not the responses are
correct. The WCST requires abstract reasoning and problem-solving skills, flexible thinking, and the ability to benefit from feedback.

The Word Learning Test is a version of the California Verbal Learning Test (CVLT). It involves learning a list of 16 items in 4 semantic categories over 5 trials. This is followed by a one trial of learning a new list (the B list), and a free recall and cued recall of the first list (the A list). After 20 minutes there is another free recall and cued recall of the A list, followed by recognition memory for the A list. This sensitive test of verbal learning allows for detailed analysis of learning strategies and patterns.

Verbal Attention is the Digit Span subtest used in many neuropsychological tests, and Visual Attention is the Spatial Span from the Wechsler Memory Scale—3, a pointing span task. In the Stroop Test (Golden version) the person reads a page of color names as fast as possible for 45 seconds. The person then names the colors of a series of Xs printed in different colors. Finally, the person names the colors of the inks of color names printed in different colors (e.g., the word “red” printed in blue ink and the person must say “blue.”), a difficult task which involves suppressing the tendency to read the word. This task is sensitive to processing speed and resistance to distraction.

The BNE is normed by age, education, and geography (the US-Mexico border, and Spain).

Test Barcelona:
The Test Barcelona is a comprehensive neuropsychological test battery in Spanish with a behavioral neurology orientation. It incorporates abbreviated and adapted subtests similar to the Boston Diagnostic Aphasia Examination and 7 subtests of the Wechsler Adult Intelligence Scale; and tests of mental control; story, word-list, and drawing memory; visual perception; praxis; and other functions. Norms are by age and education from Spain and Mexico.

Neuropsi:
The Neuropsi is a neuropsychological screening test in Spanish which includes subtests of orientation, attention (repetition of digits backwards, timed visual scanning for a target, backwards serial 3s), memory (learning a list of 6 words over 3 trials, with 15 minute recall, category cueing, and multiple choice recognition; copy and 15 minute recall of a semicomplex figure), confrontation naming (8 drawings), sentence repetition, auditory comprehension (6 Token Test-type items), verbal fluency (animals and words beginning with “F”), reading a story aloud and for comprehension (3 questions), sentence dictation and copying, similarities (3 items), mental calculations (3 items), copying visual sequences, and copying complex hand movements. Norms are from Mexico by age and education.

Neuropsi Atención y Memoria:
The NAM is a neuropsychological test battery in Spanish which includes subtests of Orientation; orientation to time, space, and self
Attention: repetition of digits forwards, pointing span forwards, timed visual scanning for a target, vigilance for spoken digits, serial 3s,
Memory:
Working memory: digit span backward, pointing span backward
Encoding: learning a list of 12 words over 3 trials; learning a list of 12 word pairs over 3 trials, with 15 minute recall; immediate recall of two short stories; copy of a
semantic or complex figure; memory for two faces and names; and
Recall: 15-minute delayed recall, category cueing, and multiple choice recognition for
word list, with 15-minute delayed recall for word pairs, stories, figure, and names, and
15-minute delayed recognition for faces.

Executive functions: verbal fluency for animals and words beginning with “P,” non-verbal
fluency for line drawings, concept formation; copying complex hand movements and the Stroop
test.

Norms are from Mexico and Colombia by age and education.

**Montreal Cognitive Assessment**
The MoCA is a brief mental status exam that is slightly longer than the well-known Mini-Mental
Status Exam (MMSE) and much more sensitive to Mild Cognitive Impairment and dementia. It is
suitable to people with and elementary education or more. It includes short items of Trailmaking
(alternating numbers and letters) copying a cube, drawing a clock face, naming 3 drawings of
animals, repeating 5 digits forward and 3 digits backward, auditory vigilance, backwards serial
7s, verbal fluency, sentence repetition, memory for 5 words after 5 minutes, and orientation. It is
available in many languages, but most of the translations have not been renormed or validated.

**Cross-Cultural Neuropsychological Test Battery**
The CCNB consists of 11 subtests selected or developed for cross-cultural applicability and
normed in Los Angeles on 336 participants over age 60 (average 73) in 5 ethnic groups:
African-Americans, Caucasians, Hispanic, Vietnamese, and Chinese. The last 3 groups were
mostly monolingual in Spanish, Vietnamese, and Chinese, respectively, with average education
of 8, 8, and 11 years respectively.

**Neuropsychological Battery of Executive Functions and Frontal Lobes (Batería
Neuropsicológica de Funciones Ejecutivas y Lóbulos Frontales, BANFE)**
The BANFE is a Spanish test battery based on adaptations of tasks know to be sensitive to
frontal lobe functions. This includes variants on Mazes, the Tower of Hanoi, the Wisconsin Card
Sorting Test, the Iowa Gambling Task, mental calculations, mental alphabetization, pointing
span, switching Stroop tasks, metamemory, proverbs, category formation, and verbal fluency. It
consists of 14 tasks and one behavioral rating scale. There are multiple measures for each task.
Norms are from Mexico for ages 6-55. Adult norms are divided into 4-9 and 10-24 years of
education. Administration to those with less than 4 years of education proved problematic and
such use must be interpreted with caution.

**The Bidimensional Acculturation Scale for Hispanics**
The BAS is a 24-item bilingual scale developed for Mexican and Central American immigrants
in the U.S. Items are rated on a 4-point scale, with 3 items each for Language Use and for
Electronic Media, and 6 items for Language Proficiency. Domains are rated low, moderate, or
high with respect to Spanish language and Hispanic identity and also with respect to
acculturation to English and U.S. culture.

____________________ chose to use the Spanish version of this questionnaire to rate
herself, suggesting a preference for reading in Spanish.

**Bilingual Verbal Abilities Test**
The BVAT is part of the Woodcock-Johnson family of tests. It is a screening test for determining abilities in a second language compared to English. Tests are administered in English then missed items are administered again in the second language. Norms are compared to native English speakers.

The BVAT was administered in the standard way for English, but all items were administered in Spanish rather than just missed items, in order to give a more complete picture of functioning in both languages compared to each other.

Woodcock-Batería III Spanish Tests of Cognitive Abilities
The WB-III is a well-normed and broad-ranging battery of tests of cognitive abilities. Its subtests measure various aspects of visual, auditory, verbal, spatial, and conceptual abilities, along with measures of processing speed, memory, planning, and problem-solving skills. It gives age and grade-equivalent scores equated to U.S. age and educational levels in English. It is NOT, therefore, normed to a Spanish-speaking population and cannot be used for a direct comparison of possible deficits.

Woodcock-Batería III Spanish Tests of Achievement
The WB-III is a well-normed and broad-ranging battery of tests of academic achievement in Spanish. Its subtests measure various aspects of reading, writing, arithmetic, social studies, science, and humanities achievement, based primarily upon knowledge of content, but also including some writing, conceptual, and problem-solving skills. It gives age and grade-equivalent scores equated to U.S. age and educational levels in English. It is NOT, therefore, normed to a Spanish-speaking population and cannot be used for a direct comparison of possible deficits.

Fuld Object Memory Evaluation:
On the Fuld the person reaches into a bag containing 10 common objects and identifies each object by touch (a tactile integration and object-naming task). The objects are returned to the bag and the person is asked to recall them. Reminders are given of the items missed, with interference tasks between the learning trials Norms are by age. This test has been found to be valid in individuals from a variety of cultures and in those with visual and auditory impairments.

The Five Digit Test
The FDT is an analog to the Stroop test designed for people with little or no education. The person first reads a series of the first 5 digits as rapidly as possible, each printed in a box. On the next page the person counts the number of asterisks in each box, always a quantity between one and five. On the next page, the person counts the number of digits in each box, always a quantity between one and five. In this interference condition the person must suppress the tendency to read the digits in order to count them. The final condition is like the interference condition, except that some boxes have a thick border, and for those the person must read the digits rather than count them. This task is sensitive to processing speed, resistance to distraction, and mental flexibility. Norms are by age from Spain, although other norm groups are also available and may be applied, as appropriate.

Animal Naming Test
On the ANT the person is asked to say all the animals s/he can think of in particular category in one minute. Norms are by age, gender, race, and education (Heaton norms), or by language, age and education for non-English speakers (various norming studies).

Bilingual Aphasia Test
The BAT looks at all modalities of language in a linguistically complete analysis. It is designed with a “low ceiling,” that is, all of the tasks easy and use basic vocabulary and grammar and can typically be done by any native speaker of the language (except that those tasks requiring literacy can only be done by those with basic literacy). It also includes subtests that look at interpreting skills for bilinguals. The test is available in over 50 languages and over 100 language pairs, and each translation/adaptation has been carefully adjusted to the linguistic properties of the specific language.

Informant Questionnaire on Cognitive Decline in the Elderly
The IQCODE consists of 16 items regarding everyday memory, attention, and executive functions. The informant rates the person as much improved, a bit improved, not much change, a bit worse, or much worse compared to 10 years ago. An average change score is calculated ranging from 1-5, with 3 indicating no change, greater than 3 indicating a decline, and results over 3.31 being consistent with dementia. The IQCODE is sensitive to the changes of dementia and insensitive to levels of education and acculturation.

World Health Organization Disability Assessment Schedule II
The WHODAS-II is a rating scale of abilities in many domains of daily functioning that has been developed and validated in many countries and cultures around the world and is available in many languages. Disability for each activity is rated as 0. None. 1. Mild. 2. Moderate. 3. Severe. 4. Extreme/Cannot do. Each domain contains 4-8 items, with a total of 34 items. The rating covers the previous 30 days. There is also rating of global health, and of how many days there were difficulties, reduced abilities, and inability. The WHODAS-II is available as a questionnaire and as a structured interview, and in self-report and informant-report formats.

Harvard Trauma Questionnaire
The HTQ is a cross-cultural instrument for the assessment of trauma and torture. In Part I, 46 traumatic events ranging from “lack of food and water” to “rape” to “torture” are rated as: “Experienced,” “Witnessed,” “Heard about it,” or “No.” The HTQ has been developed, adapted, and translated for refugee populations from Bosnia, Croatia, Cambodia, Laos, Vietnam, and Japan and in Arabic and Farsi versions.

Hopkins Symptom Checklist-25
The HSC measures symptoms of anxiety (10 items) and depression (15 items). Symptoms are rated as “Not at all,” “A little,” “Quite a bit,” and “Extremely.” It has been developed, adapted, and translated for Bosnian, Croatian, Cambodian, Laotian, and Vietnamese populations and research supports its use in these populations.

Generalized Anxiety Disorder-7
The GAD-7 is a 7-item self-rating questionnaire with items on a 4-point Likert scale. It measures diagnostic criterion symptoms for Generalized Anxiety Disorder. It is available in many languages via careful translation procedures and has been revalidated in many languages.
Patient Health Questionnaire-9
The PHQ-9 is a 9-item self-rating questionnaire with items on a 4-point Likert scale. It measures diagnostic criterion symptoms for Major Depressive Disorder. It is available in many languages via careful translation procedures and has been revalidated in many languages.

Patient Health Questionnaire
The PHQ is a self-rating screening questionnaire. It has 55 items but, because of its screen-and-probe format, can be completed by some in as few as 26 items. It measures diagnostic criterion symptoms for Somatization Disorders, Major Depressive Disorder, Panic Disorder, Generalized Anxiety Disorder, Eating Disorders, and Alcohol Abuse. It is available in many languages via careful translation procedures and has been revalidated in many languages.

Structured Interview of Reported Symptoms
The SIRS is a structured interview that uses major strategies to detect malingering of mental illness. It has more research supporting it than any similar instrument and is considered the “gold standard” for this purpose. The Spanish translation follows the test translation and adaptation guidelines of the International Test Commission and has been revalidated.

CONCLUSIONS:
Diagnoses:
There are many critiques concerning the cross-cultural application of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition of the American Psychiatric Association (DSM—V). The diagnoses considered here and by other examiners may not be entirely appropriate to describing ______________________’s difficulties.

Cultural/Linguistic Considerations:
Neuropsychological evaluation in cases such as this one can be helpful in ruling out major neuropsychological deficits, but it is more difficult to evaluate subtle symptoms with confidence because of limitations of appropriate tests and norms and other limitations of cross-cultural communication. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition of the American Psychiatric Association (DSM—V) specifies that the cultural formulation of a diagnosis in a multicultural setting should take into account the following:

RECOMMENDATIONS:
Cultural/Linguistic Considerations: I recommend that, whenever possible, professionals working with ________________________ work directly in her language of __________, use a professional interpreter, or, if necessary, a telephone Language Line. It is generally best not to use family members as interpreters, except for minor matters. If it is necessary to deal with ________________________ directly in English it is very important to check if she has understood, not just by asking her if she has understood, but by asking her to explain back.

Evaluation of Malingering:
Contemporary forensic neuropsychological practice calls for the evaluation of the possibility of malingering. Such inferences are particularly difficult in cross-cultural contexts because of culturally variable means of expressing symptomatology, and because of limited
cross-cultural data on symptom validity tests. Aspects of test behavior pertinent to test validity were obtained include the following observations of clinical interview and test performance:

**Culturally-relative intellectual disability**

* performed in the mildly intellectually disabled (formerly called mentally retarded) range compared to normative populations from both and the U.S. This is not based upon norms for this test and the test is not based upon culturally typical materials, ways of thinking, or concepts of intelligence, and so these results may not signify intellectual disability relative to her culture of origin. These scores may reflect limited education or an education not oriented towards the skills measured by this test, rather than limited intellectual potential. However, these results do suggest that * is likely to function intellectually at a level typical of the mildly intellectually disabled in the U.S. when it comes to dealing with U.S. formal institutions (child welfare, health care, legal system, education, mainstream employment, worker’s compensation, immigration, banking). This functioning may include concrete thinking; difficulty applying abstract concepts, rules, and regulations; difficulty generalizing from one situation to another; difficulty coping with complexity; difficulty following extended arguments or lines of logical reasoning; and difficulty contemplating hypothetical or conditional (if, then) reasoning.

**GLADP:** The Guía Latinoamericana de Diagnóstico Psiquiátrico (GLADP, Latin American Guide to Psychiatric Diagnosis, 2004) is a cultural adaptation of the Classification of Mental and Behavioural Disorders portion of the International Classification of Diseases, (ICD-10) of the World Health Organization (http://www.thcc.or.th/ICD-10TM/gf60.htm). The ICD-10 is the most widely used psychiatric diagnostic guide in the world. GLADP diagnoses often capture more accurately than the DSM-V the distress and disorders of people with some Latin American cultural identity.

**ICD-10**
The Classification of Mental and Behavioural Disorders portion of the International Classification of Diseases, (ICD-10) of the World Health Organization (http://www.thcc.or.th/ICD-10TM/gf60.htm) is the most widely used psychiatric diagnostic guide in the world. It is less culture-bound and more comprehensive than the DSM-V.

**Enduring Personality Change After Catastrophic Experience**
The EPCACE diagnosis (Coded F62.0) is from the ICD-10.

- Enduring personality change, present for at least two years
- Follows exposure to catastrophic stress (e.g., concentration camp, torture, captivity, victim of terrorism)
- Includes some of the following:
  - hostile or distrustful attitude toward the world
  - social withdrawal
  - feelings of emptiness or hopelessness
  - a chronic feeling of "being on edge" as if constantly threatened
  - estrangement
- Post-traumatic stress disorder (F43.1) may precede the condition but is not currently present
In reviewing these criteria * is felt to have EPCACE.

Elaboration of Physical Symptoms for Psychological Reasons
EPSPR (coded F68.0) is diagnosed when physical symptoms compatible with and originally due to a confirmed physical disorder become exaggerated or prolonged for psychological reasons. An attention-seeking behavioural syndrome develops that may include additional complaints without physical origin. Typically there is distress and preoccupation regarding the pain and disability. Dissatisfaction with treatment is common. Some cases are motivated by financial compensation from injuries.

In reviewing these criteria * is felt to have EPSPR.

The following sample report language is courtesy of Daryl Fujii, PhD:

Cultural Accommodations and Impact on Testing-Communication/Rapport
Writer not familiar with language, thus an interpreter was used for the evaluation. Interpreter briefed before evaluation as to purpose of evaluation and role of interpreter that included being a cultural broker and assisting with interpreting behaviors and facilitating rapport, cooperation, and effort. Interpreter is experienced/fairly new and familiar/unfamiliar with client's specific dialect and cultural nuances. Rapport between interpreter appeared good/fair/poor, thus the fidelity of interpreter-mediated translation including literal content, culturally mediated meanings, affective tone, and nonverbal “body language” is believed to be good/fair/poor. Writer's rapport with client was believed to be good/fair/poor.

Comfort Level/Disclosure
Per literature review (____), similar persons in client's culture are believed to be comfortable/uncomfortable in one on one testing situations due to frequent/infrequent exposure to tests during school and situations with male/female male/male female/female interaction can be/is not typically a cause of discomfort in that society. Persons of similar culture tend to similar to/more open/more guarded in disclosure when compared to U.S. norms. Given these norms, client's amount of disclosure appears to be normal/better than expected/ lower than expected when compared to persons of that culture.

Test Selection
Test selection was based upon availability of translated and validated tests in the neuropsychological literature. [if none] According to neuropsychology literature, there are no tests validated on client's culture, thus tests from WHO battery (Anger et al., 1993; Maj et al., 1993) were selected due to demonstrated cross cultural validity. Formally translated version of the tests were obtained, thus there is confidence in the validity of the translation/ not obtained as there are no formal translations of tests, thus tests were translated by the interpreter with best adherence to ITCG (2010) standards.

Test Administration
Tests/(specific tests) were administered in a non-standardized manner which included repeating of instructions/additional practice/untimed. Although tests administered in this manner may impact validity of test results, given clients’ poor exposure to tests due to low education level/potential difficulty with translation/complexity of instructions, these modifications are believed to be justified per AERA (1999) to insure fairness in psychological testing due client’s background and circumstances.

Effort

Per literature review (____), similar persons in client’s culture are likely to be similarly motivated/poorly motivated for testing in comparison to U.S. standards due to cultural values of competitiveness/noncompetitiveness/guardedness about disclosure/etc. which would not/negatively impact effort on tests.

[In addition, cultural norms/beliefs/values of slower time sense/smart is equated cautious responding/etc may negatively impact performance on timed tests.]

If passed Symptom Validity Tests (SVTs):

In spite of potential cultural influences for lower motivation for testing, client passed SVTs.

If failed Symptom Validity Tests:

Client failed SVTs, which may/would indicate he/she put suboptimal effort into testing. Poor performances may be/is not believed to be due to cultural issues impacting motivation for test taking as one study reported foreign born TBI were significantly more likely to fail at least one SVT (Webb et al., 2012)/[other rationale]

Test Results

The following test scores should be interpreted with caution as the tests were normed and validated in the U.S. and thus biased towards American culture. Biases are stronger towards persons who do not speak English fluently or grew up in a different country with different values, educational opportunities, and experiences. Thus although test scores are reported for client, they are most useful as measures to compare skills and abilities within the client’s repertoire to determine neurocognitive patterns associated with different neurological disorders. Due to biases, scores may be less useful as absolute measures of abilities.

On neuropsychological tests developed and normed in the U.S., client's premorbid IQ was estimated to be ___, placing him/her within the ___ range. Premorbid abilities are based upon using an estimate of IQ of country of origin taken from the literature ( ) as a baseline and adjusting for client's education and functioning within his/her culture.

Formulation

Based upon history, self-report, behavioral observations, collateral sources, and test results, interpreted within the client's culture and cultural experiences, the client's presentation is most consistent with diagnosis, as evidenced by behaviors/pattern of test results. This diagnosis is made with a weak/fair/strong degree of confidence. Client's neuropsychological deficits are believed to be mild/moderate/severe as evidenced by ____ with most significant impact in the functional areas of ______. This estimated severity of deficits is made with a weak/fair/strong degree of confidence. This
opinion is based upon available data, but could change if new information is made available that may alter evidence for the formulation.

Semi-structured Interview of Language, Immigration, Acculturation History, Adaptive Behavior (Tedd Judd)

Ethnic/Cultural/Language/Migration Background
Before we talk about what brings you here to see me, I’d like to ask some things about your background, because it is important for me to understand who you are and where you come from. (For immigrants): Where were you born? What was the name of the town? How large is that town? What ethnicity(ies) do you identify with? Do you belong to a particular group or tribe? What was your first language? Do you speak any other languages? How far did you get in school? What language(s) was your schooling in? What kind of school was it? Were you a good student? Did you repeat any years? Did you do any further schooling or technical training for work? What kind of work did you do in your home country? When did you come to the US the first time? Why did you come? How did you come? (Be careful in deciding to use this question because it could be threatening if they are undocumented.) What was it like moving to a new country? What was it like for your parents, siblings, grandparents, cousins? Did anyone have a particularly hard time? Have you gone back? When and for how long? Do you plan to go back? When you got to the US did you study English? Did you have any other schooling? What kind of work have you done in the US? What is your best language now? What language(s) do you speak at home? At work? With friends? What language(s) do you think in? (For non-immigrants): Do you speak any languages other than English? How did you learn that language? What is your best language now? What language(s) do you speak at home? At work? With friends? What language(s) do you think in? What is your ethnic background? What things do you do that maintain your connection with that culture?

Professional Organizations Relevant for Psychologists Working with Hispanics

• National Latina/o Psychological Association (http://www.nlpa.ws)
• California Latino Psychological Association (http://www.lati-nopsych.org/)
• Latino Psychological Association of New Jersey (http://www.lpanj.org/)
• Midwest Association of Latino Psychologists (http://www.latinopsychology.org)
• Hispanic Neuropsychological Society (http://www.hnps.org/)
• Society for the Psychological Study of Ethnic Minority Issues (http://www.apa.org/divisions/div45/)
• Association for Multicultural Counseling and Development (http://www.amcd-aca.org/amcd/)
• National Hispanic Science Network on Drug Abuse (http://nhsn.med.miami.edu/)
**Special Interest Groups**

- Section on the Clinical Psychology of Ethnic Minorities (Section VI) of the Society of Clinical Psychology (APA Division 12; http://www.apa.org/divisions/div12/sections/section6/)

- Section on Ethnic and Racial Diversity of the Society of Counseling Psychologists (APA Division 17; http://www.div17.org/serd/)

- Ethnic Minority Affairs (EMA) Subcommittee of the Public Interest Advisory Committee (PIAC) of Society for Neuropsychology APA Division 40 (http://www.div40.org/Committee_Activities_Pages/Advisory_Committee/ethnic_min_affair _com.htm)

**Other Related Online Resources**

- National Resource Center for Hispanic Mental Health: http://www.nrchmh.org
- Resources for Cross-Cultural Health Care: http://www.diversityrx.org
- The Provider’s Guide to Quality and Culture: http://erc.msh.org/quality&culture
- Office of Minority Health CLAS Standards: http://www.omhrc.gov/CLAS/
- SAMHSA’s Cultural Competence Standards in Managed Mental Health Care: http://www.mentalhealth.org/publications/allpubs/SMA00-3457/default.asp
- National Center for Cultural Competence, Georgetown University: http://www.georgetown.edu/research/gucdc/nccc/

**Web Resources For Researching Cultural Background**

- www.ethnomed.org Harborview Medical Center, Seattle, profiles of groups most common in US
- www.xculture.org Cross-Cultural Health Care Project, Univ. of Washington
- http://www.cal.org/co/publications/profiles.html Cultural Orientation Resource Center
- Wikipedia
- Travel websites
- Country- and region-specific websites
- http://www.culturecrossing.net/index.php Culture crossing: etiquette & understanding
- Online Readings in Psychology and Culture http://www.wwu.edu/~culture Center for Cross-Cultural Research, Western Washington University, Cross-Cultural Psychology Textbook

**Free Tests!**
Bilingual Aphasia Test http://www.mcgill.ca/linguistics/research/bat/ Available in over 100 language pairs, comprehensive.

19 languages, sensitive to dementia, insensitive to culture/language/education, other screening tests and data on the same website

Montreal Cognitive Assessment: http://www.mocatest.org/default.asp Screening mental status exam like the MMSE, many languages, but not always renormed or revalidated. Somewhat unsatisfactory culturally, especially for low levels of education.

PHQ, GAD-7 http://www.phqscreeners.com/overview.aspx Screeners for depression, Generalized Anxiety Disorder, and other common disorders translated into many languages, but not always renormed or revalidated.


DSM-V Cultural Formulation Interview Link
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Cultural

References


**APPENDIX OF SPANISH ASSESSMENT INSTRUMENTS**

Hispanic Neuropsychological Society

**Buyer Beware!** Many tests are offered in various languages with inadequate translation, adaptation, documentation, renorming, and/or revalidation.

<table>
<thead>
<tr>
<th>TESTS IN SPANISH</th>
<th>AREA</th>
<th>TYPE OF NORMS/TRANSLATION</th>
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<td>Cognitive Linguistic Quick Test</td>
<td>Several Cognitive domains; Ages 18:0-89:11</td>
<td>Adapted; Spanish speaking norms</td>
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<tr>
<td>Test Barcelona-Revisada (Spanish and Catalan)</td>
<td>Several cognitive domains</td>
<td>Developed in Spain and co-normed with other measures</td>
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<tr>
<td>NEUROPSI Screener</td>
<td>Several cognitive domains; Ages 16-86</td>
<td>Developed in Mexico with Mexican normative sample</td>
</tr>
<tr>
<td>NEUROPSI Attention and Memory</td>
<td>Several cognitive domains; Ages 6-85</td>
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<tr>
<td>Batería III Woodcock-Muñoz</td>
<td>Several cognitive domains and achievement; Ages 2-90+</td>
<td>Spanish adaptation/translation of WJ III; diverse U.S. Spanish-speaking normative sample</td>
</tr>
<tr>
<td>Batería Neuropsicológica en Español</td>
<td>Several cognitive domains; Ages 18-65+</td>
<td>Adaptation; U.S. Spanish speaking and Spanish nationals normative data</td>
</tr>
<tr>
<td>Test Name</td>
<td>Description</td>
<td>Sample Notes</td>
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<tr>
<td>Neuropsychological Screening Battery for Hispanics</td>
<td>Several cognitive domains; Ages 16-75</td>
<td>Spanish adaptation/translation; U.S. monolingual Hispanics normative sample</td>
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<tr>
<td>Spanish and English Neuropsychological Assessment Scales</td>
<td>Several cognitive domains; older adult emphasis</td>
<td>Matched Spanish and English versions</td>
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<tr>
<td>Batería Neuropsicológica de Funciones Ejecutivas y Lóbulos Frontales</td>
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<tr>
<td>Geriatric Depression Scale</td>
<td>Depression; Ages 17+</td>
<td>Translated</td>
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<tr>
<td>Beck Depression Inventory</td>
<td>Depression; Ages 13-80</td>
<td>Translated</td>
</tr>
<tr>
<td>Beck Anxiety Inventory</td>
<td>Anxiety; Ages 17-80</td>
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<tr>
<td>Beck Hopelessness Scale</td>
<td>Depression; Ages 17-80</td>
<td>Translated</td>
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<tr>
<td>Center for Epidemiological Studies-Depression</td>
<td>Depression</td>
<td>Translated</td>
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<tr>
<td>Children’s Depression Inventory-2</td>
<td>Depression; Ages 7-17</td>
<td>Translated</td>
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<tr>
<td>Revised Children’s Manifest Anxiety Scale, 2nd edition</td>
<td>Anxiety; Ages 6-19</td>
<td>Translated</td>
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<tr>
<td>Brief Symptom Inventory</td>
<td>Personality; Ages 13+</td>
<td>Translated</td>
</tr>
<tr>
<td>MMPI-2</td>
<td>Personality; Ages 18+</td>
<td>Translated</td>
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<td>MMPI-A</td>
<td>Personality; Ages 14-18</td>
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<td>MCMI-III</td>
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<tr>
<td>Millon Adolescent Clinical Inventory</td>
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<tr>
<td>SCL-90R</td>
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<td>PAI-Spanish Edition</td>
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<td>Translated</td>
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<tr>
<td>PAI- European Spanish with norms</td>
<td>Personality; Ages 18-older years</td>
<td>Adapted test; Spanish-speaking norms</td>
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<tr>
<td>Personality Inventory for Children-2</td>
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<tr>
<td>Piers-Harris Children’s Self-concept scale, 2nd edition</td>
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<tr>
<td>Battery for Health Improvement-2</td>
<td>Biopsychosocial; Ages 18-65</td>
<td>Translated</td>
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<tr>
<td>Test Name</td>
<td>Description</td>
<td>Age Range</td>
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<tr>
<td>Brief Battery for Health Improvement-2</td>
<td>Biopsychosocial; Ages 18-65</td>
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<tr>
<td>Brief Symptom Inventory 18</td>
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<td>Millon Behavioral Medicine Diagnostic</td>
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<td>Pain Patient Profile</td>
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<td>Adaptive Behavior Assessment System-II</td>
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<td>Connors-3</td>
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<tr>
<td>Pervasive Developmental Disorders Screening Test-II</td>
<td>Behavior questionnaire; Ages 1-4</td>
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<td>Social Skills Improvement System Rating Scales</td>
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<tr>
<td>Vineland-II</td>
<td>Behavior; Ages vary</td>
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<tr>
<td>BASC-2</td>
<td>Behavior; to assess preschool-adult</td>
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<tr>
<td>Comprehensive Executive Function Inventory</td>
<td>Behavior Rating of Executive functioning; Ages 5-18</td>
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<tr>
<td>Developmental Profile 3</td>
<td>Behavior functioning in various areas; Ages birth-12</td>
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<tr>
<td>Woodcock-Munoz Language Survey-Revised Normative Update</td>
<td>Language (several areas); Ages 2-90+</td>
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<tr>
<td>Boehm-3</td>
<td>Speech/Language; Grades K-2</td>
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<tr>
<td>Boehm-3 Preschool</td>
<td>Speech/Language; Ages 3-5</td>
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<tr>
<td>Bracken School Readiness Assessment-3rd Ed.</td>
<td>Speech/Language; Ages 3-6</td>
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<td>CELF-4 Spanish</td>
<td>Speech/Language; Ages 5-21</td>
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<tr>
<td>CELF- Preschool 2 Spanish</td>
<td>Speech/Language; Ages 3-6</td>
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<td>Test Description</td>
<td>Area</td>
<td>Type of Norms/Translation</td>
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<tr>
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<tr>
<td>Expressive One-Word Picture Vocabulary Test-4th edition</td>
<td>Speech/Language; Ages 8-80+</td>
<td>Translated; Spanish-bilingual</td>
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<tr>
<td>Receptive One-Word Picture Vocabulary Test, 4th Edition</td>
<td>Speech/Language; Ages 2-80+</td>
<td>Translated; Spanish-bilingual</td>
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<tr>
<td>Oral Language Acquisition Inventory &amp; the Oracy Instructional Guide</td>
<td>Speech/Language; Ages PreK-3rd grade</td>
<td>Adapted (criterion scores)</td>
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<tr>
<td>Preschool Language Scale-4 Spanish</td>
<td>Speech/Language; Ages Birth-6</td>
<td>Adapted test; Diverse US Spanish Speaking norms</td>
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<tr>
<td>Test of Early Language Development-3rd Edition: Spanish</td>
<td>Speech/Language; ages 2-7</td>
<td>Spanish-speaking norms</td>
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<tr>
<td>Test of Phonological Awareness in Spanish</td>
<td>Speech/Language; Ages 4-10</td>
<td>Spanish-speaking norms</td>
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<tr>
<td>Test de Vocabulario en Imágenes Peabody</td>
<td>Speech/Language; Ages 2:6-17:11</td>
<td>Translated; Spanish norms from monolingual children in Mexico and Puerto Rico</td>
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<tr>
<td>Escala de Inteligencia Wechsler para Adultos-III</td>
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<td>Adapted; Spanish norms</td>
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<td>RIAS y RIST-Spanish</td>
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<tr>
<td>Kaufman Assessment Battery for Children-2nd ed.</td>
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<td>Spanish translated instructions and acceptable answers</td>
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<td>Kaufman Brief Intelligence Test-2nd ed.</td>
<td>Intelligence; Ages 4-90</td>
<td>Instructions in English with acceptable Spanish answers</td>
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<td>WISC-IV Spanish</td>
<td>Intelligence; Ages 6-16</td>
<td>Adapted; Spanish speaking norms</td>
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<tr>
<td>Word Accentuation Test- Chicago Edition</td>
<td>Intelligence</td>
<td>Developed for Spanish speakers; diverse U.S. Spanish speaking normative sample</td>
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<tr>
<td>Prueba de Habilidades Académicas Iniciales</td>
<td>Achievement; school aged children</td>
<td>Adapted; Spanish-speaking norms from Mexico</td>
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<td>WCST-Spanish</td>
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<td>Translated; Spanish-speaking norms</td>
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<td>TESTS IN MANY LANGUAGES/NONVERBAL</td>
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<td>TYPE OF NORMS/TRANSLATION</td>
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<td>BETA III</td>
<td>Nonverbal intellectual abilities; Ages 16+</td>
<td>U.S. English norms; Directions also in Spanish</td>
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<tr>
<td>Test Name</td>
<td>Domain</td>
<td>Adaptation/Normalization Details</td>
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</tr>
<tr>
<td>Bilingual Aphasia Test (in 59 languages)</td>
<td>Aphasia</td>
<td>Adaptation to specific language and culture of that language; no norms but some references on website</td>
</tr>
<tr>
<td>Bilingual Verbal Abilities Test (Spanish, Arabic, Chinese, German, Hindi, Korean, Polish, Turkish, French and Russian)</td>
<td>Bilingual verbal ability; Ages 5-90+</td>
<td>Adapted; tests are equilibrated across languages and compared to self and also U.S. English norms</td>
</tr>
<tr>
<td>Comprehensive Test of Nonverbal Intelligence- 2nd Edition</td>
<td>Nonverbal Intelligence; Ages 6-89</td>
<td>Nonverbal tasks; some subtest instructions in manual in Spanish, simplified Chinese, French, Tagalog, Vietnamese, German, and Korean</td>
</tr>
<tr>
<td>Consortium to Establish a Registry for Alzheimer’s Disease (Bulgarian, Chinese, Dutch, Finnish, French, German, Italian, Japanese, Korean, Arabic, Norwegian, Portuguese, and Spanish)</td>
<td>Several cognitive domains; Ages</td>
<td>Normative data vary by language</td>
</tr>
<tr>
<td>Five Digit Test</td>
<td>Attention and executive function; Ages 4-75+</td>
<td>Minimal verbal level; normative data from Spain and clinical subjects in Canada</td>
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<td>Fuld Object-Memory Evaluation</td>
<td>Memory; Ages 70-90</td>
<td>Used in many languages; some studies with Spanish-speaking sample</td>
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<td>Green Word Memory Test (many languages)</td>
<td>Validity</td>
<td>Translated; normative data represented for some languages</td>
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<tr>
<td>Harvard Trauma Questionnaire (Japanese, Vietnamese, Arabic, Farsi, Bosnian, Croatian, Laotian)</td>
<td>Trauma Questionnaire</td>
<td>Developed, adapted and translated for respective refugee population</td>
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<tr>
<td>Hopkins Symptom Checklist-25 (Bosnian, Cambodian, Croatian, Japanese, Laotian, &amp; Vietnamese)</td>
<td>Depression and anxiety inventory</td>
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<tr>
<td>Informant Questionnaire on Cognitive Decline in the Elderly (4 forms; 19 languages)</td>
<td>Questionnaire for cognitive decline by informant</td>
<td>Cut-off points by form; studies with language versions on website</td>
</tr>
<tr>
<td>Montreal Cognitive Assessment (in over 35 languages)</td>
<td>Several cognitive domains; Varies by language: some versions are direct translation, other are adaptations and have been normed</td>
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</tr>
<tr>
<td>Mini-Mental Status Examination (over 40 languages)</td>
<td>Cognitive screener; Ages 18-100</td>
<td>Translated (possibly adapted); clinical use of cutoff ranges should be based on the scientific literature</td>
</tr>
<tr>
<td>Test Description</td>
<td>Details</td>
<td></td>
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<tr>
<td>Mini-Mental Status Examination-2nd ed. (German, French, Dutch, Spanish, Chinese, Russian, Italian, and Hindi)</td>
<td>Cognitive screener; Ages 18-100</td>
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</tr>
<tr>
<td>Naglieri Nonverbal Ability Test- 2nd ed.</td>
<td>Nonverbal reasoning and problem solving; Ages 5-17</td>
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<tr>
<td>Patient Health Questionnaire-9 ; GAD-7; and Patient Health Questionnaire-Full (many languages)</td>
<td>PHQ-9: Depression questionnaire; GAD-7: Anxiety; Full version: Mood, anxiety, alcohol, eating and somatoform inventory</td>
<td></td>
</tr>
<tr>
<td>Raven’s Matrices: Standard, Coloured, and Advanced</td>
<td>Nonverbal Intelligence; Ages 5+ (depending on version of Matrices)</td>
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<tr>
<td>Seoul Neuropsychological Screening Battery</td>
<td>Several cognitive domains; Ages</td>
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<tr>
<td>Wechsler Nonverbal Scales of Ability</td>
<td>Intelligence; Ages 4-21</td>
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<tr>
<td>World Health Organization Disability Assessment Schedule II and 2.0 (available in 11 languages and continuing development in others)</td>
<td>2.0 version: Cognition, mobility, self-care, getting along, life activities, and participations</td>
<td></td>
</tr>
</tbody>
</table>

Translated (possibly adapted); clinical use of cutoff ranges should be based on the scientific literature on the MMSE/MMSE-2 by language

Normative data from U.S. sample

Careful translation of English version and revalidated

Nonverbal; some research literature on normative data in different groups

Adapted

Cross-cultural application study in 19 countries; reliability and validity field studies using multicenter design
**LINGUISTIC DIVERSITY**

<table>
<thead>
<tr>
<th>Indigenous Latin American Languages with the Most Native Speakers</th>
<th>Approx. number of speakers</th>
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<tr>
<td>Quechua</td>
<td>8 million</td>
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<tr>
<td>Mayan languages</td>
<td>6 million</td>
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<tr>
<td>Guarani</td>
<td>5 million</td>
</tr>
<tr>
<td>Aymara</td>
<td>2.5 million</td>
</tr>
<tr>
<td>Nahuatl</td>
<td>2 million</td>
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<tr>
<td>Mapudungun</td>
<td>500,000</td>
</tr>
<tr>
<td>Mixtec</td>
<td>475,000</td>
</tr>
<tr>
<td>Zapotec</td>
<td>450,000</td>
</tr>
</tbody>
</table>

**Neuropsychology of Indigenous (“Indian”) Latin Americans: A Beginning**

**LINGUISTIC DIVERSITY**

- Indigenous languages encompass 43% of global linguistic diversity with approximately 550-700 languages.
- 56 language families and 73 isolates (Europe has 2 language families and 1 isolate).
  - For example, the Quechua family (from the Inca Empire) has 8 million speakers and about 46 languages/dialects and is an official language in Peru and Bolivia.
- Many of these languages are severely endangered.
- **Phonetic distinctiveness:** Many indigenous languages are tonal with unique/rare speech sounds.
  - For example, **Mayan** (in Colombia) has 37 consonants and 20 vowels (English has 24 consonants and 20 vowels; Spanish has 20 consonants and 5 vowels).
- **Grammatical distinctiveness:** Hixkaryana in Brazil has the rare Object-Subject-Verb word order. Polysynthetic languages such as **Nahuatl** (Aztec) link stems and affixes into complex words such as **“Ak’mo’ aksta’ aqapi: tzaqaniku: kamputuma: w”** (We were wanting to make him finish washing his ears.)
- **Semantic distinctiveness:** Indigenous languages reflect the historic worldviews and habitual semantic habits and abstractions of their users.

**Neuropsychology of Linguistic Diversity: Clinical challenges**

- **Identifying interpreter needs:**
  - Clients may not know the name of their language.
  - Clients may not be able to communicate their need in a language understandable by service providers (isolated individuals have been taken for psychotic on this basis).
  - Clients may hide their indigenous language for sociopolitical reasons (e.g., discrimination, abuse, marginalization).
  - Many neuropsychologists are not trained in translating language history and identifying interpreter need (e.g., a Mexican client was evaluated forensically 3 times in Spanish before it was discovered that his primary language was Mixteco).

- **Interpreter access:**
  - Rare languages may have few or no trained, proficient interpreters available.
  - Interpreter and client may share the same language (e.g., Mixteco) but speak a different dialect (e.g., Mixteco alto vs. Mixteco bajo).
  - Live in the same community therefore know each other.
  - Chain interpretation with two interpreters may be required (e.g., Quechua to Spanish to English and back).

- **Interpretor use:**
  - Indigenous languages, unlike European languages, often lack terms for medical concepts, various European abstractions, and even household items (e.g., chair, scissors). The semantic fields for psychological concepts may be very different from European languages.

- **Testing issues:**
  - There are virtually no neuropsychological tests available in indigenous languages. There is little validation specifically for ILAs of tests in other languages (Spanish, Portuguese, English; Donlan & Lee, 2010). Exceptions: 5 Digit Test in Quechua, Harvard Trauma Questionnaire and Hopkins Symptom Checklist-25 in several languages.

- **Cognitive issues:**
  - Some illiterate ILAs do not comprehend some tests, e.g. Block Design (Ardisla, 2001).
  - Some ILA groups (Pame, Maya) show distinctive cognitive profiles (e.g., visual-spatial strength) that vary with education (improves verbal memory, working memory; Ostrykos-Solis, et al., 2004).
  - Markedly distinctive ways of regarding time (Aymara: Nuñez, 2006; Napo: Uzendoski, 2006; Maya: Linstroth, 2009), space (Maya: Li, 2002), causality (Quechua: Darghouth, 2006), and individualism (Quechua: Rengifo, 2005, Theidon, 2006), among other basic abstractions suggest fundamental clinical challenges to assessment and treatment.

**TRADITIONAL MEDICINE**

The International Labour Organization (ILO), Indigenous and Tribal Peoples in Independent Countries, and Pan American Health Organization (PAHO) have establish guidelines to help incorporate indigenous perspectives, traditional medicines/healing practices, and therapies into primary health care. Guidelines include:

- The need for a holistic approach to health
- The right to self-determination
- Respect for and revitalization of indigenous cultures
- Reciprocity in relations
- The right to systematic participation by indigenous peoples
- The acceptance of traditional medicine/healing practices and their integration into national health-care systems
- Guarantees of participation and autonomy for indigenous peoples in the management of health resources

**Neuropsychology of Traditional Medicine: Clinical challenges**

Some herbs may be beneficial and/or toxic and/or drugs of abuse, such as coca and ayahuasca. Getting a clear history and understanding of herb impacts can be difficult, especially for substances with little research (Barbosa, et al., 2012).

- Relatively low levels of “PTSD” in severely traumatized populations (Maya: Sabin, 2006; Quechua: Tremble, 2009; Suarez, 2013) suggest the possibility of exceptional culturally-mediated resilience, recovery, and/or treatment that may be of pertinence to treating such populations and others.

**RESEARCH CHALLENGES / OPPORTUNITIES**

- Linguistic diversity presents opportunities to determine if psycholinguistic and neurolinguistic findings generalize widely (thereby suggesting universality and a greater likelihood of reflecting neurologic constraints on language and cognition or a common historic origin) or if they are particular to European and other highly studied languages.
- Linguistic diversity presents opportunities to determine if findings in the cognition of bilingualism apply equally well when the two languages are remote as when they are closely related (Sanchez, 2006).
- Distinctive preferences for spatial reference give an opportunity to determine if and how linguistic representation of spatial information impacts spatial reasoning (Danziger, 2011; Li, et al., 2011; Nuñez & Cornejo, 2012).
- Understanding the neurochemical underpinnings of the phenomenology of hallucinations and other altered states of consciousness (Luke, 2011).
- Potential for discovering new medicines.
- Potential for discovering new approaches to dealing with neuropsychological and psychological disabilities (Suarez, 2013).

**CONCLUSIONS**

Real progress towards the autonomy and access to power for indigenous peoples has been slow. Thus, more support is required for the socio-political status of indigenous peoples to gain momentum in order to strengthen health care where well-being and health combines indigenous knowledge with the benefits of modern medicine.
CROSS-CULTURAL PSYCHOLOGY PRACTICUM

Description:
General: This is a supplementary, not primary, practicum. Students needing a practicum with a fixed schedule and guaranteed number of hours will need to seek that elsewhere. This practicum is designed to give students practical and focused experience in working with non-English speakers. Scheduling is irregular and dependent upon the availability of clients and locations. Students come from several different universities and are responsible for assuring that all proper administrative requirements for their university are attended to.

Focus: This practicum focuses on working with immigrant populations through interpreters or directly in their own language if the student speaks that language. The emphasis will be upon learning cross-cultural clinical skills. The nature of the work is primarily assessment for forensic and administrative purposes, although there is a possibility of treatment, as well. Dr. Judd is a neuropsychologist so assessments with him are primarily cognitive and for neurological disorders such as stroke, traumatic brain injury, developmental disorders, and dementia, although the purpose of the practicum is not for training in neuropsychology or in forensic psychology. Dr. Montoya is a clinical psychologist, and work with her can cover clinical psychology issues. Both supervisors are available for consultation on language/cultural issues from other practicum sites, provided that appropriate arrangements are made with those sites.

Supervisors:
Dr. Tedd Judd is a cross-cultural neuropsychologist with 35 years of experience in clinical and forensic settings. He is fluent in Spanish and has worked throughout Latin America. He is board certified in neuropsychology, a Fellow of the National Academy of Neuropsychology, and past president of the Hispanic Neuropsychological Society. He teaches neuropsychological assessment at Seattle Pacific University. He began the cross-cultural practicum 10 years ago.

Dr. Heidi Montoya was one of the first students in the practicum. She is Colombian in origin and bilingual in Spanish and English. She is in private practice in clinical psychology and has a varied practice with adults with a specialty in Spanish speakers.
Evaluations: The bulk of the assessments involve N648 evaluations for medical exclusion from the English and U.S. history and government examination requirement for U.S. citizenship. These examinations involve determining whether or not the evaluatee has a medical disorder that prevents them from learning English and/or U.S. history and government for the examination to become a citizen. These brief (2 hour) exams give an opportunity to sample a wide variety of populations, languages, and diagnostic issues. Other assessments (depending upon availability) may address immigration asylum petitions, work-related brain injuries, disability, competence to stand trial, mitigating and aggravating circumstances to a crime, sentencing recommendations, parenting capacity, mental health treatment, health care management, and other issues. Observing depositions, court testimony, and attorney consultation are also options.

Individualized experiences: We attempt to match student’s interests and abilities to their experiences. Specific case experiences are offered on the calendar and students sign up for the cases they would like to see, which may match their interests based upon client ethnicity and/or the clinical/administrative/forensic issues to be addressed. Students with more skills will have a greater variety of experiences available. There is an option for a specific ethnicity focus for those who have an interest in a particular ethnic group, and they can focus their experiences on that group.

Tests: The focus will be on interview skills, but tests administered may include the Fuld Object Memory Evaluation, verbal fluency, subtests of the WAIS-4 and Woodcock Johnson scales, various Spanish neuropsychological tests, the Test of Memory Malingering, the Competency Assessment to Stand Trial for the Mentally Retarded, Sensory-Perceptual and Motor testing, the San Diego Odor Identification Test, improvised and informal testing to address specific issues and circumstances, and others.

Populations: Populations seen may vary but to date have included Latin Americans, Ukrainians, Russians, Belarusians, Moldovans, Bulgarians, Somalis, Ethiopians, Eritreans, Indians, Pakistanis, Iraqis, Iranians, Vietnamese, Bhutanese, Turks, Armenians, Native Americans (in English) and others.

Format: Students will initially observe Drs. Judd and Montoya and advanced students and gradually assume responsibility for evaluations as they are able. Students will receive direct instruction in working with an interpreter. Students will research the evaluatee’s culture in advance of the evaluation and will review medical records when available. Students will write evaluation reports appropriate to the referral question. There will be a few didactic sessions, as needed, and students will receive individual and group supervision and feedback on written work. Students will be expected to reflect upon and discuss their own cultural, emotional, and personality characteristics to the degree that it has an impact upon the clinical work. Supervision includes support for the emotional burdens of such work, such as secondary traumatization, frustrations with existing
policies, etc. There is a strong focus on coping with competing ethical and legal mandates in such work.

**Options:** There are 4 options available under this practicum:
1. **Evaluations only,** requires a minimum commitment of 3 months and a minimum of 20 clinic hours and about an equal number of self-directed hours dedicated to Internet and literature research, reading, and report writing.
2. **Spanish track,** students fluent in Spanish can work with Drs. Judd and Montoya directly in Spanish with Spanish-speaking clients. Those with adequate Spanish comprehension can observe.
3. **Specific ethnicity focus,** individually negotiated, to prioritize work with a specific ethnic group.
4. **Treatment,** requires a minimum commitment of 9 months. Not yet available.

**Prerequisites:**
1. 3rd or more year graduate student in good standing
2. Courses in ethics, cross-cultural psychology, psychological assessment, psychological testing, psychopathology, and either cognitive psychology or neuropsychology
3. Permission of the instructor

**Objectives:** The student who completes this practicum will:
1. Know and follow the major professional ethics, laws, and guidance concerning cross-cultural psychological work.
2. Be skilled at researching a client’s culture, language, and background, especially with respect to psychological dimensions.
3. Be skilled at working with an interpreter.
4. Be skilled at establishing rapport across cultures.
5. Be skilled at taking a cultural, language, acculturation, and migration history.
6. Be skilled at taking a diagnostic history with few or no pertinent medical records available, and from evaluatees and their family members with limited or no education and knowledge of medicine.
7. Understand and be able to take into account cultural and educational considerations in testing, including how to test individuals who are test-naive.
8. Understand and be able to take into account cultural considerations in mental health, symptoms, perceptions, and presentation, including culturally distinct mental health disorders and cultural limitations of the DSM-5.
9. Be able to take culture into account in planning interventions.
10. Be aware of his/her own cultural perspectives and background in approaching cross-cultural work and its impact on the encounter and on their judgment and be able to take steps to adjust for that to achieve an ethical and responsible outcome.
11. Be skilled at communicating findings and recommendations to diverse clients/families.
12. Be skilled at communicating cultural considerations to other professionals in written and oral formats.

**Hours:** The work will be on different days of the week, with attempts to make them on those days that students have available. Sessions will be half-day or full-day.

**Locations:** The practicum will take place at various community agencies in the Greater Seattle area. These may include:

- Lutheran Community Services (SeaTac)
- Ukrainian Community Center (South Seattle)
- Federal Detention Center (SeaTac)
- King County Jail, Kent (and other regional jails)
- Dr. Montoya’s office (Seattle)
- Dr. Judd’s office (Bellingham)
- Other private mental health offices
- Attorneys’ offices

Students will be expected to provide their own transportation, although carpooling may be possible. Students will have options in the sites they visit and the cases they see.

**Logistics:**

Scheduling is organized via a Google Calendar shared among the participants and readings and other materials are posted on a shared Google Drive folder.

**Orientation:**

There is a required orientation evening session in September.

**Research:**

There are optional research and professional writing and presentation opportunities within the practicum for those students with initiative for such projects.

**Evaluation:**

Students are evaluated on the basis of their information gathering prior to clinical encounters, clinical work, skill development, and report writing. The evaluation format of their university is followed.

**Readings:**

**Required prior to orientation:**

Students will be expected to be familiar with:


*Cross-Cultural Psychology Practicum, 2014, page 4*


**Required reading:**


**Required prior to beginning the practicum:**

Judd, T. Unpublished manuscript on N648 assessments.

**Materials concerning**

The Fuld Object Memory Evaluation  
US Citizenship History/Government questions  
Citizenship Literacy  
IQCODE  
Name Memory Test  
Scenery Picture Memory Test  
WHODAS-2  
PHQ-9  
GAD-7  
Montreal Cognitive Assessment  
Harvard Trauma Questionnaire  
Hopkins Symptom Checklist  
Judd’s interview/report format  
The N648 form and instructions

**Recommended:**  

*Cross-Cultural Psychology Practicum, 2014, page 5*

Those interested in testing issues are recommended to read:


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CROSS-CULTURAL PSYCHOLOGY PRACTICUM

This practicum focuses on learning cross-cultural clinical skills through assessing immigrant populations through interpreters. The focus will be on interview skills, but will also include cultural background research, medical record review, limited testing, and report writing. Populations will include Latin Americans, Russians, East Europeans, Northeast Africans, South Asians, and others. Students will initially observe and then conduct evaluations under direct supervision. There will be a few didactic sessions, as needed, and students will receive individual and group supervision and feedback on written work. Prerequisites are 3rd or more year graduate student in good standing in clinical psychology and permission of the instructor. The work will most often be on Wednesdays and Thursdays, with some opportunities on other days. Students may participate for a half-day or full-day, but must make a minimum commitment of 20 clinical hours over the quarter. The practicum will take place at various community agencies in the Greater Seattle area, most notably Lutheran Community Services (SeaTac), and the Ukrainian Community Center (Renton). Students must provide their own transportation, with carpooling possible. Please see the full description and contact me with any further questions and to enroll.

Tedd Judd, PhD, ABPP-CN
This is an agreement concerning a clinical psychology practicum experience in cross-cultural psychology. It is a letter of understanding, not a legally-binding contract. This is an agreement between Tedd Judd, PhD, neuropsychologist and instructor and ______________________ doctoral student in clinical psychology at __________________________________________.

The practicum is described in a separate document. This practicum will begin on __________ and terminate on _______________

Dr. Judd agrees:
To provide instruction and supervision in cross-cultural psychology in various community settings.
To take full responsibility for all clinical work.
To abide by the laws of the State of Washington regulating the profession of psychology and the ethics of the American Psychological Association.
To keep the student informed of requirements and scheduling.
To provide the professional support needed to allow the student to function appropriately in the clinical setting.
To abide by the practicum requirements of the student’s university.
To provide ongoing feedback regarding clinical performance and learning of the student.
To provide evaluations as needed.
Dr. Judd may, at his option, provide needed letters of recommendation, or may refuse to do so without explanation.

The student certifies that s/he:
Is a 3rd or more year graduate student in good standing.
Has had courses in ethics, cross-cultural psychology, psychological assessment, psychological testing, psychopathology, and either cognitive psychology or neuropsychology.

The student agrees:
To abide by the laws of the State of Washington regulating the profession of psychology and the ethics of the American Psychological Association.
To keep Dr. Judd informed of university requirements.
To keep Dr. Judd informed of their own scheduling for clinical experiences.
To abide by the practicum requirements of the student’s university.
To maintain a log of practicum hours and experiences.
To abide by agreed-to deadlines for reports and other paperwork.
To provide feedback to Dr. Judd regarding teaching and any difficulties or needs.
To participate in group supervision, including with students from other universities.
To engage in a moderate amount of self-disclosure as is necessary for dealing with the personal emotional and cultural impact of the work.
To participate for a minimum of 20 clinical hours and 20 self-directed/didactic hours per quarter.

____________________________      _____________________________   _____________
Tedd Judd    ____________ (student)                Date