Cultural Diversity in Neuropsychological Assessment
Developing Understanding through Global Case Studies
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Multicultural Education and Training in Neuropsychology

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2 Multicultural Education and Training in Neuropsychology
Let’s Talk About Skill Acquisition!

Orlando Sánchez and Tedd Judd

Taka ma ŋayi nguiakoi ŋayivi ŋatu na ja’a tnu’u ja kusa’a ndeva’ña-i, su’uva kajito va’aña-i, yuka ku ja jiniñu’u ja kukototna-i. – Ñuu Savi (Mixteco) language

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of [community].

(Universal Declaration of Human Rights, Article 1)

Section I: About This Chapter

This chapter is intended for neuropsychologists and neuropsychology trainees interested in the practical clinical application of Western neuropsychology to non-Western contexts. While we certainly do not presume to have all the answers to this complex dilemma, we offer at least a preliminary solution; a conceptual, clinical framework grounded in more than four decades of research relevant to multicultural education. In addition, the framework draws from the first author’s insights as an indigenous Ñuu Savi (Mixteco) immigrant neuropsychologist, as well as the second author’s expertise with more than 40 years of cross-cultural clinical neuropsychology experience working with underserved populations from around the world.

Context: Why Do I Lack the Skills to Work with Diverse Populations?

In the 21st century, the notion of delivering high-quality “culturally competent” care to humanity is a universally espoused value within healthcare professions, including psychology. Yet, bringing “culturally competent” care to fruition on a wide scale remains a daunting challenge. While it would seem that the independent and scientific discipline of psychology is well-positioned to meet the needs of diverse communities, in fact, most minority groups continue to be underserved and psychology continues to struggle to recruit, train, and place sufficient practitioners in these communities. Why? We propose that our education and training are among the primary barriers preventing us from meeting this challenge head-on. Specifically, these barriers include:

1. Literature relevant to multicultural education is hidden, overlooked, partially acknowledged, and/or not easily accessible. Basic empirical science relevant to multicultural education and training is scattered and broad. The literature on cultural competency is overwhelmingly vast within the United States alone and even more formidable in a global context of multicultural psychology, cultural psychology, international or global psychology, cross-cultural psychology, and transnational psychology. Though the literature base is enormous (and growing), it

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lacks depth (e.g., consensus on constructs and theory development\(^1\)). Overall, the literature on multicultural education requires periodic synthesis to facilitate access and effectively inform training and clinical practice in psychology.\(^{1,2}\)

2 Multicultural education and training remain an incoherent, “hodgepodge” of strategies with minimal focus on skill acquisition. Education and training in general psychology, at least in the United States, are the foundations of clinical neuropsychology—the latter competencies building upon the former. While both general and subspecialty acknowledge “Individual and cultural diversity” as a core competency,\(^3–9\) efforts are largely disconnected and the same appears true in other parts of the world.\(^{10}\) Though some details concerning cross-cultural conceptual and practical elements have recently emerged in neuropsychology,\(^{11}\) systematic skill training has yet to be described. We argue that, like other core elements in psychology, multicultural education requires an organized, developmental approach (i.e., graded complexity from graduate school to postgraduate training and beyond) ultimately designed to foster skills required for clinical assessment and intervention. We know of no such approach in psychology anywhere in the world. Currently, there is wide variability among graduate and postgraduate programs in the United States, and similar variability in other parts of the world.\(^{12}\) Overall, multicultural education and training remains an incoherent, “hodgepodge” of strategies with minimal focus on skill acquisition. Available evidence suggests that programs almost exclusively focus on content-based knowledge (e.g., teaching broad facts about heterogeneous racial/ethnic groups) and “awareness” (e.g., racism/discrimination, biases), but with minimal attention to education or training targeting specific, practical clinical skills that are desperately needed to address existing health disparities.\(^{13–18}\)

3 The concern with the politics of identity. There is growing criticism within the United States that social science research is yielding constructs with inherent sociopolitical ideological biases.\(^{19}\) Given the universal influence of Western psychology, this has implications for the field in other parts of the world. The concern and criticism are not only towards ideological bias in research but that this is negatively influencing multicultural education/training with the risk of it being viewed as another biased structure promoting a left-leaning political-ideological agenda under the guise of training.\(^{19–21}\)

Overall, considering the aforementioned, it is no wonder that the majority of us lack the skills to effectively work with individuals who are markedly different than ourselves. While the issue is complex, one thing is certain, disparities in access to psychological and neuropsychological services will persist as long as the issue of training clinical multicultural skills remains unaddressed.

The Story behind the S-JMVAM

Before jumping into the empirical foundations of the Sánchez-Judd Minneapolis VA Model (S-JMVAM), allow us to share how this model emerged. Since the multicultural movement surged in the 1980s, Tedd Judd has been addressing healthcare disparities in a direct and practical manner. During that time, he has evaluated clients from approximately 90 countries with a special interest in the most marginalized populations including Amerindians (e.g., Makah, Lummi, Zapoteco, Maya, etc.) and refugees (e.g., Somali, Iraqi, Meskhetian Turk, Nepali-Bhutanese, etc.). In addition, Tedd has taught neuropsychology in 25 countries observing the varied cultures-of-neuropsychology, including their adaptations and applications in different cultural and language contexts. This experience produced many insights about Western psychology in non-Western contexts, which he subsequently began to share with others in our field, including trainees. Tedd’s trainees have included
immigrants and speakers of 17 different languages. Orlando Sánchez was one of these trainees and has been collaborating with Tedd for over ten years.

Orlando Sánchez was born in a small, impoverished indigenous (Mixteco) village in southern Mexico. In pursuit of the coveted “American dream,” he and his family immigrated to the United States in the early 90s. While completing a basic formal education in the United States, Orlando simultaneously was immersed in his indigenous culture (e.g., learning indigenous philosophy and the art of living with wisdom in service of the community, living according to indigenous values/principles, honoring indigenous traditions). Given his commitment to indigenous philosophy, as Orlando contemplated higher education, a career in psychology appeared an obvious fit. The ambition and desire were to learn from Western science and technology and use this knowledge to serve his community. Unfortunately, Orlando grew increasingly discouraged and disappointed in Western psychology and contemplated abandoning this endeavor. Fortunately, Orlando met Tedd in his second year of graduate school before officially withdrawing from his program and the rest is history.

In 2016, Orlando took the teachings from Tedd and, in partnership with the Minneapolis VA, piloted this model within their psychology training program. This subsequently informed and produced a more refined training curriculum with emphasis on skill acquisition. Thus, in the absence of multicultural education and training in psychology specifically aimed at developing and promoting culturally informed clinical skills, the formal S-JMVAM was born.

The S-JMVAM

Sue and colleague’s tripartite model (Awareness, Knowledge, and Skill) has enjoyed widespread development in psychology and related disciplines, it has broadly informed multicultural education, and it has offered a useful foundation for multicultural neuropsychology. However, as previously stated, the general training currently offered (i.e., “hodgepodge” of strategies) is highly inadequate for the specific skills needed for competent multicultural neuropsychology. In response, we offer a conceptual, clinical framework (S-JMVAM) as a possible solution.

The S-JMVAM is a developmental, interdisciplinary model rooted in the pioneering works of Sue and colleagues. Briefly, in our model, we retain Sue’s original categories (Awareness, Knowledge, and Skill) but redefine these with an eye towards more precise skill development. It is our belief that all three of these domains develop continuously throughout the professional lifespan. The Awareness component is thoroughly reviewed and discussed elsewhere in this book (see chapter by Dr. Swanda on using reflective self-awareness); consequently, this will not be reiterated here. Instead, we will focus on those components of Knowledge and Skill that are more specific to neuropsychology.

Foundational Knowledge Base

Ideally, trainees should develop a firm multicultural knowledge base before engaging in clinical practice. This knowledge base would enhance critical thinking, reasoning, problem-solving, and judgment with respect to cross-cultural work. In our model, this Foundational Knowledge is defined as encompassing three components:

1 Science and history. Trainees should be familiar with the history of cross-cultural psychology (late 1960s) and multiculturalism (1980s), relevant theories and constructs (e.g., acculturation), seminal works (e.g., Sue’s Tripartite Model), the science of multicultural education and training in psychology, and the strengths/limitations of this broad body of
literature (see Table 2.1 for sample reading recommendations). As is true in every discipline and area of study, history and foundational scientific knowledge are the bedrock of “cultural competency.”

Table 2.1 Sample of history and foundational scientific knowledge

<table>
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<tr>
<th>Foundational knowledge</th>
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2 **Recognizing ourselves as cultural beings.** This is the knowledge that serves to inform the *Awareness* component of cultural competency. Within neuropsychology, some of the most important components of this awareness relate to our interpersonal, family, and social values; perspectives on health, illness, and healing; patterns of communication, language, and literacy; and experiences of education, cognitive skills, and testing. By recognizing ourselves and others as cultural beings, we can enter the other’s worldview and use our clinical expertise in a socially responsible manner to facilitate optimal evaluation and treatment in a collaborative manner (see Table 2.2 for sample reading recommendations and sample exercises).

3 **Clinical practice knowledge.** This includes, for example, the importance of researching a client’s background, how to facilitate an effective clinical relationship, how to conduct a culturally competent clinical interview, how to use the DSM-5 cultural formulation, how to work effectively with interpreters, how to access and use cultural consultation, and how to use measures and norms with cultural competence.

We believe that this knowledge should be introduced early in the training sequence. We would never expect someone to be a competent psychologist/neuropsychologist after a couple of classes, seminars, workshops, and/or years of jumbled up, incoherent training, particularly training that is dissociated from *skill* development. The same is true for multicultural education; in the United States, a firm foundation in graduate school is key to developing clinical skills during practicum, internship, and beyond. Consequently, we strongly urge the field to adopt a systematic, coherent, focused, developmental approach to multicultural education and training. The S-JMVAM is an attempt at such approach and is very much in line with the movement towards competency-based education, training, and credentialing in psychology and neuropsychology.3–9

**Clinical Practice (Skill Development)**

Appropriate skillsets for multicultural neuropsychology training need to be worked out by our profession at large and will vary with the setting. We offer here a rough draft of 13 foundational skills domains. While each of these can be seen as skills that are important in all of clinical
22 Orlando Sánchez and Tedd Judd

Table 2.2 Sample identity development models and cultural awareness & sensitivity exercises

Recognizing ourselves as “cultural beings”: Awareness & sensitivity exercises

Identity development models


psychology, each skill also has important and distinctive neuropsychological features (for a review of advanced skills, please refer to Fujii, 2016):

1 Researching a client’s culture, language, and background, especially with respect to neuropsychological dimensions.
2 Working with an interpreter.
3 Establishing rapport across cultures.
4 Taking a cultural, language, education, migration, and acculturation history.
5 Taking a diagnostic history with few or no pertinent medical records available and from evalu-
ues and their family members with limited or no education and/or knowledge of medicine,
including lack of familiarity with and/or distrust in the mainstream healthcare system.
6 Understanding and taking into account influences from language, culture, and education in
testing, including test and norm selection and how to test individuals who are test-naive.
7 Understanding and taking into account cultural considerations in neurological health, mental
health, symptoms, perceptions, and presentation, including culturally distinct mental health
disorders, idioms of distress, and cultural limitations of the DSM-5.
8 Interpreting and integrating the findings resulting from culturally sensitive interviewing, test-
ing, behavioral observations, and other sources of cultural and clinical information.
9 Taking culture into account in planning interventions.
10 Communicating findings and recommendations to diverse clients/families.
11 Communicating cultural considerations to other professionals in written and oral formats
and through modeling of behavior.
12 Seeking and/or offering cultural consultation.
13 Advocating for the client and family (when needed).

Additionally, students or clinicians who intend to offer services in a language or languages other
than the language of training may pursue some or all of the following:

1 Clinical competence in the target language.
2 Interpreter/translator skills.
3 Academic proficiency in the target language.
4 Accessing target language professional literature.

Each of these can be further specified into individual subskills that can be refined and mastered
via education and training. Many of these skills can be taught initially through didactics and con-
sultations with interpreters and cultural experts from various disciplines. Skill practice can then
be trained through clinical exercises and role plays prior to deploying these skills with clients. All
of these skills can also be readily targeted in clinical training by providing appropriate clinical
experiences with culturally competent supervision, ongoing academic study, and clinical cultural
consultation. As a profession in science and practice, neuropsychology has done little to develop
preclinical exercises in multicultural neuropsychology; to define, describe, and train culturally
competent supervision; and to develop models, networks, habits, and payment systems for multi-
disciplinary cultural consultation.

Section II: Case Study

The following is an amalgam of case experiences derived from over 15 years of practicum training
in cross-cultural psychology at refugee service centers. These experiences are described in narra-
tive form to illustrate some clinical ways of training each of the skills listed above. While not all
of the details below were present in a single case, all of them have occurred in this teaching with
Somali clients, most of them multiple times. This presents a snapshot of teaching at the clinical
training stage. These students had already received clinical psychology preclinical teaching in
Awareness and Knowledge, as described above. They had preclinical training in all of the Skills
listed above (these are the learning objectives of our cross-cultural psychology practicum). They
had observed several evaluations and then gradually began participating in the evaluations to the
level represented here. They have each also developed interpreter skills and a specialty in working in their own first languages with people of multiple ethnicities. Through learning with continual feedback, as described below, they later progressed from this level to independent practice to teaching other practicum students.

A Brief Cultural Background Review (Prior to the Clinical Encounter)

Background research is fundamental in preparing to see a client from an unfamiliar country, language, or culture. Neuropsychologically pertinent information includes:

- Languages and language features (e.g., writing system)
- Neuroepidemiology
- Educational system
- Health care system (when pertinent)
- Recent history
- Social and family structures and roles
- Attitudes and beliefs regarding health, illness (causation and relief of disease), healing (traditional, religious, and Western), mental health, disability, idioms of distress
- Communication and interpersonal style
- Legal system (when pertinent)

Thanks to the digital revolution, we can now readily and rapidly access useful information about most people’s cultural background, sometimes down to the specific village (for example, the first author once did a review of his village and was surprised to find a picture of his aunt’s adobe house on a website showcasing the diversity of indigenous villages in Oaxaca, Mexico).

This initial review offers us a broad view of a client’s cultural background and supplies hypotheses about their perspectives and experiences (See the Somalia chapter in the book for further country background for this case and details of care of Somalis. The present case presentation is focused on the teaching process rather than clinical specifics of Somalis). However, individual language use, education, migration, acculturation, employment, beliefs, and values must be explored thoroughly and directly with each client. Often subsequent cultural details that are revealed during the evaluation need to be further researched.

Case Referral

Kahlid is an approximately 35-year-old Somali refugee, married female homemaker with no formal secular education who was referred by her primary care provider for an assessment concerning her failure to learn English.

Students

Olga, originally from Belarus, is a 29-year-old trilingual (English/Belarusian/Russian) female in her 3rd year of doctoral training in clinical psychology. Mohamed, a professor from Saudi Arabia, is a 32-year-old bilingual (English/Arabic) male also in his 3rd year of doctoral training in clinical psychology (both are students in our cross-cultural psychology practicum). In addition, informally, both have had to function as interpreters for their respective families. Currently, both have studied interpreter ethics and professional standards with goals of becoming certified interpreters (e.g., their training has included watching online videos concerning
interpreter use and practicing interpreter use skills with peers). Each student made distinctive contributions to the evaluation.

**Preparation and Planning**

Kahlid's medical records concerned obstetrics but were otherwise unremarkable. Both students learned about Somali refugees from several sources including:

- The Somali medical profile in ethnomed.org
- Somali language in omniglot.com
- About Somalia from reliable Internet searches

The appointment was at the refugee service center where Kahlid's family had received settlement services. We met with the interpreter, Rahmed, who was also a mental health therapist in the community mental health center portion of the refugee services. We reinforced our previous agreement with Rahmed—i.e., that her role as counselor would be separate and distinct from her role as interpreter within our evaluation process. Given that Rahmed was a refugee herself, we had also previously discussed potential secondary traumatization in hearing refugee trauma stories. Rahmed briefed us about what little she knew about this family, including that Kahlid's husband, Omar, spoke functional English and was very protective of her. Consequently, we planned on giving extra attention to winning his trust. Our tentative plan was that:

- Initially, we would all talk together until sufficient rapport was established.
- We would then initiate logistics (i.e., confidentiality, etc.)
- We would then proceed with the interview (Joint Interview 1 and 2 below)
- We would then separate for confidential perspectives, to triangulate independent perspectives, and for testing Kahlid:
  - Olga, with Rahmed as the interpreter, would interview and test Kahlid since Omar would likely be more agreeable to this (i.e., congruent with cultural customs, two women rather than men talking with his wife without his presence). Mohamed and Dr. Judd would interview Omar.

In addition, we decided that the students would use their first names with the family for warmth and interpersonal connection, while Dr. Judd would use the formal “Dr. Judd” to reinforce professional authority.

**Rapport**

Kahlid arrived with Omar and their youngest 1-year-old child (their other children were in school). As we settled into the room, Olga offered them tea while Dr. Judd played peek-a-boo with the child (Mohamed offered the child an age-appropriate toy). Since it was a snowy day, Mohamed initiated a conversation about how difficult it was for them to learn to deal with snow, a conversation that Rahmed, Omar, and, eventually, Kahlid joined in on. The conversation then progressed to a discussion about American cultural peculiarities, such as trying to make sense of Halloween and Thanksgiving. Olga then spoke a bit about her own toddler and the conversation turned to a discussion about babies. All of these topics generated laughter and a sense of connection, to the degree that we felt we had established sufficient rapport, so we proceeded to the evaluation logistics.
Mohamed explained the evaluation process, including that we would talk both together and separately. In addition, Mohamed apologized, on behalf of the team, for our not speaking Somali and asked their patience while doing our best to understand their experiences. Mohamed explained that we would do an exam with Kahlid to understand the health of her brain. He explained this as being somewhat like a doctor’s exam and somewhat like the things she did in English class. Finally, Mohamed explained the standard disclosure elements including confidentiality and the roles of the individuals present (interpreter, students, and primary/supervising clinician).

Dr. Judd elaborated on what Mohamed explained as needed, partly to clarify and repeat and partly to accentuate his authority in the process. After everything was explained, Mohamed offered the disclosure forms—first to Omar, as a sign of respect in this male-dominant culture where there is an expectation that husbands will control or oversee their wives’ interactions, and then to Kahlid so that she could mark her Xs, since she is illiterate, on the signature lines. With logistics completed, we proceeded to the clinical interviews.

**Joint Interview 1**

Olga began the interview by taking a cultural, language, and immigration history. She directed her questions to Kahlid, but Omar often answered and Kahlid deferred to him. Olga tolerated this for a while, but eventually, she said, “For this next question I would like to know what Kahlid knows about this.” We learned that Kahlid did not know her own age and that her paperwork contained a birthdate (the conventional January 1) assigned by refugee personnel. She primarily spoke Somali with some MaiMai (which she learned as a child) and some Swahili (which she learned while living at the refugee camp). With respect to her immigration history, Kahlid and her sister (her primary caretaker) fled the war in Somalia on foot when Kahlid was approximately five years old (Kahlid became tearful as Omar shared this history). Consequently, Kahlid grew up in the Dadaab Refugee Camp in Kenya. While she did not attend “government school,” she did attend Quranic school where she worked and attended part-time, from ages 5 through 8. Her work history included selling water for ablutions, basket and mat weaving, housekeeping, and childcare. During her time in Quranic school, it took her approximately three years to recite the first book, which is as far as she got (this was the extent of her education and she never learned to read). Kahlid had an arranged marriage at approximately age 13 and had her first of 6 children at age 14. Kahlid, Omar, and their children came to the United States as refugees five years prior to this interview. During her time in the United States, she mostly stayed home except for when attending English classes with Omar. While Omar benefited from English classes, she never made it past Level 1 over the course of three years.

**Consolidation 1**

Following the first portion of the interview (above), we took a break. During this time, the students researched the Dadaab refugee camp (e.g., https://www.unhcr.org/ke/dadaab-refugee-complex). They learned:

- That it is one of the largest refugee camps in the world with refugees predominantly from Somalia.
- That refugees in Dadaab learn Swahili as this is the unifying language across many tribal languages.
- That there are medical services but limited schooling, employment opportunities, inadequate security from crime and ongoing ethnic feuds, and limited ability to leave the camp.
Rahmed, who also lived in Dadaab, shared her experience with the students. In addition, Olga and Mohamed researched the MaiMai people and learned about their language and role in Somali society. Mohamed explained to Olga that the Quranic school is religious instruction for a few hours a week, that students memorize the Quran in classic Arabic, that the first book is very short, and that taking three years to learn the first book is atypical.

**Joint Interview 2**

After the break, to reinforce rapport, Dr. Judd, knowing about the clinic’s basket weaving group, shared with Kahlid and Omar photos of a basket weaving demonstration he had encountered as a tourist in the Bolivian Amazon. Kahlid was pleased with this and discussed Somali weaving techniques with Rahmed. The students showed photos of Dadaab and Omar, Kahlid, and Rahmed shared their experience living in this camp. Kahlid looked away from some of the photos. Following this, the interview continued.

Omar and Kahlid both reported that she had attended English class regularly, studied diligently, and developed friendships with a few Somali women who also attended classes. Nevertheless, Kahlid could not remember what she studied beyond a few social phrases, individual letters, and isolated simple words. On inquiry, they reported that she had memory difficulties for conversations and everyday family events. They indicated that she does not go out alone because she is afraid of getting lost. Omar and her older children manage the finances, shopping, appointments, and medications. Kahlid attends mosque and has a few Somali women friends in their apartment complex. She enjoys video calls to her sister in Dadaab and can use autodial; she can also access YouTube and Facebook by icons but has not been able to learn other smartphone functions. Omar indicated that the family made sure someone supervised when she cooked because she often forgot things on the stove. Dr. Judd asked Omar if she was a good cook and he said, “Yes, very good.” Dr. Judd then asked, “When are you inviting us all over to dinner?” (everyone laughed). Omar said, well, you can come if you want. You would love to meet our children. We then asked permission to call their oldest son, age 21, to confirm the history and they both agreed.

When Olga reviewed Kahlid’s medical history she reported that she had been told that she had been kicked in the head by a camel when she was a child, but she did not know anything else about this. She had not received medical attention. She said that she had a scar and dent and indicated the left side of her head. We asked permission of her and of Omar to examine it and they said that only Olga would be allowed to see her without her head scarf. Olga reported from this that there was a scar under her scalp and a palpable skull dent over the left temporal area. Olga asked if she had had any major illnesses and they said no. Olga asked if she had had malaria, and Omar said, “Well, everyone gets malaria.”

**Consolidation 2**

At that point in the interview, in the interest of time, we suggested that we would talk separately. We took a short break, refreshed out coffee and tea, Kahlid did a diaper change, and Dr. Judd approved Olga’s plan for a directed interview and testing. Dr. Judd reminded her of how to do a malaria interview. Dr. Judd, Mohamed, Omar, and the baby went to another room.

**Collateral Interviews (Dr. Judd, Mohamed, and Omar with His Child)**

Omar’s English was adequate for an interview, which was conducted by Mohamed. Omar reported that Kahlid had never had a good memory and that she experienced severe malaria about a year
Orlando Sánchez and Tedd Judd

before they left Kenya. He said she had been hospitalized for two weeks, was delirious for a week, and that the doctor thought she might die. Overall, she had a slow recovery and, afterwards, her memory worsened. On inquiry, he also reported that long before he knew her, he had heard that she had been attacked in the refugee camp. He said that she sometimes awakened at night screaming, that she did not like to watch the news from Kenya or Somalia that included violence, and that she was afraid to go outside. He was fairly content with her housekeeping and parenting but wished that she were more able to connect with the community. He also wished that she would someday be employed. Following the interview with Omar, Mohamed called their eldest son and confirmed this history to further triangulate and validate our data.

Client Interview 1 (Olga, Rahmed, and Kahlid)

During this interview, Kahlid said she had been sick not long before they came to the United States, but she did not remember much about it. She did not know what her illness was and did not recognize the word for malaria. On directed inquiry, she remembered having a high fever and chills a couple of different times. She also remembered taking a very bitter medicine. Olga screened for and ruled out domestic violence.

Testing 1

Olga administered the Fuld Object Memory Evaluation, a test involving memory for ten common objects. This test is reliably understood across cultures and is not sensitive to language or level of education but is sensitive to age and to memory loss. Kahlid was able to name the objects readily but used the MaiMai name for two of them and the Swahili name for one of them. Her learning curve was moderately impaired, as was her delayed recall, which was out of proportion to her initial learning. Her responses to a two-alternative, forced-choice recognition memory task for the ten items were rapid and accurate, suggesting good test effort and valid results.

Client Interview 2

During this interview, the following exchange occurred:

OLGA: “I noticed that you got tearful when Omar was talking about your leaving Somalia. I know that this can be a difficult thing to talk about and I am sorry to ask you about such a difficult thing, but I really would like to understand what has happened to you so that we can help you to adjust to life in America.”

Tearfully, Kahlid shared that the Somali army invaded her village and killed her parents in front of her, but she was saved by her sister. She shared fragmentary, frightening memories of their long, dangerous walk to Kenya. Olga, using the “some people” construction she had been taught, said: “Some people who have such experiences still carry it heavily in their hearts. Is that true for you?” Similarly, she asked about dreams, flashbacks, avoidances, and the photos of Dadaab that she had turned away from earlier. Olga learned that Kahlid had been attacked in Dadaab at about age 11. She confirmed nightmares, flashbacks, and avoidances. Once these were confirmed, Olga judged that she had enough information for our purposes; she thanked Kahlid for her trust, changed the subject to children, and eventually called for a break.
Testing 2

We took a break and consolidated our findings, including checking on clinic resources with Rahmed. We all came together again and Dr. Judd improvised informal testing with Kahlid. She was able to read the letters of the English alphabet reliably, and these include all of the letters of the Somali alphabet. She was able to sound out short words in English. She was then presented with writing in Somali, which she had never attempted. To her delight, she was able to slowly sound out and understand short words in Somali.

Feedback

Dr. Judd introduced the feedback in order to give it the weight of his authority, but the students explained the results. Mohamed explained that Kahlid’s slow learning was likely due to being kicked in the head by the camel and also because of the illness she had while in Dadaab (i.e., malaria that infected her brain). Mohamed explained that we would complete the immigration form to give her a medical exemption from learning English and United States history and civics for the US citizenship exam. Olga thanked Kahlid for her trust and explained that she carried a heavy burden on her heart from the war and her attack while living in Dadaab. Olga carefully explained that those experiences still cause pain and are keeping her from being able to adjust to American life. She explained that there is help available to lift that burden and suggested that Kahlid see Rahmed for psychotherapy. Mohamed repeated this offer, framing it in an Islamic worldview, which both Kahlid and Omar appreciated. Omar and Rahmed agreed that Kahlid would see Rahmed for psychotherapy. At Dr. Judd’s invitation, Rahmed switched roles from interpreter to therapist and briefly explained what treatment would entail. In addition, Rahmed offered Kahlid the opportunity to join the clinic’s Somali women’s basket weaving and support group, which delighted Kahlid.

Dr. Judd then suggested that Kahlid had the potential to learn literacy in Somali and that this might be more realistic than learning English. He suggested that her older children might also eventually be able to teach her more Internet access using Somali, including the use of a translation application. Rahmed volunteered to include this in her treatment plan. The feedback was repetitive on all of these points, with questions answered. We thanked them for their trust and honesty and for the joy of bringing their baby along. Gratefully, Kahlid offered to take the teacups back to the kitchen and wash them for us; we thanked her but declined her kind offer.

Debriefing

At our debriefing, immediately following this 2½ hour appointment, Rahmed explained that Kahlid’s Somali had a MaiMai accent with some MaiMai words mixed in. She had the Bantu appearance of her MaiMai heritage. These things could subject her to some discrimination in parts of the Somali community. We fine-tuned Olga and Mohamed’s interpreter-use skills as well as our rapport- and trust-building strategies. Mohamed and Rahmed discussed some of the dynamics of arranged marriages and of Islamic worldviews, including how that would figure into Rahmed’s therapy with Kahlid. She explained how she would use prayer and family involvement to work on anxiety and phobia desensitization; she assured us that she was experienced in pacing her therapy and that she would unpack Kahlid’s war traumas and the trauma of the attack in Dadaab with a pacing that Kahlid could handle. We discussed possible diagnoses of PTSD and depression and the cultural limitations of DSM-5. We recommended that Rahmed record summaries of their session recommendations on Kahlid’s cell phone and collaborate with her family in training her in accessing them to accommodate for Kahlid’s memory impairment. Rahmed informed us that there is no Somali word for depression and little in the way of a cultural concept of depression.
We reviewed the cyclical fever and chills of malaria, the bitter taste of the treatment of quinine, and the impact of cerebral malaria falciparum. Mohamed, who is interested in neuropsychology, decided to read about it further. Dr. Judd explained how the transparent orthography of Somali contrasted with the opaque orthography of English and how that manifested in the informal reading testing we did. This also factored in our recommendation that Kahlid learn to read Somali.

We acknowledged that, when we were discussing children during rapport building, Olga had referred to her own wife as her husband. We also acknowledged that this suppression of her own identity was an appropriate and valid professional ethics decision made in the interests of building rapport and trust with the clients. We then acknowledged how we all had to suppress our feminist urges in order meet this couple where they were and serve them appropriately. In context, we reviewed the timing of when Olga asked Omar to allow Kahlid to speak for herself, how and when to request to speak to their eldest son, how to ask and when to proceed to separate interviews, and the choice of having just Olga examine Kahlid’s scar. Rahmed affirmed that our behavior and decision-making had been culturally sensitive and appropriate.

We discussed the secondary gain of citizenship and the potential for dishonesty. We reviewed our indicators of validity—indeed independent confirmation of her history including failure to learn English with three years of good effort, the dent in her skull congruent with her history of childhood head injury, her plausible history of cerebral malaria, and her plausible test performance including on an informal performance validity measure.

We reviewed our process in our incidental discovery of her emotional trauma symptoms and our process of referral for treatment. We reviewed precautions in clearly identifying Rahmed’s dual role as interpreter and therapist and when she was switching, the necessity of such roles in small language communities, and the advantage in this context that this couple had the opportunity to get to know her before making a decision, making therapy seem more familiar. We reviewed Olga’s decisions about how far to go in eliciting Kahlid’s memories of her emotional traumas so as to get necessary information while minimizing retraumatizing.

**Report**

In our report to her primary care provider, we recommended precautions regarding the choice of Somali interpreters to avoid possible discrimination against her as a MaiMai. We included recommendations concerning family involvement in her care because of her memory impairment. We recommended that Kahlid might be a candidate for medications such as prazosin, a beta blocker, and/or a selective serotonin reuptake inhibitor for trauma symptoms, but we suggested that medication might best be managed by the refugee clinic’s psychiatric prescriber.

**Follow-Up**

On our next clinic visit, we enjoyed the Somali dessert that Khalid sent to us via Rahmed. In addition, we ran into her at the clinic six months later and she proudly displayed her citizenship certificate. She said via Rahmed, “Now I can talk with Rahmed about what happened, because now I know they can’t send me back.”

**Section III: Lessons Learned**

Although this amalgam case is relatively extreme with respect to the client’s cultural distance from mainstream white US culture, it is nevertheless fairly typical of the Somali refugee population and has many features similar to many other refugee populations. This case description touches on the training of all 13 of the multicultural neuropsychology skills listed above. In our practicum, not
every case touches on all 13 skills, but most cases touch on most of them, and the above description is reasonably typical of such case training experiences.

Clinical training in neuropsychology often begins with the more extreme cases—severe traumatic brain injuries, severe strokes, more advanced dementias or severe developmental disorders. This allows the trainee to see neuropsychological phenomena when they are obvious—severe amnesia, aphasia, left neglect, disinhibition—so that they are better able to recognize these phenomena when they are less obvious—mild memory impairment or word-finding difficulties or mild distractibility. Similarly, training with clients who are culturally quite distant from the trainee such as non-English-speaking adult immigrants, allows for the recognition of, and sensitization to, cultural differences when they are more obvious. This facilitates recognizing them when they are more subtle, such as with English-speaking second or third-generation immigrants.

**Takeaway Points**

1. Neuropsychological cultural competencies include, but go well beyond, the cultural competencies of clinical psychology.
2. Prior knowledge and research about a language and culture are helpful for generating hypotheses and for preparing for modes of communication and rapport. Nevertheless, additional knowledge is typically needed and may be gained from the client, family, other informants, cultural experts, and further research. In the case reviewed here, additional knowledge included information about the MaiMai, Dadaab, Quranic school, arranged marriages, cerebral malaria falciparum, and basket weaving, which was acquired from Kahlid, Omar, Rahmed, Mohamed, and the Internet.
3. Neuropsychological assessment can involve educating and acculturating clients about things that may be culturally unfamiliar like confidentiality, testing, snow, Halloween, and psychotherapy. This process can contribute to trust and rapport.
4. Training for cultural competence is challenging, but it is also quite possible. It often requires departing from our usual clinical habits and reaching out to diverse patient and professional populations geographically, linguistically, and culturally.
5. There are multiple routes to the elusive cross-cultural rapport—respect, common ground, empathetic communication, spontaneity, flexibility, research, pacing and humor. Rapport is a factor in every contact and communication throughout the clinical encounter and beyond. Cultural humility is an important aspect, as well, and may need to be stated (e.g., one way is to apologize for not speaking their language or for bringing up sensitive topics).
6. Training cultural competence is facilitated by going to where the clients are: refugee and immigrant service centers, legal services, community clinics, community centers, and similar institutions, and even into homes, either directly or via teleneuropsychology.
7. Training cultural competence may involve reaching out to interpreters, cultural consultants, allied professionals, and culturally competent supervisors. These approaches can allow for more precise linguistic and cultural services.
8. Diverse trainees also require training in cultural neuropsychological competence, including regarding their own languages and cultures. Those who have learned their own language and culture as small children may not be aware of how these have formed their own belief systems.
9. Diverse trainees can contribute their own knowledge and skills with language and culture in the context of a learning community but should not be used as primary instructors of these skills unless they have been specifically trained to do so.
10. Exercising neuropsychological cultural competencies not only serve our legal and ethical obligations but also serve social justice. And finally, they are tremendously rewarding both personally and professionally.
References


