Introduction

The state of New Mexico is a richly diverse cultural environment within the United States, known for a large number of distinct Native American tribes and pueblos that have inhabited the region for centuries, as well as descendants of the colonial Spanish, who were the earliest European settlers in North America. This chapter began as an attempt to characterize the challenges of neuropsychology practice in this diverse cultural environment. However, it became apparent along the way that the diversity of New Mexico, far from exceptional, may actually be typical of the diversity that is present in most regions if one is prepared to see it.

The most obvious goal of this chapter is to share a model of cultural competence training, based on Reflective Self-Awareness, that is intended to help a culturally informed neuropsychologist find the rich cultural diversity that I believe is present in every region of practice. By actively looking for that diversity and examining culturally based assumptions that can influence attitudes, emotions and behavior, the neuropsychologist is more likely to appreciate the diversity that surrounds us and less likely to commit unintended cultural errors.

My cultural path in neuropsychology was marked by my first job coordinating neuropsychological services at Bellevue Hospital in New York. This was a setting that served large numbers of immigrants from all around the world, so many of the referred patients spoke native languages other than English. It became clear almost immediately that no single neuropsychologist could possibly possess meaningful cultural information about all of the patients we were expected to serve. And even with a “language bank” of nearly 2,000 volunteers, we could not necessarily even communicate effectively with some patients.

Some of the most valuable lessons I learned through that experience had to do with the considerations that had to be faced when working with persons whose language and culture I did not know. I learned that it was important (i) to refine the referral question and clarify realistic expectations for the goals of the evaluation, (ii) to identify cultural and linguistic limitations in the assessment approach and materials that were available, (iii) to gather as much objectively documented history and medical information as possible, and (iv) to be as aware as possible of my own underlying cultural assumptions, knowing that those assumptions would potentially influence any clinical interactions and interpretation of the testing performance.

“Universal Precautions” and Reflective Self-Awareness

The years I worked in New York (1985 to 1991) were a critical time in the AIDS pandemic. The causal virus, HIV, had not yet been identified, and effective treatments were still on the horizon. Fear of contagion was creeping throughout the city, and increasing discrimination was being...
leveled against already-marginalized groups that were sometimes labeled the “Four H’s” (hemophiliacs, heroin addicts, homosexuals, and Haitians), all of whom were perceived to be agents of infection. However, in 1985, the Centers for Disease Control (CDC) issued a set of public health guidelines called “Universal Precautions.” This new policy called for health care workers to treat all bodily fluids as potentially infectious. By following such policies, some of the discriminatory practices toward targeted groups gradually subsided since the public was taught to treat every patient the same, without knowing anything about their health status.

By the time I moved to New Mexico in 1991, I recognized that, even with the challenge of getting to know the major cultural communities in the state, I was never going to learn all I would want to know about the various sub-groups of Native American and Hispanic communities. By that point, however, I also realized that, even if I had knowledge of “typical” characteristics of persons from a specific cultural community, I would still have to learn from each specific client in what ways they were or were not typical of that culture. This point was driven home for me when I once asked a Navajo woman, in my most culturally sensitive manner, whether she thought traditional Navajo ways of healing would be helpful for addressing her issues. She replied, “No. My family is Baptist.” In my mind, this cultural blunder will always represent a classic example of an unnecessary cultural error, which resulted from my own unexamined cultural assumption that all Navajo people would value traditional ways of healing. The assumption was based on a stereotype, of course. But the error drove home the importance of assuming that every interaction has potential cultural significance.

The cultural approach of “Universal Precautions” that I try to apply to the work of neuropsychology is to assume that every interaction has potential cultural significance. From a cultural perspective, then, I treat all patients the same, assuming that every patient has a rich and unique cultural identity that I cannot know unless they let me know. Whether the client is Hispanic, Native American, Anglo, Asian American, African American or any other ethnicity, the lesson I have learned in New Mexico is that, when I assume that all of my clients have interesting and unique cultural backgrounds, they are able to teach me about their interesting and unique cultural backgrounds.

Culturally Competent Practice in Neuropsychology

Neuropsychology still has a long road ahead to meet the challenge of fully integrating cultural competence into the routine practice of neuropsychology. However, the road to that destination is illuminated by increasing visibility of cultural diversity issues in educational forums and journals, as well as policy and advocacy work in the large professional organizations that represent neuropsychology. For example, the American Academy of Clinical Neuropsychology (AACN) published Practice Guidelines for Neuropsychological Assessment and Consultation that specifically called attention to practice guidelines for addressing cultural and language issues in underserved and diverse populations. Those guidelines generally focused on the importance of taking unique cultural, language, and ability information into account and called attention to the risks associated with the administration and interpretation of tests with individuals for whom insufficient test adaptations, normative data, or validity studies exist. The same practice guidelines emphasize that neuropsychologists who agree to evaluate members of diverse populations should have experience in administering and interpreting procedures that are relevant for the patient in question, and they should take care to report on the methods and effectiveness of their efforts to communicate with the examinee. Interpreter-mediated communication should include culturally mediated meanings, affective tone, and nonverbal “body language” in addition to literal content. Practical elements in the guidelines remind us that culturally competent neuropsychologists avoid...
using family members, friends, or other untrained individuals as interpreters and emphasize the importance of considering threats to validity that can be introduced by cultural bias in both translated and adapted instruments. Neuropsychologists are also reminded, when working with populations for whom tests have not been standardized and normed, to make use of direct observation, with particular consideration of adaptive functioning within the “real-world” community of the examinee.

Rivera-Mindt, Byrd, Saez and Manly summarised a proposal for increasing culturally competent neuropsychological services for ethnic minority populations. This was based in part on Sue’s conceptualization of cultural competence that emphasizes (i) self-awareness of one’s own assumptions, values, biases, and stereotypes about ethnic minorities and how such beliefs and attitudes could negatively impact the provision of neuropsychological services; (ii) knowledge and understanding of one’s own worldview and that of the perspective and culture of one’s clients; (iii) acquisition of specific and culturally appropriate skills for assessment, intervention and communication to effectively work with ethnic minority groups, and (iv) development of core cultural competencies at the organizational level, based on theories, practices, policies, and organizational structures that are responsive to all groups. Rivera-Mindt et al. reviewed historical foundations and applicable ethical guidelines that are addressed in ethical standards having to do with boundaries of competence. Practical limitations were identified, having to do with the relatively small number of neuropsychologists who self-identify as culturally competent as well as other health disparities for ethnically diverse people. Recommendations were offered to remedy the “broken pipeline” of neuropsychologically trained professionals from ethnically diverse groups by expanding training opportunities at the early stages of professional development for neuropsychologists from diverse backgrounds. Four goals were identified including increasing multicultural awareness and knowledge within neuropsychology, increasing multicultural education and training, increasing multicultural neuropsychological research, and increasing provision of culturally competent neuropsychological services for ethnically diverse people.

More recently, Fujii has introduced the ECLECTIC framework for conceptualizing different facets of culture that are pertinent for understanding a culturally diverse client and how these facets can impact performance on a neuropsychological evaluation. The components of the framework include E: Education and literacy; C: Culture and acculturation; L: Language; E: Economics; C: Communication; T: Testing situation: Comfort and motivation; I: Intelligence conceptualization; and C: Context of immigration.

Increasing Self-Awareness of Cultural Assumptions

Sue’s multidimensional model of cultural competence reminds us that, as human beings, the attitudes, beliefs, biases, stereotypes and prejudices we hold are based on a foundation of underlying assumptions about the world. These assumptions reflect a worldview and perspective that is nurtured and grows out of the unique cultural matrix in which each individual develops and lives. This is the same cultural matrix through which information, attitudes and beliefs are filtered, consciously or not, with the potential to influence each individual’s behavior, emotions and interactions with others in the environment of the real world.

These underlying assumptions about the world and about the people with whom we interact may be implicit or explicit, conscious or unconscious. They may be questioned or unquestioned, denied or embraced. But they are nonetheless ever-present, persistently influencing behavior and interactions, whether or not the individual is aware of their existence. It follows that the more we can be aware of our own underlying cultural assumptions, the better we might be able to manage our behavioral and emotional responses. If we can recognize culturally sensitive issues when they
arise, we have a better chance of responding in a deliberate and intentional way that can lower the risk of unintended cultural errors.

**Responsibility for Management of Cultural Factors within the Professional Relationship Rests with the Neuropsychologist**

Responsibility for managing cultural factors in a professional relationship rests squarely in the hands of the neuropsychologist, who generally holds greater power in the relationship and has both a professional and ethical responsibility for integrating cultural competence into their practice. Whether or not the neuropsychologist explicitly recognizes and is aware of any critical cultural assumptions that might influence their professional interactions, the neuropsychologist must still take responsibility for any cultural errors that develop by having failed to identify and clarify the unexamined assumptions. A culturally competent neuropsychologist, then, must bear responsibility for actively examining and identifying to the greatest extent possible any underlying cultural assumptions that might be relevant to an effective outcome in a professional interaction.

**Reflective Local Practice**

A specific training model is presented below, as well as some tools that are intended to add to the effort to increase multicultural awareness and knowledge as well as multicultural education and training in neuropsychology. This model is particularly focused on the expectation that a culturally competent neuropsychologist should be able to identify and be aware of underlying cultural assumptions that are likely to influence their professional interactions.

The name, Reflective Local Practice, is a mnemonic for elements of a model that emphasizes awareness of underlying assumptions, attitudes and bias through reflective introspection. Knowledge of the local culture, traditions, and language of the region is encouraged, as well as the development of professional skills and communication that are needed for the culturally competent practice of neuropsychology.

**Development of a Cultural Diversity Training Model**

This model grew out of a cultural diversity training seminar for psychology interns and postdoctoral residents that was developed at the Albuquerque VA Medical Center over 20 years ago. The consortium-based psychology internship training program was accredited in 1993, in partnership with the local offices of Indian Health Service (IHS) and the University of New Mexico Medical Center. Working in collaboration with my colleague, Evelyn Sandeen, we initially designed a program of cultural diversity seminars that included a series of speakers who represented various ethnic and sociocultural groups from the local area. The series was well-received and helped trainees adjust successfully to rotations in the VA, University Hospital, and IHS settings that served the 1,000-year-old pueblo village of Acoma (Sky City), about 50 miles west of Albuquerque. However, after a few years, we felt our program was falling short of our goal for trainees to acquire a broader degree of cultural competence that would prepare them for culturally competent practice in any region of the country or world. We knew that many of our trainees would eventually move on to work in other regions, and we wanted to offer cultural diversity training that would help trainees hit the ground running, and find their cultural bearings, wherever they might land.

A review of our program helped us realize that our training model had primarily emphasized the knowledge and skills components of Sue’s multidimensional model of cultural competence, but frankly, we had neglected the important component of self-awareness. The seminar schedule had
been filled with monthly presentations of knowledge and information by cultural “experts” who represented various cultural groups in the region. The training and supervision we had provided were designed to develop professional skills in interview, communication and interventions. But we did not have a systematic approach to emphasize self-awareness of culturally based assumptions. Our review concluded that the cultural diversity training we had provided up to that point had lacked any systematic or coherent approach for helping trainees explore and identify their internal sources of bias, prejudice and unexamined assumptions that might seep into the interactions of a professional relationship. We also identified the need to develop more effective tools for discussing difficult issues.

Goals for a Cultural Diversity Training Model

Based on our program review, we resolved to design a training model that would (i) be relevant and adaptable to serve any cultural group in any geographic region; (ii) provide tools that would help training participants improve culturally based communication and minimize unintended cultural errors; and (iii) help psychologists understand their professional responsibility for identifying and managing cultural factors in any professional interaction.

Six Assumptions of Reflective Local Practice

In addition to the goals set forth above, the Reflective Local Practice model is based on a set of six assumptions, all of which are discussed in Sandeen, Moore and Swanda. These six assumptions are summarized here, with specific application to the practice of neuropsychology:

1. Everyone has a culture. Although it seems unnecessary to state that “Everyone has a culture,” it is not unusual to realize in the course of the discussion that some training participants hold a very narrow sense of “culture,” as if culture refers only to “others” who are different from themselves. Some training participants have wistfully expressed regret that they did not grow up within a rich and diverse culture. In my experience, the failure to appreciate the universality of culture is not usually a consciously formed belief but an unquestioned cultural assumption that comes from a place of naivete.

   In New Mexico, discussion of cultural identity offers an opportunity to discuss the diverse and complex cultural identities that are represented in this state. If a neuropsychologist in this region wants to understand the cultural heritage of a client, they would be well-advised to listen carefully and ask delicately, not knowing what underlying emotions might be associated with the topic. For example, “Native Americans” in this state are represented by at least 23 sovereign tribes, including Navajo, Apache, and 19 distinct Pueblo tribes, who may or may not share significant cultural traditions or language. Among Spanish-speaking New Mexicans, those who identify as “Hispanic” commonly regard themselves as direct descendants of the Spanish conquistadores, many of whom proudly trace their family lineage many generations back to the earliest European settlers in North America. Mexican Americans usually identify with Mexican roots, even though their families might have lived several generations in the region. The terms “Latino” or “Chicano,” when used in New Mexico, usually encompass geographically broader Spanish-speaking populations and are often used with connotations of political activism. Many New Mexicans also identify with mixed heritage, in combination with Pueblo, Navajo or other Native American tribes, although even within the same family, some members might embrace mixed heritage while others strongly identify with only one side of their culture. Some Hispanic New Mexicans have embraced the cultural identity of “hidden Jews” or “crypto-Jews,” after learning that their ancestors had been persons of the Jewish faith who had fled Spain in the aftermath of the Spanish Inquisition.
Rex M. Swanda

2 Individuals exist within a matrix of intersecting cultural identities. This model emphasizes that cultural identity is based not only on racial and ethnic identity but also encompasses a complex matrix of intersecting biologically and socially defined roles, relationships, and affiliations. The term intersectionality was originally used in 1989 by Kimberle Crenshaw to call attention to multiple overlapping, or intersecting, social identities that are associated with discrimination and oppression, especially among women of color. The concept of intersectionality has since been applied more broadly by others, including Cole, who has discussed the concept in the context of research in psychology. In this Reflective Local Practice model of training, participants are asked to consider their own cultural identity in light of intersecting socio-economic factors, education, employment, religious affiliation, sexual and gender identity, as well as family roles (parent, child, sibling). We ask them to explore their own cultural identity through the lens of “family culture,” such as mealtime traditions (who ate together, was there any discussion, and if so, what topics were acceptable or unacceptable for discussion), household rules, and family secrets. We also prompt participants to consider cultural characteristics that might have been instilled through developmental experience with any community and social groups with which they were affiliated.

The diversity of cultural identities in New Mexico also consists of a complex network of intersecting cultural identities. The description of Native American and Hispanic New Mexico above fails to acknowledge the many other ethnic groups that make up the rich diversity of this state, including the Anglo and African American communities, Asian Americans, and other Latin American cultural communities that may not fit neatly into any of those groups. Other distinct cultural communities in New Mexico include the LGBTQ+ community, as well as many veterans and active military service women and men, for whom military and veteran culture is their primary cultural identity. Communities of differently abled persons include, but are not limited to, persons with hearing impairment, as well as persons who live and work with spinal cord injuries. Most spiritual and religious identities are represented in the state, including Latter-Day Saints, many versions of Christianity, Judaism, Islam, and others. Harder to classify, but no less valid as a cultural identity include increasing numbers of people who might identify politically and culturally as liberal or progressive and show up for a Black Lives Matter protest, or those who identify with conservative, white supremacist or the gun culture of nationalist militia groups.

In our training, information about the diverse culture of New Mexico is presented by representatives of many of these cultural communities. We encourage trainees to get out into the community to learn about local culture through restaurants, festivals, music, Pueblo feast days and local museums. However, we also emphasize that the example of their approach to cultural exploration in New Mexico is intended to serve as a template that can enhance their appreciation for future cultural experiences in any other setting.

3 Culture is ever-changing. Social and political changes are ongoing in local communities, the nation and around the world, most of which impact the cultural identities of individuals in some way. Changes in an individual’s underlying attitudes and beliefs can be related to age and changing economic status of an individual, while national or world events, such as the current world-wide pandemic, might result in significant shifts in cultural attitudes and beliefs among many individuals or across entire cultural groups.

4 Bias is universal. A fundamental part of this cultural diversity training model encourages training participants to accept that bias, stereotyping, and formation of prejudicial attitudes are normal outcomes of the human struggle to develop schemas and make sense of the world. These normal, implicit processes of grouping and categorizing begin in our earliest
development and continue throughout our lives. However, the insidious aspect of bias, prejudice, cultural blindness and other cultural assumptions is that they are woven so tightly into the fabric of our cultural selves that we often cannot even be aware of their existence, much less their origins, unless we consciously turn our attention to look for what is there. Consequently, this training model recommends that neuropsychologists who are committed to cultural competence should use some of the tools that are described below to develop professional habits that can help them consciously explore underlying attitudes and assumptions in order to more explicitly take potential sources of bias and prejudice into account.

5 **An understanding of group power structures and history is a crucial foundation for cultural competence.** Although there is a tendency to view bias, prejudice, and discrimination through the lens of race and ethnicity, we encourage training participants to consider the effects of power and powerlessness as the foundational basis for *white privilege*, bias and discrimination. In the state of New Mexico, for example, discrimination and prejudice can be found among cultural groups with superficially related ethnic identities. A person from a generations-old Hispanic family might express prejudice against first-generation “Mexican-Americans,” with the same complaints (e.g., “They will take our jobs”) that are often leveled against immigrants in many other societies, regardless of race or ethnicity. Many examples can be found around the world, in which persons from related ethnic communities display prejudice or discriminate against persons of different religious or political beliefs, usually in association with the relative power of the oppressor in relation to the powerlessness of the oppressed. Colorism is not uncommon, in which persons with relatively darker skin tone experience prejudice or discrimination from others within the same ethnic community. Persons who identify as LGBTQ+ around the world have certainly experienced the effects of prejudice and discrimination at the hands of persons who otherwise share significant cultural identities of race and ethnicity.

6 **Cultural competence is a foundational aspect for the ethical practice of neuropsychology.** Basic ethical principles of beneficence and nonmaleficence call for neuropsychologists to do no harm, and a general goal of cultural competence in this Reflective Local Practice model is to avoid cultural errors that might inadvertently bring harm to a professional relationship. Integration of cultural competence into neuropsychology practice should be considered a core standard of practice, especially in light of AACN’s 2007 publication of practice guidelines that specifically addressed underserved and diverse populations. Those guidelines have put the field of neuropsychology on notice that there is an ethical obligation to practice in a culturally competent manner.

**Hot Spots, Blind Spots, and Soft Spots**

**Identifying Barriers and Resistance to Necessary But Difficult Cultural Discussions**

In order to help training participants take responsibility for identifying and managing cultural factors in their professional interactions, we knew it would be important to identify barriers and resistance that would be likely to arise in the discussion of difficult issues. Silence or reluctance to engage is a common barrier to the productivity of difficult but necessary cultural discussions. Whether the reluctance to engage is driven by fear (e.g., fear of sounding foolish or expressing inappropriate or socially undesirable statements) or lack of effective communication skills, an important goal of this Reflective Local Practice training model has been to provide some tools to facilitate communication in discussions of challenging cultural issues.
In order to lessen the impact of defensive, shy, or fear-based reactions to discussions in cultural diversity training, we wanted to come up with a more neutral vocabulary that participants could use to talk about strong emotional responses that often emerge as a natural part of any cultural discussion.

We laid the groundwork for introspection and self-disclosure in our discussions by emphasizing in our six assumptions that bias is universal. As human beings, we reflect the product of our cultural influences, which include bias, prejudice and stereotypes, all of which are human cognitive tools that are used to categorize and bring order and perspective to the chaotic world into which we are born.

With a nod to the power of language, we also reasoned that if we could find a less emotionally evocative language with which to communicate about strong emotions, we might be able to help training participants engage more effectively in these “difficult but necessary” cultural conversations. With this goal in mind, we adopted the terms hot spots, blind spots, and soft spots to help training participants be more aware of culturally based assumptions that have the potential to influence their behavior, emotions and interpersonal interactions and to facilitate the expression of those culturally related concerns in group discussion.

**Hot Spots** are areas of strong emotional sensitivity, often borne out of trauma or developmental experiences, which have the potential to evoke strong emotional responses. In Sandeen, Moore, and Swanda, we write that “Hot spots may arise when persons who have experienced powerlessness in certain areas of their lives have understandably strong emotion associated with that dimension.” We also note that “Strong emotion is a normal reaction to having been powerless, oppressed, or harmed.” Some common examples of hot spots include:

- A person of color avoids reacting to perceived slights and microaggressions while having a drink at a bar but simmers internally, with racing thoughts and fears that any overt response might result in a bad outcome. The hot spot involves feelings of powerlessness and oppression that are related to their perspective of historic bias and discrimination toward the ethnically diverse aspect of his or her cultural identity.
- A gay professional is momentarily distracted, wondering what his client thinks about him after she describes her new hair stylist with the comment, “He’s so flamboyant – you know, ‘that way!’” The hot spot, in this case, involves instinctive fear of being discovered and feelings of powerlessness associated with the sexual orientation aspect of his cultural identity.
- A woman considers whether she should speak to Human Resources after her supervisor comments that he really likes it when she dresses this way. She is torn between her interest in putting a stop to personal comments and fear that it would hurt her chances for a desired change in her work assignment. The hot spot here involves feelings of pent-up anger, resentment and powerlessness associated with her supervisor’s condescending attitude and objectification of the female aspect of her cultural identity.

By normalizing and humanizing the experience of strong emotions, training participants seem much more receptive to the idea of introspectively examining their inner emotional self in order to identify their own “hot spots.” In the context of cultural diversity training, the goal is not to embark on a therapeutic experience but to encourage participants to engage in the reflective experience of scanning their inner emotional self for “hot spots,” which they are not necessarily expected to share with the group. Participants typically respond quickly and intuitively to the term, and in later discussion, it has not been unusual for a training participant to share that a
discussion comment had tapped into a “hot spot.” The term normalizes the presence of strong emotional triggers and offers a rational way to refer to or think about the trauma associated with those triggers.

**Blind Spots** are found in those aspects of life that are taken for granted by an individual or a class of people that have never had to confront a challenge or a barrier in that area, usually due to higher levels of privilege, power or authority in an environment of unequal power. In Sandeen, Moore and Swanda, we wrote that “Blind spots refer to those situations in which a psychologist is unaware of relevant cultural information regarding the client because of unexamined assumptions related to the psychologist’s own background.” We added that “Blind spots tend to occur in dimensions of experience in which the person has held relative power.”

- Many of our training participants, who were raised with an expectation for achieving a college education, have been able to acknowledge their own blind spots having to do with education, in failing to appreciate the struggle that many of their clients face to finish high school, let alone go on to college, especially in an era of skyrocketing student debt.
- One of our trainees once shared the shame they felt upon discovering how “blind” they had been to the challenges faced by a client who had incurred a third “no show” appointment. After entering a termination of treatment note, due to the “no shows,” the intern revealed that they had “assumed” and taken for granted that the client had convenient transportation when, in fact, the client had to arrange for someone else to look after a relative with dementia and a pre-school child, while allowing about an hour and a half each way to negotiate a series of bus lines. In this case, a culturally competent approach might have avoided the blind spot of assuming that our clients have the financial means and support to arrange for easy transportation with coverage for family care needs.

**Soft Spots** refer to those instances when unexamined assumptions lead to deviations from usual practice, usually having to do with lowered expectations or overidentification with a client. Soft spots often reflect a perceived power differential in either direction. A person who is perceived as holding more power might feel sympathy for a less powerful person or might make special accommodations for a person who is perceived to be more powerful. Soft spots can be subtle and difficult to identify but may be present when a professional is considering altering their usual practice in a way that might violate professional boundaries or pose ethical risks. The following examples involve scenarios in which cultural factors may or may not be obvious central issues but illustrate the role that differential power relationships can play in professional decision-making.

- A neuropsychologist, who ordinarily sees clients only in the office, would be advised to introspectively check for “soft spots” in their underlying attitudes, beliefs and assumptions if they agreed to make an exception and instead meet at a coffee shop for an initial “interview” with a client who was perceived to be wealthy and powerful.
- A prescribing provider should consider whether any unexplored “soft spots” might contribute to their decision to “make an exception” to continue a prescription for Valium for a patient who reminds her of a beloved aunt who had suffered from a “nervous disorder.”
- A psychology instructor realizes that he is inclined to find a way to justify a passing grade for a very engaging young Hispanic man, who is the first person in his family to finish high school and attend college, even though he has performed below objective standards for passing. The instructor wisely takes a step back to consider whether his own internal biases and sympathies (soft spots) might be contributing to his decision-making process.
Applying Reflective Self-Awareness to Your Professional Practice

Like most of our development throughout training and professional practice, the process of incorporating new ideas and skills usually begins by consciously and explicitly considering and evaluating those new ideas. If the idea of reflective self-awareness is intriguing enough to explore further, then the next step would be to find ways to incorporate those ideas and skills and apply them as a routine part of your practice. We all have our own unique styles of learning and growing professionally. But, if you think that “reflective self-awareness” might have value for improving cultural competence in your practice of neuropsychology, please consider the following three suggestions for incorporating reflective self-awareness into your practice routine.

Perform a Cultural Self-Assessment

A matrix of cultural influences is presented in Table 3.1 to help identify some of the multiple, overlapping aspects of our own cultural identities as neuropsychologists. As an exercise in cultural self-assessment, examine the cells of the matrix in Table 3.1 and identify the various dimensions that you would consider to be important aspects of your own cultural identity. Some people might identify one or two dimensions that strongly contribute to their cultural identity, while other persons might select 6 or 7 dimensions as important aspects of their cultural identity.

As discussed earlier in this chapter, “power” and “powerlessness” are thought in this model to be critical modifiers of the various dimensions of cultural identity. To better understand the way that power modifies the cultural experience that is associated with each of these dimensions, rate each of the dimensions you selected according to the degree of power that you would associate with that aspect of your cultural identity. Keep in mind that “power” in this exercise refers to the degree to which a person has felt more or less powerful in each of the dimensions.

Table 3.1 Intersectional matrix: Dimensions of cultural identity

<table>
<thead>
<tr>
<th>Social class</th>
<th>Sexual orientation</th>
<th>Gender identity</th>
<th>Education level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family role</td>
<td>Looks/body type</td>
<td>Geographic origin</td>
<td>Veteran status</td>
</tr>
<tr>
<td>Profession/work/retirement</td>
<td>Political affiliation</td>
<td>Religion/spirituality</td>
<td>Health/disability</td>
</tr>
<tr>
<td>Survivor status</td>
<td>Race</td>
<td>Ethnicity</td>
<td>Age</td>
</tr>
</tbody>
</table>

Source: Adapted from Sandeen, Moore, and Swanda.

Assign ratings of power to each of the dimensions that contribute to your cultural identity:

(+ powerful = your experiences in this dimension have given you power and privilege over others; this may predispose you to a BLIND SPOT or, under certain circumstances, a SOFT SPOT

(0) neutral = your experiences in this dimension have been neutral regarding power over others (are you sure?)

(−/+ mixed = your experiences in this dimension have both given you power over others and others have had power over you; this may lead you to inconsistent reactions

(− powerless = your experiences in this dimension have put you in a one-down position relative to others; this may predispose you to a HOT SPOT or if shared with your client, a SOFT SPOT

We have assigned self-ratings of power that range from “Powerful” (+), “Neutral” (0), “Mixed” (+/−), and “Powerless” (−). Each of these ratings of power, especially on the extreme ends of
“powerful” and “powerless,” are likely to be associated with the various “spots” that have been discussed above. Persons who have experienced less power in some dimensions of cultural identity would be more likely to identify “hot spots” within those dimensions.

Consider an example of a “hot spot,” which tends to be associated with feelings of powerlessness, helplessness or trauma in certain dimensions:

Board certified neuropsychologist Gloria Martinez was elated when the department chair called her in to tell her that she had been selected to take on the leadership role for a challenging clinical service, with a significant increase in pay and benefits. She had worked for such a long time to reach this goal, and this was one of her best days in a long time, being congratulated by so many colleagues. As she came down a hallway, however, she heard an unseen but familiar voice from around a corner comment that, “It must sure be nice to benefit from affirmative action.” Dr. Martinez immediately felt crushed and deflated and decided to skip meeting her colleagues for a celebratory Happy Hour, because she thought none of them would understand. A few weeks later, she found herself in a cultural diversity training, reflecting on a matrix of aspects of cultural identity. She had rated several cultural dimensions as “Powerful,” including dimensions of Education, Profession, Spirituality and her Family Roles as a responsible daughter, a strong mother, and a loving wife. She had identified another aspect of her cultural identity as “Hispanic” and wanted to mark Powerful, when she thought of the pride she felt for her traditional culture. But when she thought about the broader socio-economic structure of the country, and her personal experiences as an occasional target of racial discrimination, bias, and microaggressions, she had to admit to herself that she would rate any race or ethnicity besides white as “less powerful.” She suddenly recalled the recent incident of micro-aggression, when the words of one person had had the effect of dampening her joy on what should have been one of the best days of her life. In that moment, she understood how the feelings of powerlessness she had felt as a target of discrimination and bias over the years had come to represent a “hot spot” within the matrix of her cultural identity. She resolved to use her increased self-awareness of that “hot spot” to anticipate and better manage situations that might arise in the future. She considered alternative responses, such as confronting a “micro-aggressor,” moving ahead with positive plans, and seeking support, and she began to feel as if she could reclaim her sense of self-esteem. She resolved to continue to find ways to take care of herself in the future.

Persons who rate themselves as more powerful in certain dimensions may be predisposed to experience “blind spots” in those areas:

Neuropsychologist Ted Smith rated dimensions of “Education level” and “Profession/Work” as “Powerful” aspects of his cultural identity, because he is proud that he has met his goals for an advanced degree and he is aware that he has attained higher levels of education than most of the people he knows. He also feels fortunate to work in a profession he loves. After performing this Cultural Self-Assessment exercise, however, he began to think about a client who had reported that she had recently completed an Associate’s degree. He realized with chagrin that he had followed up in the interview by asking whether she had any plans to “finish” her schooling with a Bachelor’s degree. He worried that this question might have conveyed an attitude of discounting her achievement, as if her Associates degree was not “good enough.” Upon reflection, he realized that his response probably did represent a “blind spot” in his assumptions, and an attitude of bias. He was able to acknowledge that the phrasing in his question reflected unexplored cultural assumptions that 1) of course, anyone would naturally
have a goal of completing as much education as possible, and 2) anyone (in his worldview, at least) would be capable of meeting the significant financial and time demands that additional education might require. He resolved to take steps in the future to avoid repeating this potential “cultural error” by revising his interview template to include more culturally-sensitive questions. Instead of asking how many years of education they had completed, he would ask clients to describe their goals in education or work and how far they had progressed toward meeting those goals. Rather than making unwarranted assumptions about their goals, he thought he could follow up by asking clients if they face or anticipate any barriers that would get in the way of meeting their goals.

Another scenario provides examples of hot spots, blind spots, and soft spots that are associated with different dimensions for the same individual:

Frank Thomas left school in 11th grade, and went on to build a successful business with 50 employees. In a cultural diversity training exercise, he completed a matrix of cultural identity, indicating that he felt less powerful on the dimension of education. In fact, he was aware that he would usually shrink away from discussions having to do with past school experiences. However, as a leader in the business community, he assigned a very powerful rating on the dimension of Profession/Work. During discussion, he thought that he might identify the dimension of education in his own cultural identity as a “hot spot,” in which he feels less powerful compared to most of his associates. He also recalled a couple of times in the past when he had angrily reacted to someone “with a fancy degree.” When he considered the dimension of work/profession, however, he realized that he had exhibited a “blind spot” toward others in the past who were struggling to find work in times of economic distress. Without previously realizing where his attitude was coming from, he could see how unsympathetic he must have sounded, by making comments that he expects people to “make it on their own,” and “pull themselves up by the bootstraps,” just like he had to do. However, he thought that he had acted in a sympathetic way that might have represented a “soft spot” by passing over a highly educated job applicant and instead, “giving a break” to a person who, like himself, had struggled through school. He didn’t know whether that had been the right thing to do, because his usual hiring policy was to take education into consideration, but he had to admit that this person had impressed him because he reminded him of himself.

Provocative Questions

Another way to explore various dimensions of cultural identity is to consider questions about culturally based values and assumptions that were probably formed and reinforced through early experiences within the family and cultural community in which a person was raised. The article by Sandeen, Moore and Swanda7 provides a link to supplemental training materials that include a long list of “Provocative Questions” that have been used for discussion in cultural diversity training. Some examples of those questions include:

- What was the attitude toward education in your family?
- Describe an experience when you became acutely aware of cultural differences between yourself and those around you.
- Describe an experience when you became aware of cultural differences between how you were raised and how you had developed as an adult.
- Describe a professional experience in which you made a “cultural error.”
• Describe a prejudice or bias that you acquired in childhood.
• Describe a time when you felt shame about some aspect of your family of origin.
• Describe a time when you felt hurt or damaged by cultural blindness on someone else’s part.
• Did your parent enjoy his/her work?
• What were your parents frightened of? How did you know this?
• How was emotion handled in your family? Which emotions were “allowed” and which were not?
• What was your family’s attitude toward the armed services? Were there veterans in your family?
• What group did your parents talk bad about behind closed doors? What was the “cover” or “core” issue they did not like about this group?
• Are there rituals or customs that you had as a child that you miss today? Any rituals or customs that you are glad to have shed?
• What was dinnertime like in your family? Who cooked, if anyone? Were you all together? Were there discussions or arguments or mostly silence?

These questions are designed to evoke reminders of past experiences that a neuropsychologist might not typically think about in the realm of “culture.” But where else would our values, prejudices, biases and other attitudes come from? And the very reason these questions are posed is to provoke consideration of unexplored cultural assumptions, to identify those assumptions, to better understand what the assumptions represent, and to explicitly decide how to express the assumptions. This is the main goal of reflective self-awareness, to make implicit assumptions explicit and to explore previously unexamined assumptions.

Establish a Habit

For those neuropsychologists who are interested in developing a more culturally competent professional practice, I recommend starting with one small behavioral change that will establish a new habit. For example, neuropsychologists frequently deal with templates and forms for data collection, summarizing results and reporting conclusions. I suggest that the route to increased self-awareness can be as simple as making a few strategic changes to templates that are routinely used in professional practice. For example, in a previous scenario dealing with “hot spots” about a person’s education, it was suggested that questions about education and occupation could be altered to emphasize a client’s goals and barriers to those goals. This kind of a small but intentional change to a form might serve as a sufficient reminder that would reverberate throughout the rest of a clinical interview. One intentional change to an interview question might serve as a starting point to remind the neuropsychologist to think a little more explicitly about the cultural assumptions that underlie other questions. This change can have the effect of helping the neuropsychologist to be more sensitive to “blind spots” or to watch for culturally significant comments and questions that might otherwise have the potential for offending or discounting.

Summary

As a concluding reminder, this model of cultural competence suggests that increased self-awareness through reflection on unexplored cultural assumptions can improve a neuropsychologist’s cultural competence and enhance cultural understanding between the neuropsychologist and client. Although it will always be an advantage to gather as much information as possible about the cultural traditions and practices of our clients, the neuropsychologist’s level of cultural competence
can also benefit from any opportunity to engage in reflective self-awareness. The more self-aware we can be of our own cultural identity and cultural assumptions, the more sensitive we can be toward others. By observing these cultural “Universal Precautions” and routinely examining the assumptions we bring to interactions with every client, the more successful we will be in engaging with all clients in culturally competent practice.

Glossary

Conquistadores. Literally, “conquerors” refers to explorers and soldiers of the Spanish and Portuguese empires who brought colonialism to many parts of the world, especially including present-day Spanish and Portuguese-speaking areas of North America, South America, and the Philippines.

Cultural error. Similar to microaggressions, cultural errors involve indirect or unintentionally offensive behaviors or remarks made toward persons of a different culture. Cultural errors typically reflect lack of cultural awareness and result when unquestioned cultural assumptions are acted upon.

White privilege. Advantages in social and economic power that are automatically conferred on white persons that are not shared by persons of color in an inequitable social structure.

References