Cultural Diversity in Neuropsychological Assessment
Developing Understanding through Global Case Studies
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A Cultural Approach to the Development of Neuropsychology in Cuba


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Section I: Background Information

Terminology and Perspective

Neuropsychology practice is highly influenced by population characteristics typically related to the diversity of ethnicity, language, educational level, values, socio-economic status (SES), and population health. In our perspective, in order to address neuropsychology practice, each of those factors needs to be taken into consideration to understand that higher mental functions are based on a complex dynamic system with a social origin. In this chapter, we address current neuropsychology practices in the Cuban population by sharing our perspective as neuropsychologists and neurologists practicing in Cuba.

Geography

Cuba is a Caribbean Island located in the northern Caribbean Sea at the confluence of the Gulf of Mexico and the Atlantic Ocean. It constitutes the largest island in the Caribbean and is the 17th largest island in the world by land area. The local climate is warm, tropical, and moderated by northeasterly trade winds that blow year-round. Cuba’s population is currently 11,193,470 inhabitants, with the highest population density in the capital city of Havana, with a total of 2928.1 inhabitants per km.

History and Ethnography

The Cuban population is very diverse in its origin and is made up of various ethnic groups. Population ancestry includes European and African and to a lesser extent (<3%) other populations such as Native Americans and Asians. Self-identified races include whites, blacks, and mulatos, where the latter group is described as the result of mixture of the first two population groups.

Population diversity in Cuba was shaped by Spanish colonization. Due to the systematic disappearance of the native Cuban population as a result of slavery, African origin populations were introduced to Cuba by Spanish Conquistadores to increase the workforce and expedite exploits for the Crown. African populations and Spanish conquistadores were also ethnically diverse. Africans in Cuba were originally from the west coast of Africa, the Gulf of Guinea, and southern Angola. A small proportion were brought from the central region of the African continent. Spanish settlers came from Valencia, the Canary Islands, Asturias, Galicia, Andalusia, Catalonia, and Castile. This process resulted in a great mixture amongst the people and the creation of a multicultural and multi-ethnic population.

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According to the last census carried out in Cuba in 2012, the Cuban population was anthropologically classified as white (64.0%), black (9.3%), and mestizo, the vast majority, mulatto (26.6%), and Asians 1.0%. This admixture process created a very strong transculturation process that shaped the Cuban culture, with influences from exchanges with and between multiple cultures. Modern Cuban culture is therefore the result of an active transition between the confluent of Iberian European (white), Central West African (black) components, with influences from other Chinese cultures. This cultural influence is manifested above all in a diversity of music (danzon, chachacha, salsa, jazz, rumba), dance (Spanish dance, casino or Cuban salsa, ballet, folklore), and food with a variety of flavors. The influence of the admixture process in the culture also shapes the personological characteristics of the Cuban population to be more supportive, happy, affective, sociable, and uninhibited during social interactions. These idiosyncratic characteristics may create confusion for professionals from other cultures who may see these traits as part of a Behavioral Psychological Symptom of the disease (e.g., disinhibition in frontotemporal dementia.

Immigration and Relocation

Immigration has played a unique role in the island, experiencing extensive diasporas in the last century, especially in the United States, and establishing well-known and large communities, in Miami, New Jersey, and Texas. Migrants are often young, and their departure has re-shaped the population structure, and as a result, the age structure of the population has changed significantly.

Language

Spanish is the official language of Cuba. Although there are no local dialects, the island’s diverse ethnic groups have influenced speech patterns. Africans, in particular, have greatly enriched the vocabulary and contributed the soft, somewhat nasal accent and rhythmic intonation that distinguish contemporary Cuban speech. Some words are of native Indian origin, and a few of these—such as hamaca (“hammock”)—have passed into other languages. Many practitioners of the Santería religion also speak Lucumí, a “secret” Yoruboid language of the Niger-Congo family. Also, we have expressions that are typical of our popular slang and we use them to refer to certain things. These are used by most Cubans regardless of educational level or social class.

Religion

Cuba is recognized as a predominantly Catholic country (60%), but the mixture of cultures from different origins has given rise to an authentic religious syncretism where, especially, African religions are mixed with Catholicism, giving rise to the well-known Santería religion. Other religions include Protestants (5%), Jehovah’s Witnesses, Methodists, Anglicans, Seventh-day Adventists, among many others, as well as Muslims, Jews, and Buddhists. Although there is great diversity in religions, to the best of our knowledge and clinical experience, there is little to no interference with the medical practice since regardless of religion, the Cuban population seeks medical attention and follows therapeutic recommendations from their physicians. The educational efforts and the expansion of free medical care to all the population, coupled with the existence of community doctors, have created a “medical culture” in the population that favors the absence of antagonistic relations between medical practice and religion. At the same time, health care providers are trained to recognize and accept the religions and cultural beliefs without exercising opposition to those. Cuban populations who practice Afro-Cuban religions will also seek advice from local healers to dispel “el mal de ojo” or some diseases but will also seek medical attention.
**Education and Literacy**

Educational level and cognitive enrichment early during life are associated with greater levels of cognitive functioning. Therefore, this is a crucial factor when trying to assess neuropsychological performances in our population. Educational levels in Cuba are relatively high compared to other countries in Latin America. This has been influenced by a few factors. In 1961, the Cuban government incited a country-wide literacy campaign, “Campaña de Alfabetización Nacional,” which allowed a quantitative and qualitative change in educational level. By the year 1962, Cuba had become the first illiteracy-free territory in Latin America. Education in Cuba is free at any level (including university and postgraduate studies) and is compulsory until middle school. In relation to university studies, there are different education modalities, including regular daytime education and nighttime courses for workers. Other types of educational programs such as technical and professional teaching are also available, with many trade schools available to facilitate the inclusion in society of those who could be trained to gain pre-university or technical education level. The National Population and Housing Census of Cuba (2019) reported a population of 11.17 million inhabitants, of which 712,672 (6.9%) are university graduates. Of those aged 30 to 59, 11.6% completed university studies and 52.1% are women. Within the general population, 46.1% have reached at least one higher education degree, 77.6% completed middle school, and 99.6% have completed primary education, of whom 52.1% are women. Compared to other Latin American countries/Hispanic populations, the higher educational level in the Cuban population plays a relevant role when assessing Cuban origin populations as this will required adjustment on the normative references to be used.

**Socio-Economic Status**

A growing body of cognitive research shows causal connections between SES and cognitive outcomes. Brain development involves different processes at different stages, and SES may shape this development and influence cognitive performance and within-population differences.

Although Cuba is a low- and middle-income country (LMIC), since 1990, Cuba has developed in the biotechnology and medical services industries. The export of biotechnology and medical services represents one of the major sources of income for the Cuban economy. Biotechnology productions also allow the substitution of imports to supply Cuban pharmacies and hospitals. In addition, the export of medical services and health tourism has grown and become the most dynamic activity in the Cuban economy, representing 75% of its GDP. Cuba also provides health services to several countries in need by sending over 130,000 medical personnel on aid missions to developing nations, primarily in the Global South.

Despite Cuban success in health care, it is important to note that due to the United States’ embargo on Cuba, there are severe limitations on Cuba’s access to international supplies of medicines and medical equipment. Furthermore, the expansion of US pharmaceutical companies over the last three decades has limited the number of companies that can export their products to Cuba without exposing themselves to penalties from the US government. The Helms-Burton Act penalizes businesses and citizens trading with Cuba. In the healthcare sector, in particular, the Cuban population is denied the latest generation of equipment and medicines, available in some cases only from US companies or only to a few with prohibitively high prices.

These restrictions have affected the practice of neuropsychology since many neuropsychological tests that we have in Cuba are donated by other professionals or obtained through collaboration projects with other countries. Despite this, there is a shortage of psychological tests accessible to Cuban neuropsychologists. Limited tests are not available in all departments of psychology, and if available, there is either only one original copy or incomplete test materials.
Values and Customs

Being generous and hospitable is highly valued among Cubans. The Cuban population considers it rude not to greet all men with a handshake and all women with a kiss on the cheek. In addition, compared to other Central and South American cultures, Cubans tend to have louder conversations, especially with hand gestures, are more expressive, and are very passionate. In addition, Cubans consider direct eye contact as a sign of respect, and it is much more preferred than indirect or fleeting eye contact. These are important considerations during behavioral assessments, and these manifestations should be considered as a display of affection and do not have a sexual connotation nor evidence of disinhibition.

Health Status

Like education, health care in Cuba is free. The Cuban government operates a national health system and assumes fiscal and administrative responsibility for all its citizens’ health care. Medical care is available to the entire population, without distinction of race, social origin, or ideological affiliation. There is a state, universal, and free character. Health is assumed from a procedural, integrative, and active view of the human being. Promotion and prevention actions aimed at reaching higher levels in the population’s quality of life are emphasized. Close interrelation of research, teaching, and assistance, that is multisectoral, international, and collaborative, constitutes guiding principles of work. The number of doctors per inhabitant in Cuba in 2019 was 1 doctor for every 116 inhabitants. The maternal mortality rate per 100,000 live births is 37.4, with an infant mortality rate of 5 per 1,000 live births. The three leading causes of death in the country are cardiovascular diseases, malignant tumors, and cerebrovascular diseases.

History of Neuropsychology in Cuba

The development of neuropsychology in Cuba had a marked influence from the former Soviet Union. Its roots date back to the late 1960s, when Cuban psychologists were trained at Alexander R. Luria’s lab at the University Lomonosov of Moscow. Dr. Eduardo Cairo Valcárcel, Dr. Luis Oliva Ruiz, and Dr. Clemente Trujillo Matienzo, mentored by Alexander R. Luria, were the first Cuban psychologists to receive training in the field. Upon return to Cuba, they used Luria’s approach in their clinical and research activities.

Dr. Eduardo Cairo, professor at the Faculty of Psychology of the University of Havana, extended neuropsychological research in Cuba and wrote several books on neuropsychology. Furthermore, he implemented psychology training at the University of Havana. Dr. Luis Oliva Ruiz and Dr. Clemente Trujillo were tasked to develop clinical neuropsychology in Cuba. Dr. Oliva Ruiz and Trujillo founded the Neuropsychology Department at the National Institute of Neurology and Neurosurgery (INN) and started sub-specialty training at the INN. For the first time, neuropsychologists and neurologists worked together to assess neurological disorders in the national Cuban health system. Since the creation of the neuropsychology department, the neuropsychology group has worked continuously at the frontline of the institution in several areas including research, training, and clinical assessment. This group was formally created in January 1971 by psychologist Dr. Clemente Trujillo, who continued the work initiated by Dr. Oliva guided by Luria’s teachings. Dr. Trujillo has trained several specialists from all over the country and is currently continuing his work at the Institute of Neurology. For their work and contributions to neuropsychology in Cuba, Drs. Luis Oliva Ruiz Clemente Trujillo and Eduardo Cairo are considered the founding fathers of the field in Cuba.
Despite the development of neuropsychology in Cuba, there are still several challenges that must be addressed in order to advance the field and the profession further. These include increasing training options and a greater need for standardized and normalized neuropsychological tests for the Cuban population.

**Neuropsychology Training in Cuba**

All Cuban psychologists study basic courses in neuropsychology, including specific courses within undergraduate psychology training such as “Biological Bases of Behavior and Cognitive Psychology.” However, this is still insufficient for those who decide to dedicate their career to this branch of psychology. As a result, most Cuban neuropsychology specialists are trained abroad or receive theoretical-practical training from more experienced neuropsychologists. There are no postgraduate doctorate studies focused on this sub-specialty in Cuba. For years, Cuban neuropsychology has been enriched by exchanges with foreign institutions and professors through courses and research collaborations. In addition, some of our neuropsychologists complete master’s degrees or other diploma courses abroad.

The master’s degree is the usual level of educational attainment for those who wish to practice clinical neuropsychology, and there is not a board certification process in neuropsychology, although there is one in clinical psychology. Recent efforts to increase Cuba’s training options include a master’s degree program created in 2004 by the Center for Neurosciences. Although the program’s scope is mainly focused on Neurosciences, there are several courses on Neuropsychology, Cognitive Neurosciences, and Infant Neurodevelopment available.

Currently, neuropsychology is practiced in several healthcare centers throughout our country. Centers like the Institute of Neurology and Neurosurgery, the International Center for Neurological Restoration, and the Hermanos Amejeiras Hospital stand out for research and training. In the Cuban health system, neuropsychology services are especially tasked with determining the presence, severity, and location of brain disorders and supporting dementia and depression diagnoses in particular. Neuropsychology services are also regularly sought for pre- and post-neurosurgical interventions and play a relevant role during neurological rehabilitation. Yet, establishing neuropsychology-specific training and practice standards at the provincial or national level is still needed.

**Neuropsychology Assessments in Cuba**

Neuropsychological test validations in Spanish-speaking populations are relatively scarce in Latin America. Cuba does not have enough normative data for neurocognitive tests to evaluate the pediatric or adult population. There is a lack of neuropsychological batteries designed to evaluate cognitive functions that can identify the different etiologies of dementia syndrome and its cognitive decline.

Currently, neuropsychological tests that are more widely used in Cuba include Luria’s assessment and the Brief Neuropsychological Evaluation in Spanish (NEUROPSI). Trail-Making Test, Digit Retention, Boston Naming Test, Wisconsin Card Sorting Test, and Category Formation tests among others. Intelligence tests, used with a relatively high frequency, include the Raven’s Progressive Matrices and the Wechsler Adult Intelligence Scale, although the latter is not available in all the centers.

Recent efforts to improve population-based measures in assessing cognitive complaints include the development of the 10/66 studies in the Cuban population. The 10/66 dementia diagnosis protocol has been validated and widely implemented in Cuba. The 10/66 protocols encompass a
Ana M Rodriguez-Salgado et al.

new method to dementia research in LMICs intended to develop a novel approach to diagnosing dementia (the 10/66 Dementia Diagnosis) and addressing difficulties in making diagnoses among older people with little or no education and the use of standardized protocols across all sites. Therefore, it is well suited to be used in our population. Further details of the 10/66 studies have been described elsewhere.29,30

More recently, the Cuban Alzheimer Research collaboration with researchers from the National Institute of Neurology introduced and validated tablet-based cognitive screening measures known as the Brain Health Assessment (BHA) to improve early diagnosis of mild cognitive impairment and dementia in primary care settings.31 The BHA is a short tablet-based cognitive battery developed at UCSF Memory and Aging Center by neuropsychologist Katherine Possin.32 The BHA was translated and adapted into Cuban Spanish by a multidisciplinary team of four language experts and later validated in the Cuban population.31

Furthermore, there are ongoing efforts to validate and introduce a structured neuropsychological battery aimed at secondary and tertiary levels of care for cognitive complaints. A newly developed neuropsychological battery is based on the UCSF Memory and Aging Center Bedside neuropsychological screening (Spanish version). This battery allows assessment of cognitive functions in older adults to facilitate the diagnosis and early identification of dementia, with rapid and reliable evaluation of episodic memory, working memory, executive functions, verbal fluency, naming, visuospatial functions, and abstract thinking. The test generally requires 45 minutes to complete.

Finally, in collaboration with international groups, we have developed a multicenter study to establish normative data for Latin American adult populations. The methodology for the development of normative data in ten Spanish-language neuropsychological tests in Latin American countries has been described elsewhere.33

The Role of Neuropsychology on Prevention and Community Care

In Cuba, mental health and well-being are a national priority of the Ministry of Public Health. In 1995, all mental health services were re-orientated to implement practices at a community level.34 Easy and accessible mental health services in a community are key aspects to better understand and assess patients’ concerns; also the easy access can prompt early consultation.

Health professionals, including neuropsychologists, psychologists, neurologists, psychiatrists, and social workers, practice in a coordinated effort throughout a network of specialized services (from primary care to tertiary care) to address the population’s care in all stages of life. There are currently more than 170 mental health departments and 421 outpatient mental health facilities available in the country that constitute the cornerstone of community care, and 3.5% of those are specialized services for children and adolescents.34 Most of the mental health services are located in the community and linked to primary health care (PHC) with the existence of Mental Health Services (SSM) within polyclinics, which are the care units of this level of care and cover a health area with a population that ranges between 20,000 and 35,000 inhabitants. The SSM multidisciplinary teams develop a comprehensive approach with a particular focus on promoting healthy, preventive, educational, and rehabilitation lifestyles and establishing a direct link between the primary care level with the second and third levels of care.

The training of human resources to address this area of health is done through the careers of medicine, with the specialty of psychiatry, bachelor’s degrees in psychology, nursing, health technology in the specialties of social work and occupational therapy as well as education, postgraduate in master’s degrees and diplomas in community mental health, health psychology, natural and traditional medicine, sexuality, among others related. In this field, a Master in
Community Mental Health is being developed, which already has 9 editions and 227 graduates from all over the country.34

Section II: Case Study — “… My Life Changed from One Day to the Next”

History of Present Illness

Mrs. PM is a 54-year-old right-handed woman, born and raised in Havana city. She had nine years of formal education, which is considered a low educational level in Cuba since only 24% of the population have nine or less years of education, according to data reported by the population and housing census of 2012. This educational level is consistent with her employment at the time of symptom of onset; she worked as an operator in a factory, which is a job typically held by individuals with similar educational levels. Other common activities in groups with similar educational levels include cleaning services and food processing centers, among others.

Mrs. PM has a history of controlled arterial hypertension and does not report any pathological family history of interest. Her husband indicates that at age 50, she received an ophthalmology consultation because his wife started to present vision difficulties where she skipped lines when reading. A visual exam completed by an ophthalmologist revealed no relevant visual defects. On a follow-up consultation with neurology, Mrs. PM showed evidence of mild cognitive impairment and visuospatial alterations. As a result, she was referred to the neuropsychology service for evaluation of possible posterior cortical atrophy.

In the interview with her husband, he reported that his wife began showing problems related to spatial disorientation and visual disturbances approximately three years prior to neuropsychological evaluation. She also got lost on the way to work, and as a result, he began accompanying her to work every day. Difficulties were also evident in managing her finances. For example, she could not make the payments or purchases that were previously routine and had issues managing money. At the age of 53, three years after visuospatial and executive symptoms began, she began with memory decline where she forgot to season her food, lost things, and put her clothes on backward. On one occasion, she went out to the street, half-dressed. However, the husband says that the memory problems were not as significant or disabling as her visuospatial disturbance. The impact of her neuropsychological difficulties is most evident in Mrs. PM’s employment. She works as a factory operator but can no longer assemble the boxes she used to assemble before and cannot pack the products properly.

During the neuropsychological evaluation, Mrs. PM was anxious when performing the tests, especially those requiring greater cognitive demand. Mrs. PM reported that she feels depressed because she depends on her husband to carry out daily life’s instrumental activities. In general, the presence of depression referred by the patient is quite common and expected in these cases. Despite significant advances in gender equality over the past decades, the historical influence of “machismo” remains present in the Cuban culture, especially related to gender-specific roles in domestic activities. Women are expected to maintain the role of homemaker and perform household tasks such as cleaning, cooking, washing, and scrubbing. Therefore, the loss of her independence to carry out household tasks successfully may create depression and anxiety, even in the presence of strong family support.

Her neurocognitive evaluation cognitive included several tests administered in Spanish by a trained psychologist. Of note, some of these tests, including the Trail Making Test, Stroop Color Word Interference Test, Hopkins Verbal Learning Test, Boston Naming Test, and the Controlled Oral Word Association Test, have normative data collected in Cuban populations as part of a multi-site project in Latin American countries (see Guardia-Olmos et al., 201535 for methodology). Details of the neurocognitive evaluation are presented below.
Test and Norm Selection

1. Hopkins Verbal Learning Test-Revised form 5HVLT-R.
2. Rey–Osterrieth Complex Figure—copy and immediate recall.
4. Montreal Cognitive Assessment (MoCA).
5. Subtest of digits in progression and regression.
7. Design Fluency Test.
8. Trail Making Test part A and B.
10. Facial Recognition Test.
11. Discrimination of superimposed images from the Barcelona Test.
13. Beck’s Depression Inventory.

Review of Cognitive, Visuospatial, and Behavioral Systems

On the MoCA, she scored 20/30 points, failing especially on visuospatial/executive processes. She did not manage to draw the three-dimensional cube properly. In the clock test, she drew the circle well; however, she placed the numbers outside the circle in a disaggregated way. She also failed in attention and calculation, especially in the consecutive subtraction “100-7” (0/3 points).

Orientation

Mrs. PM was oriented in time, space and person.

Memory

On the Hopkins Verbal Learning Test, Mrs. PM presented discrete alterations in the delayed recall; she managed to evoke (6/12) previously learned words, so she was in the 30th percentile. In late recognition, she improved discretely (7/12). This result has been discreetly diminished than expected according to their age and school level. In visual memory, her memory was compromised; she could not evoke visual material due to alterations in visual processing (0/36 points) (Rey’s complex figure). In Benton’s Facial Recognition Test, she showed moderate difficulties in recognizing faces.

Language

Expressive language (prosody and speech production) was without alteration at the time of evaluation. The functions of naming and repetition of sentences were affected due to their amnesic and attention problems. Sometimes she had verbal and literal paraphasias. Semantic Verbal Fluency (six words) and phonological fluency had decreased, especially the latter where she only managed to evoke two words in a minute.

Visuospatial Skills

In the superimposed image discrimination test, she presented simultagnosia. In the copy of Rey’s complex figure, visuocostructive apraxia (4/36 points) was found; she could not integrate the elements of the figure, incurred in intrusions of elements and incorrect spatial locations. Dress
Development of Neuropsychology in Cuba

Apraxia and ideational apraxia were also appreciated. She presented difficulties in visual tracking. In Ruff’s design fluency test, Mrs. PM showed difficulties in visual-motor programming.

Working Memory and Executive Functions

In the attention processes, she presented difficulties in selective and sustained simple sequential attention. Executive and auditory attention and working memory were greatly diminished. Digit Span Backward 1/8 and Digit Span Forward 4/9 also showed very little attentional control, which is verified in the Stroop test. In the reading-writing processes, alexia and agraphia are appreciated. In the calculation subtest, acalculia was found. A great affectation in the representation and mental execution of simple calculation operations is appreciated in the executive functions. She fails to establish common links between elements of the same semantic category, denoting little abstraction and generalization. She was unable to sequence an alternating pattern of symbols (Trail Making Test-B).

Psychiatric Symptoms

In the affective sphere, we found moderate depression (Beck’s Depression Inventory—23 points), the indicators of failure, feeling of guilt, social isolation, and inability to work stand out. It is important to note that the development of disease-related symptoms will significantly influence Mrs. PM’s emotional state and social impact. Mrs. PM has always been linked to work, providing her contribution to the community, and she will no longer be able to do it; as we mentioned earlier in the chapter, Cubans are outgoing, hospitable, and value a sense of community, with the development of disease. Mrs. PM’s social interaction will be limited due to word-finding difficulties and special disorientation.

At the end of the evaluation, she expressed feeling frustrated for not complying with the demands of the tests carried out. This may be expected, especially with Cuban populations, given the importance of healthcare and the need for positive social interactions that underlie Cuban identity.

To reassure Mrs. PM, we asked her to attend an upcoming appointment to provide strategies to improve her cognitive and functional functioning to improve her quality of life.

Recommendations and Follow-Up

Mrs. PM attended the appointment accompanied by her husband. She expressed to us feeling many doubts and concerns related to her health; the husband told us that it was also a bit complicated because he did not know what he should do to be able to help her adequately in her illness.

We began by telling him that although there is no curative treatment for her condition, there are other alternatives for disease management not limited to the use of medications, including joining a cognitive stimulation workshop at our center twice a week, with the aim of delaying the loss of both cognitive and functional skills and reducing the presence of emotional and/or behavioral problems and family support groups for the family and caregivers. These support groups may play an important role in the Cuban culture, especially because of the sense of community.

We explained that the intervention would be focused in the first place on the visual-perceptual processes that are mainly affecting their quality of life, and later we would address other functions or neuropsychological skills such as praxis, calculation, and reading-writing, always trying to favor her performance and independence in her daily activities. We suggested to the husband some tips for the home so that it would be a safe place for Mrs. PM, taking into account the visuospatial alterations, for example, the distribution of the furniture in the house, the adequate...
lighting in all the rooms, as well as the organization of her belongings to facilitate an easy visual search for her.

We appreciated in the consultation that Mrs. PM had improved her mood, and she expressed her desire, to begin with, the cognitive rehabilitation sessions.

**Section III: Lessons Learned**

- The Cuban society is very cheerful, expressive, supportive, and affective. They do not need to know someone to help them, they like to share without expecting anything in return, and they are excellent hosts. Cubans have a very good sense of humor and are always making jokes about the bad things that happen in society and in their lives.
- They feel a lot of trust and admiration for their doctors and see them as people close to them. On Latin American Medicine Day, it is common for patients to give gifts to their doctors as a token of appreciation. This relationship is reciprocal, and doctors often share their phone numbers with patients so they can call you in case they have any questions about treatment or an emergency arises.
- The Cuban society has extensive knowledge on medical issues. For years, they have tried to educate the population in this regard. There are many programs on national television with sessions dedicated to health and disease where top-level professionals are invited to explain topics of this type and share their wisdom.
- There is great diversity in the Cuban culture, especially related to religion; however, religion, medical science, and neuropsychology co-exist without antagonism.
- The high educational level in the Cuban populations should be taken into consideration during neuropsychological assessments and proper normative data should be applied.
- Neuropsychological tests can cause the patient some anxiety due to fear of failure, so it is very important to explain the characteristics of the evaluation to the patient so that they feel more confident and relaxed at the time of performing the tests.
- In the clinical or psychological interview, it is common for Cuban patients to give extensive answers and provide additional details that might not be of interest or relevant to the case, so the doctor or psychologist must be very skilled to redirect the interview and lead them to answer the question.
- There are standardized neuropsychological measures for Cuban patients; however, more validation studies are needed to generate more normative data. Meanwhile, standardized norms for similar populations in Latin America (e.g., Puerto Rico, Chile, Argentina) might be useful.

**Glossary**

**Mulatos.** A racial classification to refer to people of mixed black African and white European ancestry. The term is used as an ethnic/racial category in Cuba.

**El mal de ojo.** A superstitious curse or legend, believed to be cast by a malevolent glare, usually given to a person when one is unaware.

**References**