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Application of the Collaborative Therapeutic Neuropsychological Assessment Approach on a Venezuelan Migrant

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35 Application of the Collaborative Therapeutic Neuropsychological Assessment Approach on a Venezuelan Migrant

Aline Ferreira-Correia

Section I: Background Information

Terminology and Perspective

People from the Bolivarian Republic of Venezuela are referred to as Venezuelans. As part of the Latin American community, we may also be called Latinos, Latinas, or LatinX.

My perspective is that of a cis woman born in Venezuela from European immigrant parents. I graduated as a clinical psychologist from the Central University of Venezuela (Universidad Central de Venezuela/UCV) after the completion of a five-year study program. In the last two years, students choose to specialize and I focused on psychodynamically orientated clinical psychology. In Venezuela, psychologists who wish to become specialized clinicians can do an additional master-equivalent degree over two or three years. My degree had an emphasis on clinical neuropsychology. In 2009, I immigrated to Johannesburg, South Africa, where I obtained my PhD at the University of Witwatersrand. Here, my perspective is that of a white foreign psychologist who is an English second language speaker with dual registration (clinical psychology and neuropsychology). I work as an academic and a clinician in private practice.

Geography

Venezuela is located at the north end of South America. It shares land borders with Colombia on the west and southwest, Brazil to the south, and Guyana to the east. To the north is the Caribbean Sea and the Atlantic Ocean. Venezuela is known for its extraordinary natural beauty. The weather is generally warm and humid, with significant variations in temperature linked to altitude (from the cold-snowy peaks in the Andes to the scorching heat on the coast). We have two seasons: rainy and dry. The total population of Venezuela is approximately 28 million people, with a decreasing birth rate and a large and unprecedented diaspora motivated by the ever-worsening sociopolitical and economic crisis, leading to a population decline.

History

Settlers from North America who arrived during the Paleoindian period (20000 to 5000 BC) first occupied the territory now known as Venezuela. Heterogeneous indigenous groups constituted the original population of Venezuela and several remain in the territory. The arrival of the Spanish colonizers in 1498 also brought white Europeans and black Africans (trafficked as slaves) to the area. Rapid mixing between races and social groups during this period created a complex intersection between class and race, which is reflected in the current social structure in Venezuela. The country

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declared independence from Spain on the 5th of July 1810. Toward the middle of the 20th century, Venezuela moved from an agriculture-based economy to one relying exclusively on crude oil. The oil boom brought wealth and a great migration wave from South America and the Caribbean, Europe, Asia, and the Middle East. Our democratic era was established in 1958 but unfortunately has been characterized by consistently corrupt political systems that have depleted a once rich country. Currently, Venezuela is living the worst political, economic and social crisis in its history, creating a humanitarian disaster with horrifically high indices of poverty, hyperinflation, and violence.

**Immigration and Relocation**

Since colonization, Venezuela has received migrants from Europe, South America, and the Middle East. This has played a significant role in its growth and diversity. Until the end of the 21st century, Venezuela offered stability. Now the Venezuelan diaspora represents the largest migration, refugee, and displacement crisis in South America. Motivations for leaving Venezuela have changed in the last decade. Initial migration was to find more opportunities, but is now forced by the need for social security and survival. Approximately five million Venezuelans have left the country to escape political unrest, socio-economic decline, crime, violence, food and medicines shortages, human rights violations, and lack of basic services. A great proportion of those fleeing has incurred great risks by walking to other South American countries. The majority of Venezuelan migrants are living in countries such as Colombia, Peru, Chile, Ecuador, Brazil, and Argentina. Caribbean countries (Trinidad and Tobago and the Dominican Republic), Central (Costa Rica and Panama) and North America (United States of America and Mexico), and Europe (e.g. Spain, Portugal, and Italy) have also received many Venezuelans.

The characteristics of Venezuelan migrants vary by chronological stage. At the end of the nineties and the first decade of 2000, most Venezuelans who emigrated were highly educated, could afford travel, and went through a legal documentation process. This facilitated their adaptation to their receiving countries. In stark contrast, in the past five years, Venezuelans who left on foot have been victims of disaster-induced displacement, tend to be undocumented, poor, and with varying levels of education. They tend to become asylum seekers or refugees and face significant barriers assimilating to their host countries—many of which are now restricting inward-bound movement by Venezuelans. These migrants have left behind loved ones, often carrying only a single bag. Thus, learning about Venezuelan migrants’ motivational processes as well as journeys and losses is of paramount importance as a platform for clinical judgment of both their emotional and cognitive functioning.

**Language**

In Venezuela, Spanish (Castilian) and languages spoken by Indigenous people of the country are the official languages. Accent and lexicon vary by region in Venezuelan Spanish. Most Venezuelans speak Spanish, so the assessment of language proficiency is not common in neuropsychological assessments in the country. Spanish is spoken by 7.5% of the world population, and although there are significant regional differences in terms of lexicon and phonetics, most Spanish-speakers can communicate well with each other.

**Communication**

Most Venezuelans prefer an informal communication style. The use of titles (e.g. Dr., Ms., Mr.) is quickly abandoned. The use of first names is common in psychologist–client relations. Humor is at the core of everyday life for Venezuelans. It is used to cope and connect with others and also
to express dissidence and reflect on reality. Understanding the use of humor is important to consider when working with Venezuelan clients. We tend to make fun of everything, which may cause misunderstandings in multicultural environments. Humor can have great diagnostic and therapeutic power. For example, as a young neuropsychologist working at a large hospital in Caracas, Venezuela, a 63-year-old woman of Portuguese origin was referred to me to explore a memory complaint. She had migrated to Venezuela more than 30 years ago, although she had difficulties speaking Spanish. I attempted the interview in Portuguese, but she made fun of my mistakes and told me to stick to Spanish. Many years later, a South African client (non-Spanish speaker), referred to me for similar reasons, made fun of my accent. From a neuropsychological perspective, both these instances could have been interpreted as a sign of disinhibition, but for my Portuguese-Venezuelan client, it was an acceptable joke—we both laughed and I continued the interview in Spanish. In South Africa, it is considered offensive to make fun of accents of second-language English speakers, so the client’s comment was concerning. The neuropsychological assessment and MRI revealed healthy frontal lobes in the first client and executive dysfunction with frontal atrophy in the second.

Venezuelans are prone to minimizing social distance and personal space. We greet others with a hug and one kiss on the cheek. When I first started working in South Africa, one of my colleagues told me that I was a “hugger” which is true. I realized this was culturally influenced a few years later when a Venezuelan client living in South Africa was so happy to have found a Venezuelan psychologist that she asked if she could give me a hug at the end of our first session, because “no one here likes to hug.” This was such a powerful way to convey our cultural belonging. It is also worth noting that Venezuelans can be overly familiar with strangers and start spontaneous conversations, which is culturally appropriate. Taking time to discuss confidentiality rules and psychologist-client boundaries is thus very important, particularly when working with family systems and doing collateral interviews.

**Education**

Since independence, Venezuela’s Constitution enshrines the right to education for all its citizens. The government is responsible for providing free and compulsory education to all Venezuelans until high school and for those who wish to continue tertiary studies. The educational system includes six years of primary school and five years of secondary school. Tertiary education may include a technical degree (three years) or a professional degree (five–six years). Masters and doctoral degrees (two–three and five years, respectively) normally include coursework and theses. All levels of education can be completed in government or private institutions. Access to public universities is complex due to limited availability. Inquiring about the history of access to tertiary education is useful, in order to gauge educational opportunities when estimating premorbid level of functioning.

Unfortunately, the current crisis has not spared the educational system. Many educational institutions lack basic services and numerous Venezuelans cannot attend school due to hunger, lack of means to afford school uniforms, materials, or transport. Educators’ salaries (approximately $4 a month) is insufficient for basic survival. Obviously, these factors can compromise quality of education, and while the number of years of education is strongly correlated with cognitive performance, there is a need to gather a detailed educational history and use age and education stratified norms when available.

**Literacy**

The constitution promises compulsory and free education, but despite the social programs designed to eradicate illiteracy, Venezuela’s illiteracy rate is 4.9%. Many children of school age are excluded from the educational system and there are significant disparities between Venezuelans in
terms of language skills (reading and writing). Venezuela was declared free of illiteracy in 2005, which was far from evident in the neuropsychological unit where I used to work. Many clients arrived describing different reading and writing acquisition processes, which makes evaluating educational history crucial when designing an assessment.

**Socio-Economic Status**

Venezuela is ranked 127th (out of 140) in economic competitiveness by the World Economic Forum and 179th (out of 180) in the 2020 index of economic freedom. Hyperinflation has been calculated at 10 million percent. At least 80% of the Venezuelan population has reached extreme poverty, which is among the worst in the world. The majority of its citizens are struggling to find food, medicines and have no reliable access to basic services (such as water, sanitation, and energy). Many Venezuelans are now dependent on remittances from family abroad, support from NGOs, and food parcels distributed by the government. This has and will continue to have a negative impact on brain development and mental health.

**Values and Customs**

Over the past 20 years, Venezuela has rapidly deteriorated, which has impacted the essence of what it means to be Venezuelan. There has been great political polarization and related food, security, healthcare, educational, and judicial inequity that has led to documented human rights violations and crimes against humanity. While generalizations about Venezuelans are impossible, it is important to know the people of Venezuela within this context. Notwithstanding the obvious regional and individual differences, there are some values with which Venezuelans commonly identify and are important to keep in mind when offering psychological services.

Strong family ties and friendships (who are considered family) are at the center of a Venezuelan's emotional and social life. They provide significant care and support in times of crisis. Families can be a valuable resource that psychologists have to often rely on due to the unavailability of formal supporting structures (e.g. psychiatric hospitals, halfway houses, safe houses, etc.). At present, nearly all Venezuelans have experienced traumatic separations from family and friends and suffered painful losses, mostly driven by migration, which limits or precludes access to this important source of life support.

Boundaries between family members are therefore often unclear and it is common for people to intervene, participate or give opinions on personal issues that are considered private in other cultures. For example, my client Ana was concerned about her memory and requested an assessment. A year before our first session, Ana's husband had an affair. Her older sister (a lawyer) organized the divorce papers following the mother's request, which my client quickly signed without reflecting on the issue. Since then, Ana has been feeling sad and resentful because she was rushed into a divorce she did not actively choose and regretted. This exemplifies the importance of family hierarchies where mothers and older or educated members of the family frequently command the highest authority for decision making.

For instance, aggravated by the socio-economic crisis, family and social support are key to survival for Venezuelans. Many Venezuelans work abroad to send money back to family members

*I make use of pseudonyms when referring to clients throughout this chapter.*
to help them survive. Due to the high levels of criminality and violence, we have internalized a sense of danger and distrust. For example, a Venezuelan would not stop in the road to assist a stranger whose car has broken down, because we fear being robbed or killed by someone pretending to need help. Hence, the neuropsychologist needs to earn the client's trust and identify and manage the client's apprehension.

Due to the economic crisis, it is almost impossible for young Venezuelans to move out of their parents' homes. Many homes thus contain more than one nuclear family and/or extended family members. Similarly, many separated or divorced couples are forced to remain in the same house. Neuropsychologists must be aware of the high levels of interdependency within Venezuelan families when conducting functional or capacity assessments or when evaluating activities of daily living.

The average Venezuelan is kind and likes to express gratitude. Although accepting gifts from clients can elicit undesirable dynamics, when working in certain contexts, it may be considered rude and detrimental to the client to reject a thank you gift at the end of a therapeutic process. Francisco, a five-year-old with severe behavioral issues, was referred to me for psychological assessment in a center that provided free community services. Francisco's grandmother, who brought him to our sessions, was very distressed since the school was threatening to expel him if he did not improve his behavior. Francisco's father was in jail for having killed his mother, so his grandmother was the only caregiver and they were living under extreme poverty. After a full neuropsychological assessment and complex follow-up case management, there was a significant improvement in his behavior and school performance. His granny felt very grateful, and in our last session, she brought me a small bunch of a local fruit (mamón), which I accepted as a way to acknowledge her gratitude and her capacity to "give" in a context of so much deprivation.

**Gender and Sexuality**

Although Venezuela is matricentric (mothers are seen as the backbone of society), structurally the country remains patriarchal and sexist. This is evidenced by the high prevalence of gender-based violence, maternal mortality, teenage pregnancy, over-sexualization of girls and women, and femicide. Women are also the most frequent victims of sexual harassment and xenophobia. High prices and the unavailability of contraceptives have caused staggering increases in unplanned pregnancies and HIV infections. Reports indicate that, although women are allowed to vote and actively participate in the labor market, they are less likely than men to attain positions of political and economic power.

Discrimination in access to education, health services, and employment on any basis, including sexual orientation and gender identity, is illegal. However, instances of exclusions and violations of human rights against the LGBTQI+ community are common and severe. It is upsetting to report that the LGBTQI+ community does not enjoy equal civil and political rights. While not prosecuted, same-sex relationships are not legally recognized, which excludes rights such as marriage, civil unions, and adoption. Additionally, the constitution does not accommodate gender identity changes for transgender people.

**Spirituality and Religion**

During the colonization process, the Roman Apostolic Catholic Church played a key role in the creation of settlements and consolidation of Spanish rule. Christian missionaries’ aggressive proselytization inaugurated a religious society where the majority of Venezuelans today identify as Catholics. Nevertheless, Venezuelan religious and spiritual beliefs and practices are also marked by indigenous animism and African cosmology brought by people trafficked as slaves.
Together, these represent a complex fusion of values, beliefs, and rituals that influences the conscious and unconscious mind of Venezuelans. Venezuelan society is thus religiously syncretic and pluralist, where multiple religious denominations and practices (e.g. Christianism, Judaism, Evangelism, Santería, etc.) coexist. Neuropsychologists may encounter clients who ascribe to one religion but engage in cultural practices from different influences.

Acculturation and Systemic Barriers
Venezuelans have seemingly embraced a “mestizaje” (mixed-race) culture with abandonment of categorical racial categorizations following independence. However, there is both historical and contemporary evidence of racial discrimination including distribution of wealth along ethnic lines and upholding the European phenotype as the beauty standard. Thus, experiencing and managing race dynamics abroad may be particularly difficult for Venezuelans.

The acculturation process of Venezuelan migrants is diverse and influenced by how Venezuelans are perceived in their receiving countries. For example, despite empirical evidence to the contrary, many countries see Venezuelans as criminals who are stressing their health and educational services. Venezuelans then fall victim to xenophobic attacks of various kinds, particularly in South America. Large cultural, climate, and linguistic distances between the country of origin and receiving countries can exacerbate feelings of alienation, stress, and inadequacy. Many Venezuelans do not have access to passports and other legal documents before they leave Venezuela, which prohibits access to services, employment, and housing abroad. This is an insurmountable barrier in the adaptation process of migrants. Neuropsychologists assessing Venezuelan migrants thus need to explore the individual migration story, which can reveal key contributors to emotional and cognitive symptoms.

Health Status
The socio-economic crisis in Venezuela has impacted the physical and mental health of all citizens in dramatic ways. Difficulties accessing food, medicines, and health services, the exodus of medical practitioners, and the dire working conditions of those who remain in the country have caused an unprecedented health crisis characterized by an increase in preventable infectious diseases (such as malaria, measles, HIV), rampant deterioration of clients with treatable chronic diseases, severe malnutrition and difficulty accessing life-saving treatments. These conditions can have a significant impact on brain function. In an attempt to help, health professionals offer medical and psychological attention to those in need through several civil organizations. For example, Psicodiaspora (psicodiaspora.com) is a network of Venezuelan psychologists and psychiatrists all over the world who offer services to fellow citizens in and out of the country (rates are set by each professional, some offer pro-bono sessions).

Approaches to Neuropsychological Assessment in Venezuela and in My Practice
The development of neuropsychology in Venezuela has been promoted by the efforts of individuals and small teams in different hospitals, universities, and private practices. Its history is fractured and the community remains poorly integrated. One of the founders of neuropsychology in Venezuela, Prof. Otto Lima Gómez, adapted Luria’s protocol for the assessment of cortical functions after working with Luria himself. He published the Luria Battery-UCV (Batería Luria-UCV), a seminal work for Venezuelan neuropsychologists. Prof Lima Gómez opened an elective course in neuropsychology at the Psychology School in the UCV (Universidad Central de Venezuela), my alma mater. The neuropsychology department in that school was founded shortly
thereafter. Members of this department prepared the Manual for Neuropsychological Assessment Luria-UCV and developed norms and published psychometric studies.38,39

Two other major contributions to neuropsychological assessment in Venezuela are notable. First, the creation of the Dr. Julio Borges Neuropsychology Section at Hospital Universitario de Caracas UCV (HUC-UCV/University Hospital of Caracas UCV) in 1985. This unit is dedicated to the diagnosis and treatment of clients with cognitive symptoms. It is responsible for providing training in clinical neuropsychology for undergraduate and postgraduate students and has supported the development of several normative studies that have been published in a book edited by Psychologist Ilva Campagna.34 Second, Prof Magdalena López de Ibañez, from the School of Psychology at UCV, has trained generations of psychologists in neuropsychological assessment and written a seminal book on the topic.40 I received training in a combination of Russian and North American approaches to neuropsychological assessment and rehabilitation at the aforementioned school and neuropsychology unit.

Neuropsychology in Venezuela is taught within clinical psychology training programs, which influence the scope and style of our work. I have adopted a Collaborative Therapeutic Neuropsychological Assessment (CTNA) approach,41 which aligns with my training as both a clinical psychologist and neuropsychologist.

The CTNA is a person-centered model where the client is seen as an active and autonomous participant in the neuropsychological assessment process. The client and clinician work together to understand the problems experienced by the client. In this process, the clinician aims to provide an intervention that reduces the client’s distress, increases the working alliance, and, ultimately, provides a “transformative experience”41 (p. 39) because it aims to ease the client’s suffering, and facilitate personal development while providing insights into the nature of the cognitive problems. In brief, all encounters with the client in the CTNA approach need to be understood as therapeutic interventions and not processes in which the client is a passive test-taker. This model facilitates the expression and management of culture-dependent dynamics and individual variations because it incorporates the client’s constructions of symptoms, therapeutic interventions, and the doctor-client relationship.

During my first session with a client, I aim to establish rapport, understand the problem (reason for consultation) and how the client makes sense of it, and ensure that the client comprehends the neuropsychological assessment process (i.e. why they were referred and what the expected outcome of our relationship will be). I also explore the client’s expectations and whether they feel ready to participate in a potentially lengthy and expensive experience moving forward. The process includes an unstructured and client-guided discussion. I also ask clients to complete the Background Questionnaire Adult Version42 to identify areas that require further exploration and that I might have missed during the interview.

I used the CTNA approach with Veronica, a 64-year-old client with Parkinson’s disease. The neurologist considered her an excellent candidate for deep brain stimulation (DBS) and strongly recommended surgery to which she had agreed. My initial impression of Veronica was of a smart, successful, warm woman who was enjoying a fulfilling life. During our first meeting I realized that, unlike with other clients, her experience with Parkinson’s disease was not featuring much in our conversation. I reflected this back to her by telling her: “Veronica, I am listening to your life story and I find myself forgetting that you have Parkinson’s; this makes me wonder in which ways you imagine DBS will improve your life.” Veronica, after a thoughtful silence, replied, “this is probably the most important question to ask myself in this process and I haven’t even thought about it; I am working, travelling, doing gardening, taking care of my family … Parkinson hasn’t really impaired my life and perhaps the risk of surgery is not worth it.” She left the session having second thoughts about elective surgery, and we agreed that she would think about it until next week’s session. Veronica had the opportunity to re-frame the impact of Parkinson’s Disease on her quality of life and take an active role in the decision-making process regarding surgery. As a result of this understanding, her trust in the team (and the consideration process) was consolidated.
Clients who understand medical procedures and take active roles therein have better treatment adherence and can better tolerate non-desirable side effects.

If neuropsychological testing is needed when assessing Venezuelan clients, I use tests translated into Spanish and country-specific adaptations and local norms, which should be stratified by age and years of education as these variables have a significant impact on the cognitive performance of Venezuelans (see Appendix). Data on diagnostic validity of neuropsychological tests are limited and affected by the heterogeneity of the population; hence, expert clinical judgment is central in the assessment process, particularly when assessing Venezuelans from rural or indigenous areas. If country-specific norms are not available, the use of stratified norms (by gender and years of education) from Latin American countries should be considered as an alternative option.

Section II: Case Study — “I Lost my Lucidity”

Note: Possible identifying information and several aspects of history and presentation have been changed to protect patient identity and privacy.

Reason for Referral

Miranda was referred to my practice in South Africa by her non-Spanish speaking psychiatrist (Dr. Nkosi), who admitted her to a psychiatric hospital because she was presenting with depression, anxiety, auditory hallucinations, persecutory delusions, attention and concentration difficulties, semantic memory failures, severe difficulties in comprehending and expressing herself in English. In the referral letter, Dr. Nkosi explained that, although this was probably Miranda’s first psychiatric admission, Miranda reported experiencing visual hallucinations during childhood and seizures during a recent hospitalization. Given Miranda’s history, her presenting symptomatology, and her difficulties communicating in English, Dr. Nkosi requested a neuropsychological assessment by a Spanish-speaking professional in order to further investigate her cognitive symptoms, gather additional history, and assist with the diagnostic process.

I conducted a series of interviews with Miranda to establish rapport, understand her current situation better, gather background information, and guide my selection of tests, if appropriate. Miranda was aware that I was asked to assess her to assist the psychiatrist with the diagnostic process because she was experiencing “mental confusion” but did not know she was specifically referred for neuropsychological assessment to explore her cognitive complaints.

Cultural Background

Miranda was a 45-year-old Catholic woman. Her first language was Spanish, and her proficiency in English was low, which limited her ability to communicate with the psychiatrist and treatment team. She was born in Caracas, Venezuela, where she lived until immigrating to Johannesburg with her husband and three children in 2009, at the age of 34. The youngest of three siblings, Miranda never met her father and was raised by her grandmother in a home where she lived with her mother and extended family (including uncles, aunts, and cousins). She experienced significant physical and verbal abuse perpetrated by her family members. At 25, Miranda met Ernesto and they married after a year-long relationship. Ernesto took up a position as an engineer in Johannesburg and the family moved to South Africa during the winter months, which was very difficult for Miranda. Nevertheless, Miranda was excited about moving away from the socio-economic and political stressors of Venezuela and from family conflicts.

Health History

Miranda reported that she was born via vaginal delivery at full term with no complications. She had been generally healthy her entire life. The results from hematological tests and EEG taken
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during her hospitalization were unremarkable. Miranda's family history included a sibling diagnosed with schizophrenia and two cousins with drug addiction. She described the psychotic episodes of her sibling with ease and was obviously familiar with psychiatric and psychological care. Accessing prolonged psychiatric care in Venezuela is difficult and clients are normally under families' care, who become experts in identifying the onset of symptoms and managing crises. I believe this experience helped Miranda to seek out immediate psychiatric intervention.

I asked Miranda if she ever experienced visions or other types of hallucinations during childhood. She responded that when she and her cousins were little, an uncle used to scare them with “La Llorona” and “La Sayona,” ghost legends that Venezuelans grow up fearing and even “encountering” during childhood. What Dr. Nkosi thought could be a sign of childhood psychosis was in fact a cultural myth to scare children and superstitious people.

**Education and Employment History**

Miranda has a total of 17 years of formal education (all in Spanish). She completed primary and secondary education in Venezuelan urban public schools. Her performance in school was high-average. Miranda graduated as an economist, with average results from the best public university in Venezuela. Her academic results at university were average. She then worked in the credit card department of a large bank for three years. She resigned when she became a mother.

**Clinical Observations**

I had three assessment sessions with Miranda and one (jointly) with Ernesto. In our first interview, she was appropriately groomed to her situation (no cosmetics and no jewelry) and wearing EEG electrodes (as she was under 24-hour monitoring). By the third session, Miranda was wearing makeup and had styled her hair. She was polite, friendly, and approachable. Miranda was relieved at being able to express herself in her mother tongue. She addressed me informally (by my first name). I interpreted this as culturally appropriate and responded by addressing her similarly. Her facial expressions were congruent with low mood and she established good eye contact. Rapport was immediately established (facilitated by her sense of relief for having a Venezuelan psychologist) and her interactions were natural and spontaneous.

Miranda was fully oriented and attentive. She answered questions appropriately. She was talkative, had circumstantial speech but was able to come back to the point. Speech rate and volume were normal. Psychomotor functions were preserved. Her mood was generally dysphoric but appropriate and congruent. She was responsive to humor, but tearful, as we addressed painful topics. She reported physical and cognitive fatigue.

At the time of hospitalization, Miranda presented with persecutory delusions, auditory hallucinations (voice in her head), and depersonalization/derealization. Nevertheless, during our meetings she was able to reflect on these symptoms and provided a full logical account of the events that led to their development. Her capacity for insight was excellent as she was able to make good sense of her experience, potential triggers, and contributing factors.

**History of Present Illness**

Miranda identified the onset of her symptoms two months before seeking help. Her persecutory beliefs had an insidious onset that we traced back to a traumatic episode. While walking home from the supermarket, Miranda was attacked by someone trying to steal her cell phone and was stabbed. During a long hospitalization, she had several seizures, potentially linked to infections, which did not require medication after discharge. After returning home, she felt angry, sad and
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apprehensive, and resorted to obsessively listening to spiritual and religious videos through earphones all day and night. Sometimes she would stay up all night praying. She believes that the voice in her head was activated by the constant voices coming from the earphones. The voice in her mind was unfamiliar and instructed her to “confess, confess, everyone will find out.”

Miranda felt unsupported by her only Venezuelan friend in Johannesburg and became suspicious of those around her. She believed that people in the streets knew she was a foreigner and were planning to attack her again. Consequently, she was reluctant to leave the house and spent more time watching videos. Her crisis peaked when a computer cable was lost, and she believed that her children and husband were hiding it from her. Miranda found the cable a week after it went missing, and realized that she had put it away—a scary thought crossed Miranda’s mind: “Perdí mi lucidez” (I lost my lucidity). Miranda realized at that moment that there was something wrong with her and called her sibling in Venezuela, who instructed her to consult a doctor. Miranda’s sibling had been diagnosed with schizophrenia at 23 and told Miranda that her symptoms sounded like psychotic episodes. Miranda listened to her sibling and was hospitalized immediately. During our interviews, she displayed good insight but was still frequently unsure about the accuracy of some of her interpretations. For example, she was convinced that people did not like her because she was Venezuelan (“Venezuelans have bad reputations all around the world”).

Although feeling anxious and sad, Miranda was able to meet her “responsibilities” at home, such as cooking, cleaning, and caring for the children, and maintained her hygiene. She had excellent insight, was able to connect symptoms with specific triggers, and received my feedback and interpretations constructively. For example, she described how she was impacted by South African news on xenophobic attacks on nationals from other African countries where several deaths were reported. She recognized that this may have played a role in her beliefs that she was a potential target which eventually became a reality when she was violently robbed. She would sometimes laugh at herself when describing the ideas she had, which she found “silly.”

Application of the CTNA Approach on the Case Study

The CTNA is guided by the assumptions that the client/caregiver/referral source has identified changes in the client’s neuropsychological functioning and professional help can ascertain the nature, severity, potential causes, and prognosis of their condition. These functional changes produce distress in the client and their family. Therefore, they are looking to identify ways to reduce the impact that these issues have on different life areas. The model works under the premise that neuropsychological tests provide objective information, which is applicable to the client’s life and may provide insight into the current situation and guide the treatment plan. Moreover, CTNA assumes that clients “want to be respected and to be empowered as active and autonomous participants in treatment and decision making process” (p. 41). All sessions, especially the one dedicated to feedback, should be client-centered and empathic, which promotes the client’s collaboration in the process, accentuates their active role in the decision-making process, and reduces the resistance to difficult information, therefore strengthening the working alliance between the client and the neuropsychologist.

The first aim in the collaborative information gathering within the CTNA model is to explore the client’s understanding of the problem and the emotional experience associated with it. The subjective experience of the issue is as relevant as the objective clinical data. CTNA includes the concept of Central Cognitive-Emotional Complaint (CCEC), which aims to communicate empathic understanding of the client’s experience (including the content and associated feelings, and impact on daily life). With this premise in mind, during my first session with Miranda, I used open-ended questions to explore how Miranda was making sense of her current situation (symptoms and hospitalization) and to validate this experience as well as her capacity to make sense of it. Miranda felt relieved for
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Miranda talked in her home language and was open to describing her symptoms and history. Cognitive symptoms were not central features in her narrative around her current and past health history, and she only mentioned experiencing seizures when prompted about her neurological history.

NEUROPSYCHOLOGIST: You mentioned that you had seizures while you were in hospital after the robbery, did you notice any changes in your cognitive abilities or your capacity to do any activities after you were discharged?

MIRANDA: No. I have felt fine since those seizures. I got those seizures because of the infection I had. I think this is why I have this (EEG) on. When I started feeling like this (referring to the onset of her current episode), I called my sister in Venezuela and she told me that that was exactly how she used to feel before getting hospitalized, so I told my husband to take me to the doctor because I wasn’t well.

NEUROPSYCHOLOGIST: What about your concentration? Your memory? You mentioned that you couldn’t concentrate well and couldn’t remember where you put things, and then thought your kids were taking stuff away from you.

MIRANDA: Honestly, I don’t know. I couldn’t concentrate well on many things, I was just thinking that everyone was plotting against me. I don’t remember putting the cable in where I found it, but what broke me was that I was blaming my poor kids and made them cry (becomes tearful).

NEUROPSYCHOLOGIST: When you saw your kids crying, you worried that something maybe very wrong with you, you felt sad, guilty, and maybe even scared, but it does not sound like the problem was that you ‘forgot’ where you put the cable, but that you thought your family was hiding the cable from you.

MIRANDA: Exactly! Exactly that. Thank you. My memory is fine. I know Dr. Nkosi is worried about my memory but I don’t think that is the problem.

NEUROPSYCHOLOGIST: Miranda, I hear that you are not experiencing major changes in your cognitive abilities, but memory, for example, sometimes can be affected by emotions, like sadness, anxiety. Would it be OK if I ask you a few questions to test your memory now?

Miranda agreed, so I asked her some screening questions that were specific to Venezuelan culture and her life history. For example: In what year was UCV declared a UNESCO world heritage site? Describe the route that can take you from your house to the stadium and describe step-by-step how you would prepare hallacas (a traditional dish of complex preparation). She responded to all questions appropriately and elaborated further on her emotional experience, and accentuated that her neuropsychological performance was not a central aspect of her complaint. I took this opportunity to reflect on her CCEC, as illustrated below.

MIRANDA: I was losing my mind, I was scared, but I did not once forget to fetch my kids from school or to pack them lunch. I was on top of everything in the house … well, maybe not everything. I wasn’t really cleaning much and all I wanted to do was to watch videos, pray, or sleep. You ask me those questions and I know the answer to everything, I can even picture the routes in my head. But I couldn’t really understand what the doctor was asking me the other day, she asked me lots of questions that I didn’t know the answer to, but you know, I have been here so many years and I can’t speak English, my English is really bad (she laughs). My husband helps me but he has to work and now he also has to take care of the kids. I feel ashamed because of my English, people think I’m stupid, so I just shut down. Now that you are here, we speak in Spanish, I can’t even tell you, I feel better already, and I feel like I can’t stop talking.

NEUROPSYCHOLOGIST: Miranda, I hear that this entire experience has been overwhelming and terrifying for you, not only because of the symptoms you are experiencing but also because
your main support structure is not a space that you have been able to trust lately, and they are struggling to understand what is happening to you. Then you come to hospital and cannot communicate with the team caring for you because of the language barrier, so it is also difficult for them to understand what it’s happening to you. Talking to me in Spanish now, and being able to make more sense of what you have been feeling is already offering you some relief.

My interventions aimed to investigate the presence of cognitive symptoms using Miranda’s report as a starting point and to explore how she constructed these cognitive complaints in relation to her current situation. Miranda was not concerned about her cognitive skills. The next step was to decide with Miranda whether testing was desirable or necessary.

As health practitioners, we have the ethical mandate of informing our clients about the aims, nature, risks, and outcomes of our assessments and interventions. In alignment, CTNA takes this a step forward as it invites the patient to reflect on their fantasies and expectations linked to the assessment process, opening an opportunity for clarification and collaboration. During my meetings with Miranda, we discussed what neuropsychological assessment entails and her thoughts about the potential benefits. Miranda clearly communicated during our sessions that she did not see a significant benefit in getting tested because she did not have neuropsychological concerns. Ernesto agreed as he did not have specific concerns about Miranda’s cognitive functioning. Moreover, my clinical assessment did not flag specific cognitive issues that needed immediate exploration. I supported Miranda’s decision and, by doing this, reinforced the values of respect, autonomy, empowerment, and collaboration highlighted by the CTNA model. I communicated to Dr. Nkosi that I did not find testing necessary and the need for a full neuropsychological evaluation could be reconsidered in six months. The work done during three sessions with Miranda was sufficient to clarify her diagnosis and provide emotional relief for the client, who recovered well and was soon discharged.

Had we decided to move forward with the assessment, I would have chosen a battery of tests based on those that I have available in Spanish in my South African practice and for which I have Venezuelan norms (e.g. Mini-Mental Status Examination, Rey Auditory Verbal Learning Test, Controlled Oral Association Test, Clock Drawing Test, and Attention Test). If needed, I could have used selected subtests of the Wechsler Intelligence Scale-IV (UK) and the Wechsler Memory Scale-IV (UK) using instructions in Spanish (e.g. Digit Span, Letter-Number Sequencing, Matrix, Block Design, Visual Reproduction, and Symbol Span) taking into consideration interpretation biases due to the use of non-representative norms.

**Feedback and Recommendations**

*For the Psychiatrist*

After each of my meetings with Miranda, I discussed my impressions with Dr. Nkosi. My first session with Miranda was used mainly for catharsis, so it was difficult to formulate a hypothesis. Nevertheless, I highlighted that Miranda did not have a childhood history of psychosis and the onset and presentation of symptoms did not support a diagnosis of schizophrenia. Miranda had no history of mania or hypomania. Her depressive symptoms were reactive and did not significantly interfere with her daily functioning. The age of onset was also atypical. The results of the EEG were normal and no major neuropsychological decline was observed. Thus, the diagnoses that had been considered thus far of Schizoaffective Disorder, Bipolar Mood Disorder were excluded. Considering her clinical presentation, Miranda’s significant history of trauma, losses, and separations, it is likely that she presented with either a Delusional Disorder (297.1 [F22]) first
episode currently in full remission (persecutory type) or a Brief Psychotic Disorder (298.8 [F23]) with marked stressors. The diagnosis of Mild Cognitive Disorder was deferred until the remission of her psychiatric symptoms, which was ruled out after a six-month follow-up.

For the Client

Following her request, I organized a feedback meeting with Ernesto and Miranda. Ernesto hoped to understand Miranda’s situation better. During this session, he asked questions about the diagnosis, the risks of recurrent episodes, the medication, and the costs of psychological and psychiatric care. I had a separate feedback session with Miranda, when she was not actively psychotic, with a low mood, but ready for discharge. During this session, I linked Miranda’s childhood and recent traumatic history, potential inherited vulnerability to mental health issues on the psychotic spectrum, the alienation experienced by her after immigration, and lack of social support, as potential contributors to her sadness and psychotic episode. “I didn’t realise I had so much pain buried in my heart, and that made me disconnect with reality,” was her answer. I recommended continuous psychiatric management and psychotherapy. Miranda asked if I could continue to be her psychologist, to which I agreed, and we embarked on a year-long therapeutic process. During this time, Miranda recovered fully.

Section III: Lessons Learned

• Venezuelans have lived through a catastrophic crisis over the past 20 years, resulting in complicated traumas and bereavement. Clinicians assessing and treating Venezuelan clients need to understand the person within this macro-context and be mindful of their socio-economic and political stressors. Malnutrition, failures in educational systems, poor access to services, unmanageable levels of stress, among other contributors, have a major impact on our mental health, brain development, and neurodegeneration.

• The practitioner’s familiarity with the historical, cultural, and linguistic background of clients influences diagnostic accuracy and treatment effectiveness. Neuropsychologists must not only strive for cultural competence but should aim to improve the diversity of multidisciplinary teams to better cater to an increasingly multicultural society.

• Providing psychological services in the client’s mother tongue can be therapeutic in itself. Clinicians should thus make an effort to provide this option to clients.

• Traumatic history during childhood has a significant effect on the migration experience in relation to acculturation and the emotional capacity to adapt to the new country. Neuropsychologists must be mindful of the impact of emotional factors on cognitive health when working with migrant communities.

• Motivations driving migration, subjective experiences in this process, and the legal status of the client in the receiving country should be investigated during the initial interviews in non-threatening ways. This information is key as it provides a route to explore premorbid abilities, current stressors, coping mechanisms, etc.

• The CTNA approach is ideal for contexts with great cultural variability and for clients experiencing emotional vulnerability.

Recommended Readings

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References


