Dear Readers,

It is an honor to introduce the New York State Psychological Association’s (NYSPA) Division of Culture, Race, and Ethnicity’s (DCRE) newsletter, The Cultural Spotlight. The launch of the newsletter occurs at a time of demographic change at a national level. These national trends are reflected on a local level in our home state of New York. True to its title, The Cultural Spotlight, underscores the impact and influence that sociocultural variables have on psychological phenomena. Contributions explore the ways in which race, gender, culture, ethnicity, sexual orientation, religion, ability, and social class, among other variables, play out in our work with diverse communities and in our roles as scholars, practitioners, mentors, and teachers.

I am also delighted to introduce the newsletter’s editorial team, Daniel Kaplin, Lorna Myers, Nancy Dessources Adgoke, and Amy Lee. You can read more about these individuals on the back page of this newsletter. The work and effort of this group has transformed this newsletter from an initial concept to an emanating reality. The vision of the editorial team is reflected in the pages that follow. The article on psychological assessment with bilinguals, for instance, explores practical and ethical dilemmas related to language duality. Ethical and practical issues are also explored via the manuscript that addresses considerations in the forensic neuropsychological testing of Spanish-speaking populations. The third article explores what we mean when we talk about cultural competence. This first issue concludes with work that explores cultural issues in psychological assessment with an Orthodox and a Haitian woman. Together, these present an initial platform from which the ongoing contribution of The Cultural Spotlight will be framed.

We appreciate and look forward to your readership. We trust that the considerations raised will encourage learning and growth about cultural implications for your work and practice as a New York State psychologist.

Sincerely,

Caroline S. Clauss-Ehlers (aka CC)
President
NYSPA Division of Culture, Race, and Ethnicity
Psychological Testing of Bilinguals in 2012: fertile ground for ethical violations

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Abstract

The current paper discusses the ethical and practical dilemmas that neuropsychologists and clinical psychologists who administer psychometric tests confront when testing patients of varying levels of bilingualism. Although it is estimated that 20% of the population in the United States comes from potentially “bilingual” homes (U.S. Census Bureau, 2010 American Community Survey), many clinicians who administer psychological tests to bilinguals remain unprepared and uninformed about the complexity of bilingualism, lack the necessary measures, and continue employing unethical practices. This paper ends with practical recommendations when working with a bilingual or monolingual patient.

Keywords: bilingual neuropsychology, cross-cultural testing, et-
In 1892, Ellis Island received its first immigrant. Not long after, medical inspectors developed tests in order to detect and bar entrance to “idiots” and other undesirables. One of the medical officers, Howard Knox (1914) devised several non-verbal tests meant for Ellis Island immigrants, the most famous of which is the “Knox box” which he referred to as the “moron test.” At around the same time, Goddard began administering the English translation of the Binet-Simon Tests to immigrants on Ellis Island. The practice employed is cringe-worthy from our current understanding in that the test that was administered had already undergone a first translation from French to English and was then retranslated through interpreters “on the fly” into the immigrant’s language. What resulted from this? The majority of Jews, Hungarians, Italians, and Russians were identified as mentally retarded (Gregory R, 2006). Along the same lines, in 1923 Brigham wrote A Study of American Intelligence in which he analyzed the Alpha and Beta scores of several ethnic groups and concluded that African Americans, Mediterranean immigrants, and Alpine immigrants were intellectually inferior as compared to the Nordics. Granted, he later took this conclusion back and for this he deserves recognition.

It is troubling to imagine how a century ago these doctors “tested intelligence” in people who spoke so many different languages and differed so greatly in education. We cannot help but suspect that they must have mistakenly identified a very high number of non-English speakers or persons with limited education as “idiots.” It is tragic to imagine that they were turned back after having endured such an odyssey solely because of the administration of a faulty test. Truly this was a dark point in the history of psychological testing. But unfortunately what is even more sad and frustrating is that in 2012 not that much has changed in the assessment of patients who are not English dominant within the field of psychological testing in the USA. The main difference is that this is no longer occurring on Ellis Island but rather in private offices, testing agencies, schools, hospitals and in the courts.

Bilingualism
It is estimated that 20% of the population in the United States comes from potentially “bilingual” homes (U.S. Census Bureau, 2010 American Community Survey). Therefore it is essential that psychologists become educated about this common attribute. Bilingualism is a special form of language development in which the first key concept is that it is not monolithic. There are many variations in
regards to acquisition (sequential, simultaneous), levels of proficiency (balanced and unbalanced), and of course, the process itself is fluid and changing over time. Sequential language acquisition will vary greatly depending on the context and length of exposure to the second language. Simultaneous bilingual development may initially present as “delayed” when compared to monolingual language development, although it typically equalizes with prolonged scholastic exposure. Balanced bilinguals are equally comfortable and proficient in all areas of both languages (i.e. speaking, reading, writing, auditory comprehension) although few people achieve this. More commonly, a person may be bilingual but more proficient in one or the other language depending on the context. These persons are considered “non-balanced bilinguals” and represent the majority (Llorente A, 2008; Valdes G and Figueroa RA, 1994).

**Language Proficiency**

Language proficiency is a huge variable to take into account if performing psychometric testing with a non-native English speaker. When a patient confronts a test (IQ, achievement, memory, language, attention, or personality) in a language in which they are not proficient, what is that test really measuring? Perhaps the test is measuring English mastery or experience with test-taking situations, but there are certainly more efficient and direct ways to assess for that. And when as psychologists we simply report the numerical scores of that patient as representative of their intellectual quotient (FSIQ, VIQ or even PIQ), achievement level, memory capacity, etc., what we are doing is potentially harmful to the patient. When reporting these scores without considering the influence of language, it can lead to real life consequences in school age children such as the over-representation in special education, over-diagnosis of mental retardation, under-representation in gifted and talented programs and private educational institutions. In the courts, this practice can lead to more punitive jury decisions and less compensation. In the medical field, this practice can lead to misdiagnoses of neuropsychological and psychiatric conditions and misinformation used for surgical decisions.

**Administering tests in ways that the test was not meant to be administered**

The common practice of administering “performance” tests (that are not culturally sensitive nor designed to be given in a non-verbal administration) to non-English speakers to obtain “some form of mental measurement” is debatable (Von Thomsen C, Gallup L & Llorente A, 2008). For example, the
Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV, 2003) has seven Performance subtests, all of which do have verbal instructions. If these are translated, the examiner’s manual states “translation or bilingual administration of the test is a deviation from the standardized administration.” However, if the test is simply mimed (pointed and gestured), this also represents a deviation from the standardized procedure. From a practical standpoint, if I try to answer for myself whether I think this is an acceptable practice, I imagine a 6 year old child sitting in front of an adult who is speaking in an unknown language and is miming without providing verbal instructions. Clearly this child is at a significant disadvantage from a child who is comfortable being able to communicate with the adult and who has the added benefit of hearing the instructions along with the gestures. There are a growing number of reports that show that bilinguals and persons from different ethnic backgrounds perform variably on a number of tests, including tests that are not language-based (Hambleton R & Kanjee A, 1995, Myers L & Bonafina M, 2011, Nell V, 2000, Ponton, et al, 1996, Valdez G & Figuerroa R, 2008). In fact, Ponton et al. reported that their Hispanic sample earned very different averages on the Rey Osterreith Complex Figure Test and the Colored Trail Making Test, neither of which can be considered “language-weighted.”

In addition, the practice of administering translated tests that have been standardized and normed on a monolingual, uni-cultural English-speaking population is also problematic (Demsky YI, 1998, Gasquoine PG & Gonzalez CD, 2012). When Myers et al (2003) examined two matched epilepsy samples --monolingual Spanish and English speaking, significant sample specific differences were found on the same naming test and controlled oral word association test. Likewise, a comparison by Boone et al (2007) of patients who spoke English as a first language (or who learned English concurrently with a second language) versus those who spoke English as a second language (ESL) revealed significantly better performance in the non-ESL group for Digit Span, Boston Naming Test, and FAS.

Recommendations
In 1998, Artiola I Fortuny & Mullaney HA gave sound recommendations for clinicians encountering a patient who does not speak the clinician’s language. The following are suggested based on these recommendations and some modifications.
1) Determine whether the child or adult you are about to test is a monolingual English speaker or bilingual. If bilingual, determine (to the extent you can) whether the patient’s language proficiency in English is sufficient to take your tests.

a. A rudimentary way of screening for English proficiency is by asking a series of questions such as: Do you speak another language? Which language do you feel more comfortable in (note that sometimes self-report is not accurate)? What language do you speak at home/out of the home? How much English do you speak per day and how much do you speak your other language? In what language do you read and watch/listen to media? How long have you lived in the US? How long have you been or were you in an English language educational institution?

b. There are a number of standardized approaches to assess language mastery. Some available measures include the Woodcock Munoz Language Survey-Revised Normative Update for Spanish/English speakers (Schrank F et al, 2010) or for bilinguals of all languages, the Bilingual Verbal Abilities Test (Muñoz-Sandoval A, 1998).

2) If the child or adult is not clearly proficient in English, the clinician should not proceed with the test unless there is a very powerful reason why some form of psychometric measurement is needed and there is no appropriate referral available. If the latter is the case, however, it must be unequivocally stated in the report that the scores were obtained through an assessment in the patient’s non-dominant language with tests that were administered in a non-standard procedure and scored based on a different normative sample. Limitations of this assessment must be crystal clear for all other professionals and non-professionals who read the final report.

3) If at all possible, you should refer the patient to a neuropsychologist who is proficient in the patient’s languages.

Summary

In sum, what has been discussed above is not new and is in line with the APA Ethical Guidelines and Codes of Conduct (2002). However, the examination of this topic is necessary given that unethical practices are still occurring with striking regularity in the area of psychological testing. Peer bilingual neuropsychologists and myself can unfortunately vouch for this as we have the chance to review our bilingual (and sometimes monolingual) patients’ prior testing reports. This is a call to awareness and action especially to psychologists in the State of New York where over 100 languages are spoken just within the five boroughs of New York City. If we use one of our most distinctive and valuable professional tools, psychometric tests, without the necessary sensitivity for linguistic diversity the value of our work declines and we risk becoming like the “testers” of a century ago.
References

APA Ethical Guidelines (2002) 9.01 Bases of Assessment, 9.02 (a, b, c) Use of assessments, 9.06 Interpreting Assessment Results, 2.01 Boundaries of Competence. Article author query


"Forensic Neuropsychological Testing of Latinos: Assuring Accuracy and Fairness when Assessing Spanish-Speaking Populations"

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Abstract

The current paper reviews the ethical and practical dilemmas that forensic neuropsychologists confront when testing Spanish-speaking patients. During the past two decades, this field has grown significantly among English-speaking examinees, thus reaching a level of sophistication that intends to achieve accuracy and fairness. However, the scarcity of research and progress in this field among clients that speak Spanish is alarming. Forensic neuropsychological testing of clients in this group is further complicated by the broad diversity of the population included under the umbrella terms of “Latinos” or “Hispanics.” This paper will briefly discuss crucial issues that hamper the possibility of ensuring an adequate assessment of this large ethnic group, including the shortage of appropriately normed tests, the frequent illiteracy and low education of clients, the dilemma as to whether or not use interpreters, key factors impacting the evaluation of effort and motivation, the consequences of the lack of familiarity of clients with the legal proceedings in the United States, and the release of raw data to non-Spanish speaking clinicians.

Keywords: forensic neuropsychology, cross-cultural testing, ethics.
According to Stavans (1996), the terms Hispanic and Latino are frequently used interchangeably although some prefer the word “Hispanic” to refer to pragmatic issues such as education and health, while “Latino” is frequently associated with an atmosphere of glamour as it is commonly used to mention artists and movie stars. Therefore, for the purpose of this paper, the term “Hispanic” will be used.

The Hispanic population living in the United States is 48.9 millions (U.S. Census Bureau, 2009), which shows that it accounted for more than half of the total U.S. population increase between 2000 and 2010. During that period, the Hispanic population grew four times the nation’s 9.7 percent growth rate in every region of the United States, most significantly in the South and Midwest. Currently, the largest group is represented by individuals of Mexican origin, followed by Puerto Ricans, and individuals of Cuban origin. Since 2000, three groups of Hispanic origin surpassed a population of one million: Salvadoran (1.6 million), Dominican (1.4 million) and Guatemalan (1.0 million) (U.S. Census Brief, 2010). Nevertheless, there is an increasingly high number of immigrants from different developing countries in South America.

Undoubtedly, this ethnic change poses a challenge to neuropsychologists willing to fairly and accurately assess the cognition of these individuals in their primary language within the forensic setting. Since cognitive processing is inevitably impacted by the individual’s own culture (Manly and Jacobs, 2002), a list of crucial issues that must be taken into consideration when assessing Hispanics is listed below and will be briefly discussed:

- Testing instruments and norms;
- Fluency in Spanish;
- Frequent low level of education among Hispanic examinees;
- Assessment of effort, motivation and competence;
- Release of raw data to non-Spanish-speaking clinicians.

Testing Instruments and Norms

There are basically three instruments that are routinely used in this field: The Neuropsychological Screening Battery for Hispanics (Pontón et al., 1996; Pontón, Gonzalez, Hernandez, Herrera, and Higareda, 2000), the Evaluación Neuropsicológica Breve en Español-NEUROPSI (Ostrosky-Solis, Ardila and Roselli, 1999), and the Spanish Neuropsychological Battery (Artiola I Fortuny, Hermosillo Romo, Heaton, and Pardee III, 1999). These three batteries include tests designed to assess basic aspects of attention, executive functioning, memory, and language. However, when their normative data is closely scrutinized, such tools reflect the performance of specific subgroups of Hispanics, mostly Mexicans, with a very small number of samples from other regions, including the Caribbean countries. Given the geographic distribution of Hispanic immigrants in United States, this lack of norms for non-Mexican clients of Hispanic origin is likely to have a significant impact when testing clients in the Eastern regions of this country. When compared to the neuropsychological assessment of English speakers, these tests batteries...
have a clear limitation regarding the scope of functions assessed and could be consider falling noticeably short from meeting the same ethical standards than batteries applied to English-speakers. Consequently, neuropsychologists tend to “complement” these three main testing tools with improvised translations of tests in English while attempting to interpret their clients’ results using norms that were obtained from English-speaking samples. In this case, the bilingual forensic neuropsychologist is faced with the question of whether it is ethical to use this procedure of adding tests non-standardized among Hispanics or to avoid testing a cognitive domain (e.g., visuospatial organization, motor functioning) for lack of appropriate tools.

**Fluency in Spanish**

**Spanish language: An “umbrella” term.** There are approximately 13 to 27 different Spanish dialects (Cotton, Greet and Sharp, 1988), some of which are quite different from one another, particularly in their vocabulary and pronunciation. As a consequence, it is imperative to be familiar with each client’s specific linguistic background. Even when the forensic neuropsychologist is fluent and bilingual, his/her lack of awareness of the multiple subtleties in such variety of dialects could interfere in the communication during the evaluation process and could potentially produce invalid results. Unfortunately, this issue is not frequently addressed since there is a prevalent belief that Hispanics could be gathered under this generalization despite their country and region of origin, differences in SES, sociocultural and political environments during the upbringing, contexts of education (e.g., rural versus urban) and, again, dialects and regionalisms.

**The use of interpreters.** Artiola i Fortuny and Mullaney (1998) have set a high standard for neuropsychologists since these authors consider that only professionally-trained native speakers are appropriately fit to evaluate Spanish-speaking clients. A relatively recent survey among neuropsychologists (Echemendia and Harris, 2004) indicates that a very small group (11%) considered themselves within the “adequate” to “fluent” range in Spanish while testing Hispanic clients. Given the high specialization, among forensic neuropsychologists, this number is likely to drop significantly. When the examiner is not fluent enough to perform a forensic neuropsychological assessment, interpreters are frequently used. However, this resource is not enough to ensure an adequate translation during interview, testing and interpretation of test results. The monolingual English-speaker forensic neuropsychologist, unaware of possible translation errors, could make potentially devastating diagnostic mistakes. For example, in some cases, immigrants report being “bilinguals.” However, it is the responsibility of the forensic neuropsychologist to carefully assess the degree of fluency and comfort in each language. Depending on the
judgment of an interpreter is an unreliable tactic since bilingualism usually involves a complex spectrum of degrees of familiarity with two languages, which is frequently entangled with the degree of acculturation of the clients. The self-perception of the clients’ mastery of the English language frequently involves an inaccurate assessment of their proficiency in the non-dominant language, either by under or overestimating their functioning (Harris and Llorente, 2005). In these cases, it is imperative that a fully bilingual forensic neuropsychologist completes a dual-language testing, at the time that he/she is aware of the possibility of interference between the two languages. Indeed, the use of a bilingual and bicultural forensic neuropsychologist becomes almost mandatory when taking into account the possibility of interference between the two languages. The determination of whether the clients’ answers are “acceptable” and “correct” depends on the mastery of the neuropsychologist of the intricacies of the variety of regionalisms. While some errors could be unquestionably obvious, others may not be as evident and could remain unnoticed by a translator, thus leading to multiple diagnostic inaccuracies. Finally, bilingual and bicultural neuropsychologists, like any other clinical professional, work hard to remain neutral throughout the forensic neuropsychological testing. However, remaining objective could become a challenge even when the neuropsychologist and the client have a similar Hispanic origin: Occasionally, there could be a clash of cultures, including differences in dialects, in SES, education, nationality and, perhaps, prejudice. The professional should not ignore nor minimize these countertransference factors since they could compromise the validity of the evaluation.

**Low Level of Education**

It is fairly common that forensic neuropsychological clients have a level of education lower than the ninth grade or who are merely illiterate. The intricate meaning of “literacy” in Latin America, particularly in the low end, encompasses a wide spectrum that ranges from total isolation in rural areas of extreme poverty with no access to schooling to living in marginal urban areas with a “formal” completion of some schooling while being a functional illiterate (Artiola i Fortuny & Mullaney, 1998). Moreover, the clients’ frequent lack of familiarity with academic settings adds another layer of mistrust to the forensic testing situation, which already tends to be perceived as intimidating and hostile, and can impact the fair representation of the client’s true cognitive abilities. Given the crucial interrelationship between cognition and education, the forensic neuropsychologist should be aware of the actual level of education of the Hispanic patient, which could occasionally be poorly reflected in a grade level or in the number of years of formal education. Indeed, given the frequent intricate relationship between educational, social and political situations in Latin America, an accurate assessment should ensure that the examiner has an adequate knowledge of all these factors to avoid pathologizing normal behavior (Paradis, 2008) and/or miss unexpected diagnosis (e.g., post-traumatic stress disorder in a client that was exposed to guerrillas in his/her...
origin and the neuropsychologist is unaware of this important piece of background).

**Assessment of Effort, Motivation and Competence**

The routine administration of effort measures has become an standard practice among forensic neuropsychologists. However, there is an alarming paucity of research on the use of this type of tools among Spanish-speakers (Artiola i Fortuny et al., 2005). The illiteracy, low level of education and/or lack of familiarity with the test stimuli are even likely to compromise non-verbal and allegedly “culture-free” tests as well as seriously endanger the validity of informal translations of verbal tests. Needless to say, the scarcity of norms for these measures among Spanish-speaking populations constitutes a serious threat to the validity of the entire evaluation. Eventually, the use of informally translated tests without adequate norms could end in the unfair determination of the presence of malingering or lack of competence with the grave ramifications that such conclusions can generate in a medico-legal setting. Furthermore, grave practical and ethical issues are also centered on the lack of familiarity with legal proceedings practiced in the United States, which are frequently foreign to Hispanics. This situation is likely to be further complicated by sociocultural beliefs and values that tend to be quite diverse between Hispanics and Americans (Ardila, 2005, 2007). Among these, the perception of the forensic neuropsychologist as an authoritative figure could influence the client and he/she may tend to please the examiner. Moreover, testing could be perceived as humiliating, being asked background questions as an invasion of privacy, and working under time constraints as a puzzling demand of exchanging quality for quantity. The examiner’s clinical judgment is crucial while assessing effort, motivation and competence. The lack of awareness of the cultural disparity between Hispanic and American perceptions, tradition, and beliefs could jeopardize the possibility of making a fair evaluation.

**Release of Raw Data to Non-Fluent Forensic Clinicians**

While the APA Ethics Code mentions that raw data should be released to qualified professionals, the requisite of being “culturally and linguistically” qualified to review data gathered by another colleague in a different language is not addressed (Artiola i Fortuny & Mullaney, 1998). This poses a dilemma for the Spanish-speaker forensic neuropsychologist since the raw data including test materials, the client’s responses and, most likely, the initial interview was most likely gathered in Spanish. Therefore, the request to release the raw data to another professional unfamiliar with the test materials, their norms, and most importantly, the language is clearly absurd. Even in the case that the non-Spanish speaking forensic neuropsychologist decides to obtain help from a translator, this poses a serious threat to obtaining a valid opinion. In such situation, neither the neuropsychologist nor the Spanish-speaking aid could be jointly aware of subtleties in dialects differences, knowledge of the nuances of each test to accurately interpret the results.

**Conclusions and Recommendations**

Cross-cultural forensic neuropsychological testing is a very challenging field. In light of the rapidly growth of the Hispanic population...
in the United States, it is imperative that clients that are assessed for forensic purposes receive an accurate and fair evaluation. This could be achieved by increasing awareness about the need to promote research to develop and standardize culturally appropriate tests for the variety of Hispanic groups, obtaining appropriate training, ensuring linguistic and cultural competence of colleagues and, perhaps the most difficult, assessing one's true linguistic and cultural competence to assess each specific client. If the examiner is not fluent, he/she should refer the client to a fluent bilingual and bicultural forensic neuropsychologist. When this is not possible, the examiner should personally train an interpreter, preferably of the same Hispanic cultural background of the client, in the basics of the neuropsychological testing. Undoubtedly, progress and development of forensic testing of Hispanics will contribute to the overall advancement of the field of cross-cultural clinical neuropsychology.

References


Building Bridges: Challenges to Becoming Culturally Competent

Roy Aranda, Psy.D., J.D.

Abstract

A working definition of “culture” is an integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. This article will discuss the rapid increase in the Latino Population and it’s implications for being culturally competent. A review of the pertinent ethical standards are presented. The article concludes with applications on how prescriptive privileges for psychologists and telepsychology will be required for better service of the Latino community.

Keywords: Latino; Multicultural Competence; Ethical Standards; Immigration; Teletherapy; Prescriptive Authority
According to the 2010 Census, 50.5 million people or 16% of the population are of Hispanic or Latino origin. This represents a significant increase from the 2000 Census which registered the Hispanic population at 35.3 million or 13% of the total U.S. population. Nearly 14 million new immigrants came to the U.S. from 2000 to 2010. This large influx of immigrants "provides a challenge to the practice and science of psychology." Crossroads: The Psychology of Immigration in the New Century, Report of the APA Presidential Task Force on Immigration, APA, 2012. The challenge of developing multicultural competence for psychologists requires focusing the lens of culture in many contexts: educational, clinical, forensic, research, organizational, and a variety of applied settings.

This "challenge" is nothing short of formidable. According to the Office of Minority Health, “Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.” And, “Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.” What is Cultural Competency?, U.S. Department of Health and Human Services, Office of Minority Health, October 19, 2005.

As noted by the American Psychological Association, multiculturalism "recognizes the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, disability, class status, education, religious/spiritual orientation, and other cultural dimensions. Guidelines on Multicultural Education, Research, Practice, and Organizational Change for Psychologists, APA, 2002.

Becoming culturally sensitive and competent is a tall order, but the consequences of not evolving into culturally competent psychologists leaves in its wake a trail of disservice to Hispanic consumers and consumers of other ethnic backgrounds many of whom are over-pathologized, and others whose needs are ignored or unrecognized.

Notably, when it comes to assessment, several potential errors may arise. These are driven by a lack of culturally sensitive awareness of symptom expression, a lack of awareness of the limitations of multicultural assessment practices, a lack of culturally sensitive assessment techniques, and a lack of culturally appropriate skills. A major difficulty is that assessment tools are not normed on the populations in which they are applied. Tools, therefore, may not be valid for the intended
target populations. The outcome of assessments relying on such tools, therefore, results in a reduced confidence in the conclusions.

Further contaminating the field are pervasive stereotypes such as: all Hispanics are the same; less educated; less intelligent; less productive; and less worthy of services because they are “illegals.”

Consider the derogatory term – “anchor babies” – and the dehumanizing impact on children born in the U.S. to immigrant parents who are treated like second-class citizens. See, for instance, Arizona’s controversial immigration bill, SB1070. Anchor Baby bills seek to deny citizenship to children of illegal immigrants.

Psychologists are required to abide by the Ethical Principles of Psychologists and Code of Conduct (APA, 2010). These standards provide for the minimal or basic competencies required by psychologists and are mandatory. The Specialty Guidelines for Forensic Psychology (APA, 2011) delineates aspirational guidelines for psychologists who perform work in forensic contexts.

The Guidelines on Multicultural Education, Research, Practice, and Organizational Change for Psychologists (APA, 2002), further expounded in Crossroads: The Psychology of Immigration in the New Century, Report of the APA Presidential Task Force on Immigration (APA, 2012), are not mandatory. Like the Specialty Guidelines for Forensic Psychology, these may be viewed as aspirational, a work in progress evolving over time that psychologists strive to achieve through ongoing self-search, education, and practice.

These principles and guidelines carve out basic ethical boundaries that psychologists are expected not to cross. To wit, psychologists must be “aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status.” Ethical Principles of Psychologists and Code of Conduct, Principle E: Respect for People’s Rights and Dignity. Psychologists must take great care to do no harm (Principle A: Beneficence and Nonmaleficence), recognize the boundaries of their competence (Principle D: Justice), use assessment methods that are appropriate to an individual’s language preference and competence (9.02 Use of Assessments), and be mindful of linguistic, and cultural differences that might affect their judgment or reduce the accuracy of their interpretations (9.06 Interpreting Assessment Results). The most up to date demographic, social, economic, and housing data are reported in a recent U.S. Census Bureau. The publication, The Foreign-Born Population in the United States: 2010, American Community Service Reports, U.S. Census Bureau, May 2012 provides data based on a sample size of three million addresses in the mainland U.S. and Puerto Rico.
Significant census data reveal that California, New York, and New Jersey have the highest foreign-born proportions in their total populations. Over 1 in 4 residents of California and over 1 in 5 in New York and New Jersey were foreign-born.

The implications for the practice of psychology in New York, given the trail of disservice to Hispanic and foreign consumers noted above and the many ethical boundaries that ought not be transgressed, must consider how to accommodate effectively the needs of the more than 1 in 5 residents who are foreign-born. This must entail, among other things, the type of care, access to care, quality of care (e.g. culturally competent), cost, and advocating for – and accepting nothing less than – evidence-based practice.

Two areas not presently in the scope of practice that will likely encounter formidable obstacles, and perhaps opposition, pertain to prescriptive privileges for psychologists and telepsychology.

A more narrowed focus, namely lobbying for prescriptive privileges for psychologists and telepsychology to service the more than 1 in 5 foreign-born in New York, may garner some support. The timing is ripe; after all expanding practice areas to level the "playing field" for many of these otherwise disenfranchised “1 in 5" individuals is logical and consistent with the tenets presented in this brief essay.

References


Cultural Considerations in Psychological Assessments: A case discussion of an Orthodox Jewish woman and a Haitian woman

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Abstract

This paper explores cultural considerations when providing psychological assessments to an Orthodox and Haitian females. A review of several core beliefs of these clients are discussed in relation to their cultural belief set. These authors reflect on misconceptions that can emerge by a clinician that is not culturally sensitive to their value systems. This paper concludes with a recommendation of a value-sensitive approach to therapy.

Key Words: Psychological Assessment; Orthodox Jews; Haitians; Value-sensitive therapy;
Many factors are regularly considered by psychologists for psychological treatment. These include educational history, personal narratives and social factors. Cultural issues and multicultural factors are also considered in the understanding of the person seeking treatment. Similarly, these aspects of a patient are considered in psychological assessments. Although very limited literature is available on this issue, the evaluators have attempted to discuss how cultural factors, preconceived notions and other socioeconomic issues inform case conceptualization in psychological assessment. Two case examples will also be included.

According to Suzuki and Ponteretto (2009), culture exerts powerful, yet overlooked influence on psychological assessment. Many psychologists look at ethnicity, race, and physical appearance are often considered as “cultural.” However, many fail to explain cultural ubiquitous nature of a clinical presentation (Fish, 2000).

Many cultures are known to be psychologically mindful, while others minimize the impact of emotions on a person’s behavior and cognitive development. Hoffman (2011) suggests that psychology and Judaism have an important relationship and an extended historical connection. He speaks of a part of the Talmud in which two rabbis have a disagreement regarding the anxiety in the heart of a man. One rabbi suggests forcing it out of mind, taking a cognitive restructuring approach, and the other rabbi suggests talking with others about it, taking a psychodynamic approach. Rabbis are usually consulted first when psychological problems exist and are at times reluctant to endorse psychotherapy because they believe that most tend to reduce religiosity (Margolese, 1998; Schnall, 2006). Hoffman suggests that appropriate therapeutic support can only be given by a therapist who understands that religious prohibitions are part of the core values of the patient and that feelings and conflicts about certain issues must be dealt with within this framework, even if the therapist disagrees.

The first case exemplifies how cultural expectations of a young woman shaped her personality and the possible biases held by the evaluator can lead to incomplete findings and recommendations. A 20-year old woman of Orthodox Jewish descent, Sarah, came for a psychological assessment to determine the nature and extent of her learning disability. She was diagnosed with a neurological condition which led to low motor tone and weight gain. Sarah’s mother attended each session, and seemed to have difficulty separating. She often spoke on behalf of her daughter to shield her child from perceptually harsh ques-
tions from the evaluator. Sarah faced personal pressure to accomplish higher education, but also familial pressure to ensure she learned strategies due to her learning difficulties.

The evaluator had been brought up with more modern views of women that is suppose to pursue her career and be independent, her cultural background and feedback was a challenge. Recommendations for Sarah’s needs indicated her need to be more independent, however, by becoming independent, however, by becoming independent, she was going to be fulfilling the role to become a wife and take care of her family. Thus, it posed a struggle, to have the conflict between her becoming more independent but at the same time her independence was to fulfill what the evaluator would consider a more dependent life.

Emily, the second discussion case, is a 22-year old Haitian American. She moved to the United States to live with her mother, whom she had been apart from for her first 6-7 years, and this was central to the onset of her depression. Further, her mother’s arbitrary use of extreme corporal punishment (by the most lenient definition, more likely abuse), left her isolated, alone, and confused. She was not allowed contact with many peers, so she had little social support or outlet for her feelings. She appeared timid, and spoke at a very slow pace, low volume and avoided eye contact. This became particularly frustrated for the examiner who experienced a typical countertransference with abuse victims; there was a pull to be aggressive and a need to move her along more forcefully. Her silence felt resistant and almost passive-aggressive. Her depression was also extremely depleting. The examiner felt drained after the sessions in the same way that she goes about her daily life in a fog of fatigue. Her lethargy is likely another form of withdrawal.

In working with Emily, examiner had to be especially attuned to own countertransference to avoid falling into the role of the aggressor in forcefully pushing her through tests. The evaluator also had to gauge the energy that each meeting with her took out. Finally, an awareness of Emily’s culture helped better understand the role of physical punishment. It is generally accepted in the Haitian community, and employed readily in Haiti (though Emily was never physically reprimanded in school there). When given the opportunity to report her mother’s abuse, she also felt it necessary to consider her younger sister, who would feel the negative impacts as well. In addition, depression is not widely recognized in her community, therefore her struggles are mainly kept to herself or misunder-
biggest struggles for the evaluator, who is Caucasian, included acknowledging countertransference and the draining effect of meeting with Emily. It was also particularly difficult to accept and understand the normalcy of physical abuse/corporal punishment in her culture.

In order to counteract any misperception, Heilman & Witztum (1997) suggest a therapeutic approach called “value-sensitive.” This approach respects the values of religious patients while at the same time treating them by utilizing the religious idioms, symbols, and culture that the patient comes from in order to resolve the issue that has brought them to therapy. The therapist must be able to view the world through the eyes of the patient and most importantly understand their behavior and the cultural framework in which the patient will continue to live.

This therapeutic method may require therapists at times to settle for resolutions of problems that are less than what they had initially hoped for and accept that some problems or symptoms may not be resolvable as long as the patient is adamant about remaining within their cultural universe. Similarly to the previous article, this one suggests that therapists may in certain situations have to be content with what some may view as circumstantial progress. They do note, however, that this should be the case as long as the patient wants to remain in their cultural universe. So again, for me, the question is raised as to when it becomes necessary to explore religious beliefs as a potential barrier to the patient’s happiness.

References


The Fall edition of The Cultural Spotlight will explore the unique challenges that face the Lesbian, Gay, Bisexual, Transgender (LGBT) community. We welcome clinicians, individuals working in public sector, academics, and students alike to offer submissions to this publication. Submissions should include an abstract, complete reference page, and the content of the article should range between 500-1000 words. The deadline for the Fall edition is August 1, 2012. If you are interested in submitting an article, please contact the editorial staff at DCREsubmissions@gmail.com.

Daniel Kaplin is the President-Elect of DCRE, RxP Committee, Leadership Institute Fellow. He is interested in religious minority status and Advancements in the Asian-American Community.

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