# 74| Global Neuropsychology: Introduction – With Dr. Tedd Judd

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NAVIGATING NEUROPSYCHOLOGY

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**Speakers**: Tedd Judd, Ryan Van Patten, John Bellone

**Intro Music** 00:00

**Ryan Van Patten** 00:17

Welcome, everyone, to Navigating Neuropsychology: A voyage into the depths of the brain and behavior, brought to you by INS. I'm Ryan Van Patten...

**John Bellone** 00:25

...and I'm John Bellone. As a quick reminder for everyone, Ryan and I recently released a book titled "Becoming a Neuropsychologist". We think the book could be helpful for anyone who's interested in pursuing a career in neuropsychology, or who is already studying to become a neuropsychologist - from college and graduate school all the way through fellowship or certification and finding a job. We also wrote the first part of the book for anyone who wants to know more about neuropsychology, even for those who don't want to pursue a career in the field. We describe what the field is, where neuropsychologists work, and why someone might be interested in this profession. So if you want to become a neuropsychologist, or you simply want to know more about neuropsychology, please check out our book. You can search "Becoming a Neuropsychologist" on Amazon or Barnes and Noble. And we'd be very grateful if you left us an Amazon review after reading it.

**Ryan Van Patten** 01:15

Today we speak to Dr. Tedd Judd about global neuropsychology. Tedd is a board certified neuropsychologist specializing in cross-cultural, clinical and forensic work. He has over 40 years of experience with patients from about 90 different countries, and he has taught neuropsychology in 27 different countries. He also teaches a unique practicum in non-English cross-cultural psychology. And he describes the practicum as well as many other interesting topics in the conversation with us. So, with that, we give you our discussion with Tedd Judd.

**Transition Music** 01:51

**Ryan Van Patten** 02:00

Okay, Tedd Judd, welcome to NavNeuro. Thanks for being here.

**Tedd Judd** 02:04

It's a pleasure to be here.

**Ryan Van Patten** 02:05

Great. So in the spirit of cultural neuropsychology, global neuropsychology, I'll start by referencing your bio, which may be outdated, but I see you've taught neuropsychology in 20 different countries on five different continents. You can correct me if those numbers have increased since then. [laughs] But will you list a

few of the 20 countries in which you spent more time working in neuropsychology? And if you want to share an experience or two.

**Tedd Judd** 02:33

Sure. Well, when I was in graduate school, I decided to learn Spanish. I did that and then a lot of my focus in international teaching has been in Spanish-speaking countries. So aside from Canada and the US, much of my focus has been in Central America. I've been in every country in Central America except Belize. So Guatemala, Nicaragua, and Costa Rica have been the primary focuses. And then also El Salvador, Honduras, Panama. I've been to Mexico and taught there quite a few times as well. And then Cuba once. And a number of countries in South America. So several visits to Colombia and Ecuador. Also a very memorable visit to Bolivia. A few times in Argentina, and once in Uruguay. I don't know whether one counts doing a webinar in Peru or not. I've been to a conference in Brazil, but not really that I could say that I was specifically teaching to Brazilians as the focus of that. So that's the Americas. Also one very lovely trip, in 1999, to South Africa and Zimbabwe. And I did a four month Fulbright teaching fellowship in Spain. Also been to England and Holland and Finland and Germany for teaching. And Australia. That mostly covers it, I think.

**John Bellone** 04:10

Wow. Yeah. So you have a good sense of the global nature, global aspect of neuropsychology. And, you know, many neuropsychologists in the US and Canada, they've really only been exposed to North American-centric neuropsychology. So I'm curious what you might be able to tell us about how neuropsychology, as a construct, might differ around the globe.

**Tedd Judd** 04:31

Well, I can speak from more or less direct experience from the countries I named. But I'll also mention that there's a wonderful map that has, I think it's about a 1200 mile radius to it, a big circle over East Asia, Indonesia, taking in India and China that includes about 60% of the world's population. And I've never been inside that circle. [laughs] So there's a lot I've missed, and a lot I can't speak to in that way.

But from the experiences that I have had and in speaking with other people, neuropsychology and the needs that we serve in our field are addressed by people in a variety of disciplines. I think neuropsychology tends to get started, as it did historically in the West, with behavioral neurology. It's behavioral neurologists who tend to take much of the most initial interest in it when psychology arrives. In much

of the rest of the world, psychology does not have the same status as in what I like to call the North Atlantic countries, so North America and Western Europe. Psychologists often have a lower level of training than they do in the North Atlantic. It may be less firmly founded in science. It is often seen more as a helping profession.

In much of the world, it's much more of a female profession. It developed as a male profession in the US predominantly and now it's a very nice balance, it's right around 50/50. We haven't caught up entirely in leadership yet, though we're getting there pretty well. But, in Latin America in particular, and from what I've seen, in large part, in other parts of the world, it has been predominantly a female profession - 90% or more in Latin America. And, yet, the leadership has been predominantly male. And, as a consequence, psychology as a place for neuropsychology to start has been more of a struggle. So it has taken more to force neuropsychology to develop within the field of psychology and be accepted by the medical profession and have good relationships with the medical profession.

Now, everything that I'm talking about here is subject to correction because here we are, on International Women's Day, three white guys talking about cultural neuropsychology around the world. Three North American white guys talking about neuropsychology around the world. So there's many limits to what we may have to say here, and I'm certainly very open to corrections on these things. But those are some of the power dynamics that have had to do with how neuropsychology has historically developed and is developing in countries where it doesn't exist or is beginning to develop. And that gap in foundation within the profession of psychology is real. So it can take more work to get to neuropsychology. When the INS was founded, it was founded as an interdisciplinary organization. At the outset, it was much more interdisciplinary than it is today. Now it's very predominantly people who adhere to the profession of psychology. But that's not how what we do is necessarily practiced around the world. It's more interdisciplinary - more other people doing it.

In other than, well, the Anglosphere - the English speaking world, the English as a first language world - neuropsychology is generally practiced at the level of the master's degree. So in the US, Canada, Britain, a doctoral degree is usually required to practice neuropsychology or postdoctoral training. But, in most of the rest of the world, it's a master's degree level. So that's within psychology. So that's another real difference. But then, most of those places when you enter university you enter in your major in your discipline - you enter in psychology. So in Latin America, it's a 5-year program, but you go into psychology and you have very few

electives. Almost everything is laid out for you as a psychology career. So when you come out with five years, that may be more like a master's degree in the North Atlantic countries anyhow because you've had five years focused in psychology. Europe, the rest of Europe, European Union is now in a transition with the Bologna Process, in which you do three years for your bachelor's, and then two years for your master's, and then perhaps further training from there - one year of practice practicum, of supervised practice. So it's a 3/2/1 model.

What gets covered is still fairly variable around different countries. Europe is trying to harmonize their curriculum across countries to make it easier to go from one country to another in practice, and they're in the midst of that process. But when we talk about it with the name neuropsychology, I think we also need to consider what our overall mission is. I look at what we do, as the primary goal of what we do, is first to prevent neurodisabilities. And second, to improve the quality of life, the dignity, the social engagement of people who are living with neurodisabilities and those around them. We might serve that as psychologists. Behavioral neurologists may serve that role. Speech pathologists, special education teachers, occupational therapists, there are a variety of disciplines that address that, and address it in various ways, and do different pieces of it. Our model may not serve in other countries as well as we might like. For instance, in our training in neuropsychology, we tried to train comprehensively and broadly across a wide variety of neurodisabilities, neurological disorders. And rehabilitation psychologists, for instance, could do, and often do, a very good job with a narrower spectrum of neurological disorders. So they may get very good at traumatic brain injuries, at stroke, at anoxia, and a number of other things and have not that much skill in developmental disorders, in dementia, and so on, and still do a great job of serving our mission. I'm not sure that we recognize that type of diversity of ways of serving our mission, as well as we might. I would like us to look at that more broadly, as a discipline, and keep the bigger goal in mind that way.

**Ryan Van Patten** 11:50

Yeah, there's so much good stuff in your answer there. I love this effort of starting to think about global neuropsychology. Throughout our training, understandably, we focus a lot on the APA. Then we get licensed in our state, and we think about local, regional, national issues. And those are important, but it is a whole different way of thinking about neuropsychology when we start to learn about other models of how people are trained and what neuropsychology looks like around the world. I think we potentially have a lot to learn from people all over the world in terms of how they're doing neuropsychology. So I'm wondering, to what extent might we work toward developing global standards of training in practice? Of course, we don't want

to impose our own North Atlantic standards on everyone else as if they are better. But when the spirit of, like, the World Health Organization sort of standardizing neuropsychology, or, and these are not mutually exclusive, you know, each country, each region develops its national system and we work on global collaborations. What do you think about that sort of tension?

**Tedd Judd** 13:05

Well, I would not rule out global standards, but I think they would be premature. There may be a day where that may make sense, but I don't think it's today. I think that the regional model is much more appropriate. In part, I think, because of those very different models of education that I mentioned - are you going to go at the master's level or are you going to go at the doctoral level? Are you going to keep it within psychology? I think that the ways of moving towards that include the movement towards competency-based training - looking at the competencies that we're training and describing things in those terms. And those should probably best be matched to more local or regional priorities. So we may have a variety of models developing in different places and working towards harmonizing, but also working towards addressing priority local needs and ways of approaching and meeting those needs.

**John Bellone** 14:11

There's also been some talk of decolonizing neuropsychology, I think Xavier Cagigas has been kind of at the forefront, his group has really promoted that. The decolonization, meaning that we potentially move away from a Western-centric view of the field. I'm curious if you have any thoughts about that.

**Tedd Judd** 14:30

I certainly agree with that perspective. I think that the things that I find to be peculiar or outliers about North Atlantic neuropsychology are that it's cognitivist - it's a very cognitive bias. And I think that cognitive bias comes about, in part, because those of us who do it have gained our own sense of self and our living by being very bright in certain academic ways. So we think cognition is everything and the most important thing, and that's what we encourage. We see that as the highest value and then we focus on it in our approach to the discipline. I can't tell you that I've done a very systematic meta-analysis and review on this, but my reading of the literature overall is that for many or most of the neurodisabilities that we deal with, the emotional and behavioral and social disabilities that result from the neurodisabilities are the most disabling in terms of many other pragmatic domains - work, family, relationships, life roles - more so than the cognitive disabilities. And

yet we continue to look at and focus on cognitive disabilities more. We're a little bit like the drunk who is looking under the streetlamp for the lost keys rather than over in the dark where they were dropped because the light's better there.

**Ryan Van Patten** 16:01
[laughs]

**Tedd Judd** 16:01
Yes, it's easier to measure cognition. So cognitivist bias is one of the ways that I feel that North American neuropsychology is an outlier. And I would hope that we don't export it too much, although I'm afraid that quite a bit of that has already gone on. Another way is the very individualistic approach - the focus on the individual without looking as much at that individual's context. That's something that's been found in lots and lots of social psychology, that North Atlantic populations being very individualistic relative to the rest of the world in our focus. And finding ways that are more family- and community-oriented in what we do and how we consider things.

One of the examples, and one of the things we've exported already, is something in rehabilitation called the Functional Independence Measure, which is used in large part as a metric for progress in rehabilitation. And, yes, independence is a value that is of some importance in many different places. For many functions, you know, especially personal care and dressing and so forth, perhaps particularly important. But to make it "the" metric feels very Western, very North Atlantic, and not necessarily what we might want elsewhere. There are alternative concepts, such as interdependence, and looking at - we are all interdependent. We could put more focus and more emphasis on: Has this person in their rehabilitation achieved a healthy interdependence with those around them? Are their relationships functioning well with regard to their abilities and challenges and relative to the people who are there to help them? We don't look at that nearly as clearly or as closely or systematically.

I won't run it here, but you can just imagine this for a moment. I've written a little parody around the FIM, The Functional Independence Measure. The FIM does not have a sexuality scale. And just imagine the scene of the physiatrist trying to encourage the patient to become totally independent in his sexuality, and encouraging the patient's spouse to not participate anymore in the sexuality so that they can be independent. I don't think that's what we want.

**Ryan Van Patten** 18:33
[laughs]

**Tedd Judd** 18:33
And that makes a nice little model for how what we really want is good relationships and healthy interdependence. So that's the second theme. The first theme was the cognitivist, the second is the overreliance on focusing on the individual and including focus on independence. I think we've got a highly, highly statistically-based and test-based approach to neuropsychology. And I think that likewise has its importance, but it's out of balance. We also have, of course, a pathology focus and not as much of a strength focus. We also have a diagnosis focus, and that has its place and has its function, but there are times - and I don't think we are good enough at the skills of really looking at an understanding and considering what can be the impact of diagnosis. We presume that it's important to do that, and it's important to educate people and share that diagnosis, and so forth. But a diagnosis can produce stigma and alienation and depression, and that is going to vary with the context in which it's presented and the nature of that diagnosis. So the word dementia in Spanish, *demencia*, carries a very strong message, at times, of insanity. And so there can be a lot of stigma and a lot of shame and a lot of hiding someone with that diagnosis. And unless we're familiar with and understand the culture to be able to approach that we may not be doing a service, we may be doing a disservice. We may be not contributing to somebody's wellbeing in their quality of life, but contributing to their alienation from their sources of support.

**Ryan Van Patten** 20:35
Great stuff in there. John, did you have something?

**John Bellone** 20:37
Yeah. So, just to clarify, you're saying that these are all things for us to be aware of. They're not necessarily bad in and of themselves, but these might not travel to every context that we want them to and we should be aware that this is our North Atlantic view, these aspects?

**Tedd Judd** 20:56
Oh, they will travel and they are traveling.

**John Bellone** 20:58
Sure. [laughs] They might not be wanted.

**Tedd Judd** 21:01

Well, they may be doing damage or it may be more benign, but they may be missing out on some important stuff. They may be missing out on some things that could be particularly helpful. Because if we come in and say, "This is the way you do it", rather than, "What are you doing? What works for you? Where are you stuck? Is there something we can offer that might be able to help you move ahead in this?" There's a lot of attention these days developing regarding different ways of doing dementia care around the world. We're seeing that lots of folks do it better than we do in a variety of ways. Now, that's not to say - and some of those things we can learn from them, some of those things won't work for us because we just don't have the same set of values, the same family structures, and so on. But there are things to be learned. You go to day health programs for elderly or dementing in Latin America, they're dancing, everybody's dancing. It works really well for them, it's a great thing to do. And we've got lots of research on how healthful dancing is and how good that is for brain health maintenance. You're not likely to get that to work real well in North America. [laughs]

**Ryan Van Patten** 22:15

[laughs]

**Tedd Judd** 22:15

But, it works there. Where I live up here in Bellingham, we're right near the Lummi reservation. My wife worked at the - she's a school psychologist, educational psychologist - and she worked at the tribal school. The Lummi reservation has an assisted living nursing home type place, not all families can take care of all of their elderly. It's right in the middle of the community, people stop by all the time, it's called Little Bear. And whenever there's an assembly at the elementary school, the little bus from Little Bear loads up everybody who wants to go and they drive over to the assembly. The old people walk in with their walkers or in their wheelchairs, and they're in the front row at the assembly. And elders are very respected there. They have a role, even if they have what we would diagnose as a dementia. But there's an involvement there. The kids in the tribal school can often be boisterous, but they're very respectful of the elderly, and pay attention, and they know the importance of that. Elders are involved in the school - teaching cultural lessons, teaching language lessons, and they get a lot of good attention from the kids. There are different ways of doing things. And we need to make sure that we don't squash them by a colonialist approach to neuropsychology. Just a few little examples.

**John Bellone** 23:42

No, I agree. In your talks, I've heard you differentiate between the psychology of culture but also the culture of psychology and the culture of neuropsychology, which is important for us in this context. That we need to understand the norms that we've been brought up with in this field and try to either change them or just be aware of what else might be working elsewhere and what might be able to work for us as well.

**Tedd Judd** 24:07

Yeah, and that's an example of that as well. In Latin America, neuropsychology, and psychology as well, has also developed in a way, and it varies by country, but in which there's a big class difference. So psychology is mostly something of the upper middle and upper classes, in large part. In the cone of South America, especially further south - Chile, Argentina, Uruguay - there has been historically a strong psychoanalytic tradition. Psychoanalysis especially has been a kind of status symbol. And so it's, you know, the status for being in psychoanalysis.

When I was teaching in Guatemala a few years ago - Guatemala is about 50 to 60% indigenous, primarily Mayan. There are about 23 different indigenous languages and quite a few people who are monolingual only in their Mayan language. The remainder of the population is largely Latino, and generally more urban, and the indigenous population is more rural. There's a large diaspora of indigenous Mayans in the United States, many of them driven out by the 30, 36 years of the war, and a lot of refugees. I've worked with quite a few of them here in the United States. I was teaching about working with Mayans to a class of psychologists and Guatemalans in Guatemala, and one of them said, "I think you've seen more Mayans than we have." [laughs]

**Ryan Van Patten** 25:52

[laughs]

**Tedd Judd** 25:54

And that reflected, to some extent, the class and racial and language differences of psychology in Guatemala. That can get replicated as well in other countries, in other parts of Latin America, especially with large indigenous populations or large African populations - Afrolatino populations. So the ways in which the cultures are different aren't always things that I find necessarily admirable, but they are there. That sort of thing happens. The stigma around psychology, the role of psychologists relative to medicine that I already mentioned, and viewing psychology as a female

profession, because, well, women talk about feelings, men don't talk about feelings. So that can be some of the differences that go on there.

**Ryan Van Patten** 26:53

Right. I'd like to move into thinking and talking about non-native English speakers in North Atlantic countries. Primarily, you know, I'll be thinking about this through a US lens. I know you've done a lot of work with non-native English-speakers here, Tedd. So my first question is, Why do you think so many non-native English-speakers miss out on neuropsych evaluations here? Why are they not seen in proportion to their representation in the US population?

**Tedd Judd** 27:23

Well, they are certainly not seen in proportion. I'm not sure they're missing out. [laughs] But, we actually just, through HNS, the Hispanic Neuropsychological Society, we're writing up a survey that we did in 2017 of directors of clinical training. And there are limitations to our survey, but a general finding was that non-English speakers were being seen in probably half what their representation is in the population. So we have at least some data to indicate that that, in fact, is the case - that they're not being seen. I made a long list of that, and that's just my own observations about it.

I think this is one of the aspects of health disparities. That is one of the reasons or one of the ways in which we see that non-native English speakers have less access to healthcare. Many of the barriers are institutional and a number of them are more individual. Many, not all, of the populations - it depends on who you're talking about and some of this has to do with the educational level of the non-English speakers that we're talking about and sociocultural level - may not know about what neuropsychology is or what neuropsychological problems are. Or to have access to the professionals that might make such references. To present those problems or think that they are something to talk about to the professionals that they deal with, the physicians especially but others as well. That when they have such problems, it may not occur to them to complain about them in that context or to understand that there may be treatments for them. To know about our services. And even when such difficulties are identified, they may not get referred. The providers themselves may not see it as something to make a referral for. They may not get a timely referral. They may not get adequate information to follow through on the referral. And they may not decide to follow through on the referral. They might not be accepted by us. I certainly have seen quite a few people turn people down because they don't speak the language and don't feel that they can offer service. They may

not be able to pay for it or have insurance that pays for it. Or they might not have the transportation. They might not feel comfortable or satisfied with the process when they go through it, or feel that they're welcome when they do arrive. I think there are a whole lot of different barriers that go on.

Where I am, in Bellingham, an hour and a half north of Seattle, there's nobody within an hour of here, there are no other neuropsychologists that accept Obamacare or Medicaid to my knowledge. So that's one way. That, as a profession, we tend to see that it's perfectly acceptable to say, "I'll only take certain insurances because these others don't pay well enough." But that ends up being a structural part of the system that excludes many people who have those particular ways of paying from the system and from services. We are on the horns of an ethical dilemma. A genuine dilemma. Because our ethics say that we should only offer services that we feel competent to offer. But our training, and our research, often doesn't make us competent to see non English speakers. But our ethics also say that we need to not discriminate. And the Civil Rights Act of 1965 says that we're not allowed to discriminate on the basis of language. That's been elaborated on in federal guidance that it's an unpaid mandate that we are supposed to take on the burden of paying for interpreters and we're supposed to offer services, regardless of language. We could be sued for not doing so, and have been sometimes. We could also be sued for being incompetent with non-English speakers. So there are barriers. There's a lack of enforcement of regulation. There are our own blinders about that, in terms of the way we go about practicing what may be seen as amounting to racism by the insurances that we choose to accept. That dilemma of our competence versus our obligation to serve equitably, is a genuine dilemma. And no simple solutions. I think we do need to take that case-by-case to figure out how best to approach that situation and do it the best way we can.

**John Bellone** 32:27

I'd like to talk about your current clinical work and how you incorporate your knowledge of cultural neuropsychology into your evaluations. Because in a lot of ways you're overcoming a lot of these barriers or working around them, including through your cross-cultural neuropsychology practicum, which we are very interested in talking to you about as well. But just to start out with, I'm curious if you could talk about the importance of being in a community-based clinic and in what ways you might be integrated with your local community? You already mentioned a little bit of that.

**Tedd Judd** 32:58
Yeah. Well, I closed my office this year. And that wasn't so much because of COVID. But I looked at 2019 and I used my office for 17 days in 2019.

**John Bellone** 33:11
[laughs] You're a traveler.

**Tedd Judd** 33:14
[laughs] The rest of the time I was in the field. I consult to work in four different refugee and immigrant services agencies. One of those is actually also a community mental health center, and the others offer more administrative and social services - or two of them are community mental health services, one is legal services. And most of the time I go there, and I go there with my students in the practicum. That's a great way to train, being out in the field, because you meet the other professionals, the other people that are involved with them. The people that you're seeing are coming to a place that they're already familiar with, and they're already comfortable with. I wish I could say that it was a multicultural neuropsychology practicum, and maybe it will become that, but it's a multicultural psychology practicum. A lot of my students are clinical psychologists not necessarily headed to neuropsych, though some of them are. If they're not, we just focus on the multicultural part in the parts that they do and I fill in the neuropsych details. But being in that clinical setting, you meet the people that they are involved with. At Lutheran Community Services, for instance, that's a community mental health center, they have psychotherapists who speak, depends on the day, about 17 different languages. So by going there, you meet professionals who are trained and who work directly in language, and you see what that looks like and you'll learn about their experiences. I always tell my students, “Be sure to go to the break room. Go to the lunch room and spend time there at lunch.” Because that's when you socialize with all those people, and you hear them sharing their experiences. And the food is marvelous, as you can imagine.

**Ryan Van Patten** 35:12
[laughs]

**Tedd Judd** 35:14
So that's one of the ways that you learn. You see what posters are on the wall, and you see materials that are written in language. And you see mental health protocols that are developed for refugees that look routinely at the dimensions that are important for us to know about. So that's some of the stuff that comes from going

out in the field. Then when we go to Northwest Immigrant Rights Project, which is a legal aid project, you get to meet the lawyers and see their ways of viewing things. You hear and learn about what are the immigration snafus and problems and dilemmas and fears that people are dealing with and what are the different types of immigration evaluations that neuropsychology can serve. And likewise, there's a very multilingual, multicultural staff there. So you get to get their perspectives on things. And sit down with the lawyers and talk about what they're dealing with and what questions they have. So that kind of out-in-the-field work is very important.

The other places in the field - the jails, the attorney's offices, the child welfare offices - again, you're dealing with the attorneys, the social workers, the other people where your work is being applied by being there with them, instead of just writing something up in a report, sending it out and hoping somebody reads it and does something with it. You're there for the back and forth to do mutual problem solving and figure out what neuropsychology can contribute. Those are some domains in which neuropsychology services can get funded on a more equitable basis. Immigration Services, criminal services in certain criminal populations, child welfare - there are a variety of different settings that are forensic or administrative where neuropsychology has a role and can be applied other than just in the medical and mental health sorts of settings. And where we can make a real difference. Other than personal injury lawsuits, we're kind of underrepresented there. Neuropsychology is under-serving criminal forensics, in my opinion. It's an area where we can make a huge difference. We're under-serving the homeless population, and the nature of the services that we can offer are somewhat different.

My role has been largely in an evaluation role, not so much treatment. But even in the evaluation role, we can help the system to understand people better and understand their needs better. So that's some of the going into the community, different aspects of the community. In North Atlantic, we've made a lot of progress in the last 20, 25 years in developing mental health courts. That's a very nice model in a variety of ways in which people whose crimes have been significantly related to their mental health disorders get a type of treatment that is more sensitive to that, more involved in providing for their mental health and housing and other social needs, and have been demonstrated to be successful and to reduce recidivism. We likewise have a similar system with drug courts. We have not gotten as far - some mental health courts will cover neuropsychological types of conditions, but they tend to be oriented more towards psychosis and substance abuse. We're in need of something more like brain court. We're in need of something that addresses more clearly, in a similar sort of way, and more therapeutically, the needs of people who have significant brain disorders. We do have studies that show that the incidence,

the prevalence, of a history of traumatic brain injury in prisons and in jails is astronomically high. TBI is probably the most important of those conditions. But there are many other conditions as well highly represented there - ADHD, and ID, and other conditions. And we don't deal with that as well. I have recently discovered that there is something like a brain court in the state of Victoria in Australia. They actually have a neuropsychologist assigned to the court to assist with setting up programs, complex sentences, and treatment that will help such individuals to get on their feet and stay out of trouble and have the services that they need. I would love to see that develop more. I would love to see a brain court.

**Ryan Van Patten** 40:04

Yeah. So zeroing in now a bit to neuropsych evaluations that you do in your clinic. I'm wondering if you can say a few words about assessing culture, race, and ethnicity during our clinical interviews. I know this is a big topic that we could discuss for a very long time, but I'd like to at least touch on it. I think it can be tempting for us, especially if it feels uncomfortable or if we feel like we're not trained well in culturally responsive and sensitive interviewing techniques, to just rely on skin color or accent to detect a patient and their cultural background. But obviously, that's a flawed approach. So can you share some words of wisdom in terms of gathering a comprehensive ethnic, linguistic, migration, and acculturation history?

**Tedd Judd** 40:54

Yeah, well, you have to start long before the interview. You have to start with the training of both the knowledge and the skills for doing that. And skills of interpreter use. And just sensitivity to those differences. And the curiosity. There's a concept of cultural humility out there, which I think is part of the package and part of the attitude. But we also have to have the kind of cultural acceptance and curiosity that go with that, as part of the attitude package. You can't know all cultures - we can't expect to teach all cultures and have people universally prepared. So when we're seeing someone from a culture that is not our own, from a language that is not our own, we need to pre-research. If you had a referral for somebody with moyamoya syndrome, and you'd never seen someone with moyamoya syndrome, what would you do?

**John Bellone** 41:50

You google it.

**Tedd Judd** 41:51

Exactly what I did the first time I saw somebody with moyamoya syndrome.

**Ryan Van Patten** 41:54
You'd listen to the NavNeuro episode on moyamoya, actually. [laughs]

**Tedd Judd** 41:58
[laughs] Right. So you'd look it up. We need to do exactly the same. That needs to be part of everybody's habits and skill set. How long would you spend looking up moyamoya syndrome? Might be 10, 15 minutes. Could be half an hour. It could be a couple of hours, depending on your situation and your need and what you're going to be doing with it. Same is true for looking up a cultural background, and having some good sources for going there and doing that. The degree to which you'll have to look that up will depend on the degree of familiarity you already have, or the familiarity you may have with neighboring cultures and languages. But knowing the good sources to go to - the EthnoMed website, the Omniglot website, the Ethnologue website, the Stanford Aging website. Wikipedia serves an important role at times. The CIA Country Profiles. There are all kinds of places to go to look that information up and get background that will help you. So we need to be doing that in advance. And we need to be asking from our referral source when we can. We can't always find that out. I mean, you know, one of the things that really frustrates me is I get a referral and it says, “So-and-so Hispanic gentlemen”. Yeah, well, okay. So, for instance, like, what language do they speak? What country do they come from? And so on. But try to find out if you can in advance. So before you get to the interview, those are some of the things.

Then there has been some research looking more at physicians than psychologists that I have seen, but it has shown that - and I think this was done predominantly like with White North American physicians - but that, when working within culture, with someone of their own culture, physicians tend to spend more time on small talk and rapport at the beginning of the encounter than they do with people from a different culture. And it's exactly the opposite that we need to do. We need to spend more time on the small talk and the rapport at the beginning of the encounter with people from a different culture than we need to with someone of our own culture. Of course it's easier and more agreeable to do it with people from our own culture, but that's no excuse. That's one of the harder things to figure out and to teach, but it's necessary. You know, they're not the only ones getting tested. We're getting tested too. They are looking at us and they're asking, "Can I trust this person? Can I tell this person what's going on? Is this person going to be able to help me?" We need to be able to establish our credibility and our reliability. And that's going to take time. In much of Latin American culture there's a concept called *personalismo*, which is being personal or personable, we might say. We need to demonstrate that at the beginning. For my part, for the most part, that comes before the consent

forms. Now, you got to be careful that you're not doing anything in that small talk that treads on confidential material. But you want to make sure they're settled in, the kids are okay in the waiting area if that's what they're doing, ask about how it was to get there, do they want some tea, whatever it is. "Oh, you've got grandkids? I got grandkids too", or whatever excuse you can find to make some human connections. So that's then your next step, skipping over what it is that gets them to the office in the first place.

Then when you get into your interview, my own particular preference is to explain at the outset that it's important for me to understand who you are and where you come from. We will talk about what brings you here in a few moments when we'll talk about these difficulties, but first I need to know who you are. Now, every once in a while, you get somebody who just has to explode with what it is [unintelligible]. So I don't get in the way of that, if that's the case. But, generally, I say, "Okay, we're going to talk about your health in a little while. But first I want to find out who you are and where you come from." And my typical way of doing that, and what I teach and recommend, is doing that more or less chronologically - starting with where they're born, a little bit about their family of origin, depending on the amount of time you have and what you're interested in. If they're from a particular - and, you know, you want to ask about early childhood experiences, and so forth. Might keep an eye open to childhood nutrition, if they've come from a particularly poor area. Walk through their education. When you know something about the educational system where they come from, you're in a better position to ask questions about that. So, for instance, in some places, it makes lots of sense to ask, "Did you repeat any years?" Because they may have systems where that's very common, that you'll repeat a year. But if you're in a place that has social promotion, that question doesn't make as much sense. Go through their education, their employment, their family constellation, and their immigration. In general, that's the kind of scheme. And then what got them here. There are times when you depart from that, because there are some people who may not be here legally, where asking questions in detail about their immigration process could be threatening. So you want to have some notion of that ahead of time.

Many people who don't have a lot of formal education may have a kind of circular narrative style, or a nonlinear narrative style. So we might put a chronological structure to it, but they might not be in a chronological response mode. That's part of our interview skills that we need to work on and develop - how to listen to that and reconstruct it later. But also, something I've been working on more lately, is having my own circular interview style where you come back to critical events several times. Because each time you come back you may get a little more, you

may get a different perspective. They may have more trust and be willing to tell you more. Or they may remember something else about it that's of importance. So they may connect events on a causal basis or on a family basis, not necessarily on a chronological basis. Being open to that and being open to following that narrative, and recognizing something important may come up later and being ready for that. I do have a structure, but try not to be too rigidly stuck to it.

So those are some of the kinds of things that I'll do to get there. And, again, knowing - if you have some background knowledge about education, about the nature of the languages in someone's country. So in many countries, for instance, there are a lot of regional languages or tribal languages, and then there's a colonial language or a language of education. So when you ask about their education, you want to find out which languages their education was in and which languages did they get literacy in, if they got literacy. But your background research will help inform that questioning.

**Ryan Van Patten** 42:02

And something we can do to help with the small talk that you mentioned, can be so important to make our patients feel comfortable is, in our personal lives, travel, get experiences, go to plays, restaurants, do things that are outside of your own culture to get exposure to other cultures. We can do pre-research and that's important - reading, having a background knowledge base - but in those interactions with people who have a different lens from us, culturally, I think having built up some experiences in, there are many cultures, and we can't travel to every place in the world, unfortunately, but having some diverse experiences can help us feel more comfortable having that small talk.

**Tedd Judd** 50:17

Yes, and when you are in a community where you know that you have a substantial community of a particular ethnicity there that may be getting services in your clinic or your office or whatever, then you can make the effort to get to know that particular community. There are usually some kind of public events that you would be invited to. And just going to one or two of those can - the learning curve is steep at the beginning and going to one or two can often tell you a whole lot. And it also can give you cred. So that, for instance, here where we are, we're right near the Canadian border and there are a lot of Punjabis who live in Vancouver right across the border from me. And a lot of their family managed to get their visas to come to the United States from other than Canada. So they've moved up here to be close to their family in Vancouver. We've got a couple of Gurdwaras, that is Sikh temples -

the Punjabis are by and large of the Sikh religion. So we've got some Gurdwaras here and a whole community. I've only been out to the Gurdwara twice for ceremonies that are out there, but I have a few photos from there. And when I have Punjabi come by, I talk about the Gurdwara and where it is, and I ask this or that and maybe pull up a few photos from the celebration, it really also helps to break the ice.

Something else along those lines when thinking of the electronics and the photos and so on. I will ask people where they're from, you know, and they'll say, "Oh, I'm from Mexico." Okay, well, where in Mexico? And, you know, a lot of people don't ask them, "Where in Mexico?" You find out their town and then while you're sitting there, you Google their town, and you look at Google Images, and you pull up some photos of the town square and the fiesta and you show them and you're off and running. Then that will stimulate memories for them and things that they'll tell you about. I remember one time when I was doing an asylum evaluation for someone from Guatemala. He told me about the conflict between two different Mayan groups that lived in the same town. It was a violent and ongoing conflict and that's what he was seeking asylum from. So while we were talking about it, I googled it and pulled up an article about that conflict in the major newspaper in Guatemala. I put that up on my screen, and the article started with a photo. I turned the screen to him and he said, "That's my aunt!" You know, what kind of validation do you want besides that? [laughs] So that kind of thing can often help to, you know, build rapport and information and validation as well. Those kinds of ways.

**John Bellone** 53:04

Excellent. Can we maybe move to testing? I am wondering how you might characterize the state of the neuropsych literature in terms of test development, test selection and norms for people of non-North Atlantic backgrounds.

**Tedd Judd** 53:21

Well, one of the - when I tell North Atlantic neuropsychologists that I've been teaching in Latin America, almost always, their very first question is, "What did you do about tests and norms?"

**Ryan Van Patten** 53:36

It wasn't our first question at least. [laughs]

**Tedd Judd** 53:40
[laughs] And I usually say, "Tests? Norms?" Yeah, you know, we got around to talking about that after about six months.

**John Bellone** 53:40
[laughs]

**Tedd Judd** 53:50
So that's, again, the test-heavy North Atlantic approach to neuropsychology. I think understanding the fundamentals of what we're dealing with and developing the neuropsychological attitude and understanding and attribution is tremendously important. I think in some ways, one of the other ways in which looking at cognition is "where the light is good", is because it's easier to, in large part, attribute cognitive impairments to brain impairment. Whereas when you get personality changes and peculiarities and emotional dysregulation and so forth, you've got a whole lot of candidates for why that might be the case in someone. And that's something that it's very difficult for us to tease apart. Something that as neuropsychologists, we're not nearly as well-developed at doing, and yet something that's of tremendous importance.

I was teaching in one Latin American country and decided, okay, we're going to start with a live patient. First day of class, we had a live patient. We did all the prep and so forth for doing that, brought him in and did a little sort of Grand Rounds interview and testing in front of the group. This was someone with a stroke, with Broca's aphasia and hemiplegia that went with it and so forth. And thank you very much, went back to the ward, and talked with the class and asked them what they thought was going on. They said, "Well, the emotional shock of having the stroke and being paralyzed on one side is why he's not talking now." And so, you know, they were giving a sort of PTSD-type interpretation to what they were seeing, not recognizing what is so fundamental to us - that the brain has language areas. And so we need to be looking at that neuropsychological orientation and worldview first, and get oriented to that - and lots of other things that go into that, what are the diseases and so on. Then when we get to the point of when we have that attitude, and can do that kind of analysis through interview and behavioral observations and paying attention to those things, and then we get to testing.

One of the other reasons that I find that, at least in the beginning, that testing is less critical and norms are less critical is what I've looked at as triage in developing neuropsychology in a setting that has not had it. Which is to say, where can you get

the most bang for your neuropsychological buck? Where can we have the most impact? And it's kind of in the people with moderate impairments. Conditions that are, it's pretty clear that they've got an impairment, that something's wrong - they're in a rehab hospital or in they're in a setting like that and we know that they've had a stroke or that they've had a traumatic brain injury and we can make a difference in helping them with the rehab process. Rather than the mild injuries or the mild cognitive impairment that needs norms to bring it out. So testing can often be more neurobehavioral, and looking for signs - looking for your left neglect and things of that sort. But when it is subtler and we need to get more down to the nitty gritty, well, in Spanish, we're well set. Not as well as in English, but there are lots and lots of Spanish-language neuropsychological tests and norms for lots of different populations. I still get frustrated when I see reports that say, you know, "I couldn't see this person because there aren't any tests in Spanish", or "I saw them and did sight translation of the English test, because there aren't any tests in Spanish". You looked? Really? It's not that hard. [laughs] It's even in the English language literature, you don't have to look at the Spanish language literature to find it. So, you know, if you're doing Spanish, yeah, you go that way. But when we're looking at the rarer languages, and I know this is part of what you are getting towards, there are certainly a variety of approaches that we can take that are of use.

One of the areas that I think we're moving more and more towards a useful paradigm is the object memory paradigm. I've been using the Fuld Object Memory Evaluation for 40 years, it works very nicely. It was developed for multicultural work. That test essentially consists of, there's a bag with 10 common objects in it, and the person reaches in and feels each of the objects and names it and pulls it out. They've named all 10 objects in their own language, so we don't have to worry if we have an accurate translation or not, they've done the translation for us. They've gone from the object to the name. Then you put the objects back in the bag, you do a little interference task, and then you ask them to recall what's in the bag. You do other kinds of tests. You give a word list and you ask for a recall and they say, "Word list? Was that the similarities? Was it that naming test where you showed me...?" But the bag's on the table, they know what you're referring to. You just point to the bag so you don't get that confusion. It's got five learning trials and a delayed recall. And that's an object memory paradigm. But it's one of many. There's something called the Common Objects Memory Test, which is now my favorite for teleneuro psychology use. It's likewise 10 objects, but they're in photographs. And likewise, they name the photos and it's three learning trials, no interference task in between, and you present all 10. The Fuld has a selective reminding [task] rather than a full reminding [task]. But then there are several others. There's something called the Photo Test, which presents six photos on a single page, and there's a

European version that has 10 photos on a page. But in each of those paradigms, what has come out of the research is that memory for objects is a well understood task. People with no formal education understand it pretty consistently and you get pretty consistent results across levels of education. Now, it varies by age, but it's not terribly sensitive to the effects of education. And you get fairly consistent results across different languages and cultures. So that's awfully nice. And that's awfully handy. It's a question we couldn't answer other than empirically as to whether it would work or not. But so far, that's what it's looking like. I'm thinking that we may be moving towards using one or more of those on a more widespread basis for that particular setting. We can probably improve on them, tweak them to make them a little better than they are, but the literature is looking that way now. So that family of tests, object memory test, is a, I think, a useful paradigm.

We all like doing animal naming, animal fluency. The European experience has been actually that supermarket fluency is better, and shows less variation across levels of education and so on, then does animal fluency. What are some things you could buy in a supermarket over one minute. So that's another kind of task that can be useful. Most of our sensory perceptual and motor tasks we can use with some confidence. They often take modifications to get somebody to understand exactly what you're expecting. If you've been trained in an overly rigid manner, in which the standardization of administration has been emphasized over the understanding of the task, you may get into trouble. But if you've got some flexibility, if you can stick with it until you've sure that the person understands what you're looking for, then you can get some reasonably reliable results. I've been using something called the Coin Rotation Test as a motor task. You can administer it by teleneuro psych. You just take a coin and rotate it in your fingers. There are a couple of different versions of it. If you're looking for absolute speed, then you would really need to go for norms. But if you're looking for a test of subtle fine-motor coordination, and you're just looking for asymmetries, it can serve you a little better that way. It can just compare the person to themselves, they're their own control, comparing one side to the other. We also have a number of rating scales that are useful. The WHODAS, the World Health Organization Disability Assessment Schedule, I think it's called, has been extensively developed for multicultural application and field tested around the world. It doesn't have validity scales on it, but it is useful in many contexts in which family members can rate the person on in what areas they're having difficulties in adaptive behavior.

**John Bellone** 1:03:07

We have lots of options. This is good. And it's about getting creative with some of these tests it sounds like. And we're continuing to develop these. So I'm happy to

hear that. So I want to focus on your cross-cultural practicum now, we had alluded to it earlier. Can you tell us about the practicum students with whom you work and about the apprenticeship model that it seems like you take?

**Tedd Judd** 1:03:32
Yeah, I think this is important. I'd really like to franchise it and help other folks to do things similarly, when they would like to.

**John Bellone** 1:03:37
Yeah.

**Tedd Judd** 1:03:38
Because I think that one of the things that we've done in our profession, we're en route, is recruiting more diversity. And that's great, but it's not enough. Because we get a leaky pipeline. We need to understand more both about how to support our more diverse student population through the training process, but also how to train. We can't expect that just by bringing in somebody who speaks another language that they're going to know what to do or that they can be our source. They can contribute, but we need to know how to train them for what they do. I've been learning how to do that by doing it. I've had students - I've had probably 40 or 50 students over the last 15 years or so in this practicum. And of those, I've had students who speak about 10 different languages. First I had Spanish speaking students, and we would just work directly in Spanish together. And that was great. That was relatively easy to do and to train them. One of the things I found of importance is to not just do the clinical work in Spanish, but discuss the case in Spanish because that helps with your vocabulary and you think about it subtly differently. So that's one thing when you're in the position of being able to work together in language. We're getting more and more opportunities for that around the country now, but we don't sufficiently make that opportunity available yet.

But what about when you have a student who speaks the language that you don't speak? How can you assist them to develop clinical linguistic proficiency in their own language? I don't have all the answers, but we've been working on that. We did a webinar on this a year and a half ago, Dr. Orlando Sanchez and I, as part of Taquitos De Sesos, which is a brain series Adriana Strutt runs out of Baylor in Texas. We're working on other materials, writing this up more, the model for doing this. The first place, you want your training program to acknowledge this and make it an explicit goal. So that a student who comes in can set the goal and say, "I want to be clinically competent in this language." Most of the time, a lot of the time, that's

going to be students who have a heritage language. That is to say, they've learned this language, either because they grew up in another country or started growing up there, or because they learned it often from their grandparents in this country. So they speak it fluently, often understand it better than they can speak it, may not read or write it, but they speak it with the vocabulary of a child and with the interest of a child, and without technical and professional vocabulary. So you say, "Okay, let's make this your goal. What are your goals in all four modalities - your goals for speaking, for hearing, for reading, for writing?" Some people say, "Well, hearing and speaking, I don't really need to read and write because I'm not going to be doing that clinically. But I want to be able to serve my people." Or it may be somebody who's learned the language as an adult, as I did, and similarly making goals in that way. So what are your goals in the program? How are we going to do that as a program? How are we going to support that specifically in a clinical setting?

So here are some ways you can support that. One of the things I do in classes, I say, "Okay, you can read Lezak or you can read the same stuff in Ardeal and Ostrowski or you can look up..." So, that, I can do in Spanish. I can find the texts for them. Or I can say, "Okay, look up a Korean textbook of neuropsychology and read it there instead." So as to learn similar material, but learn it from that perspective. When you do that, try to get a textbook that's written in that language, not one that's been translated from English so that you get the perspective that comes with that as well. Somebody who's writing directly and originally in the language. So you can do it with the textbooks.

You can work at arranging immersion experiences, if they need it - working in clinics that support that language. That's part of what I do with the practicum so that my students are in clinics that are with other people that speak their languages and they're able to speak with other professionals who speak that language in that language. Sometimes it's just a matter of hooking them up with the right person. I think our training programs need to do that as well. Somebody who comes into a training program and says, "I speak Russian, I'd like to be able to serve Russian speakers." Well, we don't have any Russian faculty, but we happen to know that this other university has Russian faculty, we'll make an arrangement, they'll be your mentor. So that's another approach to doing that.

Then arranging the clinical experiences where they can actually work with the population that speaks that language. The first time I did that was with a Russian speaking student. I have a template and a semi-structured interview that I give my students. I gave it to her, and she translated the whole thing to Russian. Then what

we worked through was that she had strong Russian skills, it was her first language and her education through university, so she was both my student working directly in Russian and my interpreter. We would explain that to our patients and we would make it clear when we were switching roles. That took a little bit of doing and a little bit of working out. So I would sit there and watch her do an interview. And then after 5 or 10 [minutes] - and I looked over her shoulder because she was taking notes in English, [laughs] so I could follow what she was doing. And then every 5 or 10 minutes, she'd say, "Excuse me for a moment while I talk with my professor in English". And we would have a quick little [chat] - and then she might turn it over to me and I might do a piece of the interview that she didn't know how to do. It was a flexible model but we did our direct clinical work that way. A lot of variations on that. We have it all detailed out. Sometimes all you can do is digit span in your language, but you do that. [laughs]

**John Bellone** 1:09:58
That's great. So, yeah, I really like this model. I'm sorry, I have to jump off the call. I know I had mentioned earlier that I had something come up. But I do hope you franchise this idea of the practicum. I'll let you continue the conversation with Ryan about it. I'm nervous leaving Ryan at the wheel by himself here. [laughs]

**Ryan Van Patten** 1:10:18
[laughs] Who knows what direction we'll go in?

**John Bellone** 1:10:20
I know. [laughs] But I look forward to hearing the rest of the discussion. Tedd, it's been great. Thank you so much for the conversation. Really enjoyed it.

**Tedd Judd** 1:10:27
My pleasure.

**Ryan Van Patten** 1:10:38
You had mentioned earlier the Hispanic Neuropsychological Society, HNS, and you were president I believe from 2008 to 2010. Is that right?

**Tedd Judd** 1:10:47
Yes.

**Ryan Van Patten** 1:10:48
Can you talk a little bit about the history, the current goals, the mission of the HNS? I know it's done a lot for neuropsychology already.

**Tedd Judd** 1:10:56
Yeah, we've been around for I think about 26 years now. And as you might imagine, it was relatively small at the outset. As more and more Spanish speakers have entered the profession, and we've had more and more Spanish speakers in the country, it has grown accordingly. It has always been an organization that has been very supportive of students and early career folks and mentoring. That has been one of its primary roles. So many people have said that they felt like they came home when they arrived at HNS and who felt lonely in their own programs. We have a lot of research on student retention at an undergraduate level. And particularly with diverse student populations, it turns out that one of the factors that's most important, beyond financial support, is peer support - good mentoring, but peer support is even more important. And I think HNS has provided that. It was having peers that come through the organization and other programs. So that's been an important role of HNS all along.

About three years ago, the Asian Neuropsychological Association was founded. I also belong to that, as well as the Society for Black Neuropsychology. And those two programs have, I think, taking that lesson from HNS, they're also extremely strong on student and peer support. ANA is a student majority, in fact. And so that's been part of the process. We've also - HNS has advocated for the development of better services in Spanish in the US. HNS is predominantly a United States organization. We're open to folks from other countries if they want to join, but we're not particularly recruiting or proselytizing, because essentially that would be colonialist. [laughs]

**Ryan Van Patten** 1:13:01
[laughs]

**Tedd Judd** 1:13:01
The Latin American neuropsychological associations are doing well on their own. They have their own agendas and so forth and we don't need to be trying to tell them what to do. And they're sensitive to that, rightly so. So HNS is a North American organization and we've been advocating within the US with respect to development and provision of services. In 2009, we published along with NAN, and at the request of NAN, guidance for neuropsychological assessment of Hispanics.

And I'll mention for a moment, there's a difference between Hispanic and Latino. Hispanic, in a literal sense, means Spanish speaking. Latino means from Latin America. So they're not the same thing. And Latinx has its whole other history. And I'm just not going to go there. [laughs]

**Ryan Van Patten** 1:13:56
Fair enough.

**Tedd Judd** 1:13:57
That can go on forever. But HNS is named HNS, and I'm going to stick with that for historical reasons right now. Although I will mention that, in recent years, we've been at least beginning to also offer support to Portuguese speakers and more attention to Portuguese speakers as well. So I think that has been an important element - is the advocacy and also sharing of resources. And that also has meant, as one might imagine, cross referrals and so forth. Under my presidency, we had our first conference. There was a great team we had as our board and so I can't claim full credit for this by any means. But INS had its meeting in Acapulco that year. And so we had a conference one full day before INS, and it seemed like a great opportunity for doing that. It worked out quite well. We had a lot of people including a lot of eminent people from our organization there, and good

presentations that had a focus on Mexico and tests developed in Mexico and so on, and Mexican culture. We also had a social psychologist talking about Mexicans and Mexican Americans and their contexts. We've had a few other conferences since then. It has not been an annual or semiannual occurrence. It's been irregular. One of HNS's principles has been to stay independent, so we've had our conferences on the side of NAN and AACN. We don't want to ally with one particular organization. We're friendly with, but not sticking with, any one organization in that way. Now that we have ANA and SBN, the three sister organizations, we've been allied and there's talk about a Cultural Neuropsychology Council that would bring together all of those forces as well as interested parties from other organizations. And that may come to pass. I think in HNS, the social element has been very important. And I think that is an important element. We've tended to meet at or on the side of various organizations, as I mentioned. And they're always good parties, everybody goes dancing.

**Ryan Van Patten** 1:16:30
[laughs]

**Tedd Judd** 1:16:31

And that's just part of what it's about. Sharing that background is important. I would say that the membership has been roughly two-thirds people who have Latino heritage at some level, and one-third people who are not of Latino heritage but who have interest in working with such a population - "gringos" like myself. Not all of us are Spanish speaking but most of us are Spanish speaking. There's some people who simply serve that population with interpreters, but they're sufficiently interested to participate in such an organization and promote such values - which has included developing interpreter use models, and bilingual psychometrists models, and so forth. Which is much more viable for Spanish since it's the US's second language than it might be for other languages where you can't have a critical mass - a sufficient number of Spanish speakers to justify having a bilingual psychiatrist, for instance.

**Ryan Van Patten** 1:17:32

Right. Thank you for sharing about the HNS and everything about global and cultural neuropsychology. We want to continue to talk about this on NavNeuro and your perspectives are valued. So thank you. We also have a few bonus questions for you before I let you go. So these are about the field of neuropsychology broadly, they don't have to be about any particular topic. The first question is, if you could improve one thing about the field of neuropsychology, what would it be?

**Tedd Judd** 1:18:03

Well, I've already touched on that. I think it would be to elevate neuroaffective features to their proper place. So neuroaffective and social, emotional, behavioral - to give them the same kind of attention that, or even more attention than cognition, as I think is the appropriate thing for what we can do better. I've been frustrated. There are so many fields of psychology in which, when psychology first arrives at the field, we try to go about it the way we've always done things with the tests and the methods we've had before. And then after a while we discover, "Oh, these don't really do the job. We need to do something special." So in 1935 was when, I think, in a sense neuropsychology started in the United States with the first attempts of widespread application of cognitive tests to a neurologic population. And what's that, Weisberg and McBride, I think? And using IQ tests. And then we discovered these sort of kind of work, but we need to modify them. And then we started doing memory tests and we developed all these specialized neuropsychological tests because what we had wasn't quite doing the job. Same thing happened in forensics. At first, we just used our usual tools, and then we discovered, "Oh, we need specific forensic instruments", and we developed all of those. We're kind of

partway there with regard to neuroaffective evaluation. But we're still in the position where people seem to think that the MMPI and the PAI and other instruments that are designed for people with intact brains are adequate as an evaluation of neuroaffective conditions. And, to my mind, that's just not adequate. They don't have a neuropsychological design. They don't look at the before and after. They don't take anosognosia into account. They don't take - for the most part, they're not designed for taking an informant's perspective into account. And we do have instruments that do that, but they're still under development. We're not where we need to be there. I think that the frontotemporal dementias and autism are bringing that more into focus. But within North American neuropsychology that emphasis on the neuroaffective and the social context and so forth, elevating that that's the change I'd make.

**Ryan Van Patten** 1:20:27
Yeah, great answer. Emotions are mediated through the brain as is memory and visuospatial skills. So recognizing the importance of neuroaffective symptoms, as you said, is incredibly important.

Our final question is about trainees. So, what is one bit of advice you wish someone told you when you were training, or maybe someone did tell you that really made a positive change, a difference? So here we're looking for an actionable step that trainees who are listening could take that can improve their performance and their trajectories in their careers?

**Tedd Judd** 1:21:04
Those are two slightly different questions. I'll take them as separate questions. Something that was influential for me was - and many people have heard this from Edith Kaplan who was one of my mentors - which was that if you were on a desert island and a coconut fell on your companion's head, you ought to be able to use the sticks and sand and things around you to do a neuropsychological assessment. When I arrived in Nicaragua in 1986, there was one copy in Spanish of Luria's Higher Cortical Functions in a medical library, and that's all the neuropsychology I could find there. So I felt like I was on that desert island. I taught a course, from my head, on the spot at that time. But that background and that perspective that I got from Edith stuck with me, and has continued to stick with me.

But, as for advice, I'm not sure that that would be the same advice for trainees today. That did come up on Twitter, and I'll try to reproduce what I said at that point, which is: never, ever lose track of our ultimate goal in neuropsychology, which is to

prevent, at a global level, neurodisabilities and to improve the quality of life and dignity and understanding for the people living with neurodisabilities and those around them.

**Ryan Van Patten** 1:22:29
Great answer, I like it. Thank you for taking the time today and answering all of our questions. I think that just about does it. Anything further to say? Any questions we missed about global neuropsych, cultural neuropsych? We, you know, I could ask you questions for another three hours, if we had the time. [laughs]

**Tedd Judd** 1:22:48
Yeah, we could go on forever. I won't add anything at this point, but I want to thank you for your very perceptive questions. And for you doing all of your background research before you talked with me and being ready to ask some good useful questions.

**Ryan Van Patten** 1:23:03
Yeah, thanks.

**Tedd Judd** 1:23:04
It's been my pleasure.

**Ryan Van Patten** 1:23:05
Thank you for having great answers. [laughs] All right. Take care, Tedd.

**edd Judd** 1:23:10
Okay. Bye bye.

**Transition Music** 1:23:11

**Ryan Van Patten** 1:23:15
Well, that does it for our conversation with Tedd. Be on the lookout for more upcoming episodes related to global neuropsychology. And if you're interested in global training resources, please check out navneuro.com/global. And, as always, thanks so much for listening, and join us next time as we continue to navigate the brain and behavior.

**John Bellone** 1:24:00

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**Ryan Van Patten** 1:24:12

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**End of Audio** 1:24:30