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1

Out of the Comfort Zone

Real-World Ethics in Cross-Cultural Neuropsychology

Speaker: Laura Scott, Clinical Neuropsychologist
Event: APS CCN Conference, Nipaluna/Hobart
Date: 31st July 2026

2

Acknowledgements

3

What culture/s do you identify with?

menti.com
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Waiting for participants

4

Let's work through some scenarios…

- Before we start….
- Please treat yourselves and each other with kindness, compassion, forgiveness and understanding
- Encourage clinician development
- Acknowledge 'truth' and 'moral rightness' is not always clear
- Acknowledge the practical realities/limitations for clients/services

We are all here because we want to further the provision of quality health care to culturally diverse people around Australia!

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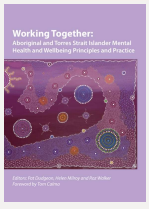
Scenario 1 – 'TJ'

You are an Adelaide-based neuropsychologist. You are contracted by a NAAJA to travel to Alice Springs to see 3 clients requiring urgent medicolegal (forensic) assessment. You have worked with a handful of Aboriginal clients from remote regions in SA but never with clients from the NT. You have experience in medicolegal assessment. You have a undergone an introductory cultural awareness course with an SA-based Aboriginal-led service.

Your first client is "TJ," a 19-year-old Anangu (Pitjantjatjara) man currently held in Alice Springs Correctional Center. TJ is facing serious charges related to a violent assault. The defence lawyer wants an assessment to determine if TJ has FASD or an ID. They could use this information to mitigate sentencing. Despite weeks of liaison with the lawyer, you only receive the full brief and health records 72 hours before you are due to fly out.



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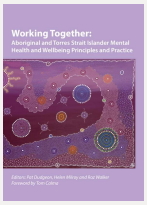
Scenario 1 – 'TJ'

The Decision Point: *Do you accept the referral, and how do you prepare for an assessment in a jurisdiction and culture different from your own?*

- **Competence/Cultural Safety:** Do you possess the cultural competence required for this scenario? Has the family been involved/informed about the referral?
- **Jurisdictional and Systemic Differences:** The legal frameworks and available services in the NT differ from SA. You risk producing recommendations that are completely unfeasible in remote Central Australia.
- **Timeframe / Consequences:** If you decline the referral, there is a significant risk that another clinician will not be available within the time frame. The court could proceed without access to an expert report.



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Scenario 1 – 'TJ' ctd...

You find a colleague in QLD who can supervise you so **you agree to proceed.** On file review, you notice TJ speaks Pitjantjatjara, Yankunytjatjara and English. The lawyer indicated that an interpreter was not required in their initial referral.

You read that TJ completed primary school in his community of Pukatja (Ernabella) then boarding school in Alice Springs until grade 10. TJ has done some work as a ranger with his community. His level of English proficiency is not clear so you make a last minute request for an in person interpreter to attend the prison. The booking was confirmed the day before the assessment while you were in transit to the NT.

You arrive at the prison but there is no sign of the interpreter. You call the AIS booking officer who says they are unavailable as they have to attend sorry business in community. They offer to arrange a telephone interpreter for you instead.

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Scenario 1 – 'TJ' ctd...

The Decision Point: *Do you attempt an assessment with suboptimal interpreter support or delay and offer video assessment at a later date or cancel and offer another booking in 3 months?*

Respect and Cultural Safety: Proceeding without an interpreter or cultural facilitator is risky. The client's 'yes' responses to you could be "gratuitous concurrence" (a cultural tendency to agree with authority figures to avoid conflict or embarrassment), potentially invalidating the interview and testing.

Informed Consent: Can TJ truly give informed consent to a complex cognitive assessment under the pressure of custody, with a non-Aboriginal, interstate clinician, without a trusted support person or ALO present?

Validity of telehealth assessment: The evidence for telehealth neuropsychology assessment suggests that it is best done with the aid of a technician on site and with specific technological set up (e.g. second camera). You have not met the client and do not know whether they would be willing to accept this model or comfortably able to engage in this way.

Timeframe / Avoiding systemic bias: As a FIFO clinician, your flight back to Adelaide is in 48 hours. If you cancel or postpone the assessment to find an interpreter, TJ's court date will proceed without any psychological evidence, likely resulting in prolonged remand.

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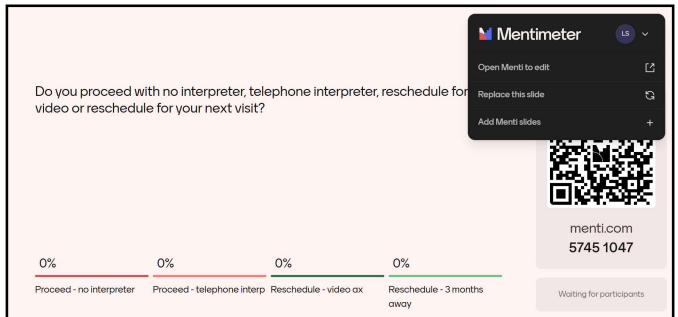

10

Scenario 1 – 'TJ' ctd...

You request a telephone interpreter and enter the prison visit area. You requested a private interview room but all that is available is a table in a large open visits area. There are 2 other occupied tables (one inside and one outside). There is a guard who walks around the area routinely with their radio chattering occasionally. There is no telephone at the table and you were not permitted to bring your mobile telephone in to the prison. There is no way to reach the interpreter. You have a maximum visit time of 2 hours and you spend 15 minutes trying to negotiate with the correctional officer that you need a private room with a telephone. They check with the senior who advises this cannot be accommodated on this day.

TJ is brought in by staff. He agrees to participate in the session but you tell him you will avoid discussing personal matters today (this will happen via video at a later date). He is polite but quiet with limited eye contact. His English language skills in conversation are good and he returns a strong reading score which you estimate to be about a high school equivalent. He is engaged and attentive and grasps instructions quickly. He occasionally smiles/giggles e.g. when copying the 'smiley' on the Rey Figure.

You had brought along various alternative versions of standard tasks (e.g. KICA, Colour Trails Test, L'Hermitte Spatial Learning Task, Frontal Assessment Battery) in the event that TJ's English-proficiency did not allow for standardised measures to be administered. However, given his conversational capability and test results you wonder whether you should try the standard tasks (e.g. RAVLT, TMT, Logical Memory, DKEFS Stroop)?

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Scenario 1 – 'TJ' ctd...

The Decision Point: *Do you administer your standard battery, do you omit any tasks relying on verbal output or do you substitute tasks that may be more appropriate given TJ's cultural heritage but could be too basic given his demonstrated ability?*

Confidentiality: Clinical assessment in an open area poses a serious risk to privacy both for the client (who may not wish to speak about personal medical and legal matters before guards and other prisoners) and the clinician (who has a responsibility to maintain test security).

Over/underestimating capacity: Although TJ has acquired basic English language skills, it cannot be assumed that he has had the same exposure to 'testing', abstract categorisation and speeded performance as standard normative groups.

Using appropriate tests: If you administer standard verbal tasks you risk introducing significant bias and comparison with inappropriate norms. Giving exclusively visual tasks may not be sufficient to adequately minimise the risk of bias. If you administer screening tasks you risk collecting insufficiently robust data to make meaningful diagnostic/behavioural conclusions.

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Do you administer your routine battery, partial routine battery or low cultural impact tasks only (e.g. KICA, CFS, FAB, L'hermitte)?

0%	0%	0%
Full Standard Battery	Standard tasks - visual only	Low risk tasks only

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Scenario 1 – 'TJ' ctd...

To utilize your limited time, you decide to proceed cautiously, prioritising non-verbal cognitive tests and behavioural observations, while explicitly documenting the practical limitations. You plan to follow up via video with an interpreter to discuss his personal history in greater detail and administer some verbal tasks.

Test results show a generally borderline to extremely low profile on the WAIS with strong learning on the RAVLT and good recall on the Rey Figure. The FSIQ score is 61. TJ easily passed the CFS and FAB but returned extremely low scores on animal naming, TMT and Stroop tasks.

You wonder whether TJ may have a neurodevelopmental disability but are concerned the test results may be biased. You decide that corroborating information from family about early childhood and daily function will be critical. TJ consents for you to call his grandmother (Margaret) and his cousin-brother (Edwin). He also consents for you to gather educational records.

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Scenario 1 – 'TJ' ctd...

You text Margaret to let her know who you are, why you're contacting her and to ask if it is ok to call. She says 'Yes please call me tomorrow morning'. The following morning you ring Margaret (who lives in community). You can hear her calling out to the children and a dog barking. She puts you on speaker phone and you can hear at least 3 adult voices in the room. You ask who is there today and are informed that Margaret has her daughter and son-in-law living with her and her niece is there too.

The Decision Point: *Do you conduct a corroborative interview with Margaret while other family members are present?*

Confidentiality vs Cultural Safety: You do not have signed consent to speak to the additional family members. However, they are likely active participants in TJ's kinship network and excluding them could undermine the cultural safety of the yarning and cause suspicion/injury/shame for Margaret.

Informed Consent (Margaret/Ewin): Do the corroborators require an interpreter in order to give their own informed consent to speak with you and to have their comments written in a formal report?

Appropriate Assessment Methods: Does a standard task like the Vineland/ABAS translate appropriately to the remote community setting. Does it proritise behaviours that are meaningful to the Anangu? How best to guage the level of function of this man within his world?

15

How do you respond when Margaret puts you on loudspeaker?

0%	0%	0%
Request private chat	Reschedule - seek consent	Proceed with caution

16

Scenario 1 – 'TJ' ctd...

You proceed cautiously. Margaret informs the family that the lawyer engaged you. It is apparent they know he is in jail and facing criminal charges. You explain your role and that you are hoping family could share some information to go into your report to the Judge. You are hoping they can tell you about TJ's childhood and daily life in community. You avoid disclosing any further information that TJ shared with you or that relates to his medical or legal information.

The family interview reveals that TJ's mother was drinking near daily during pregnancy. He was delayed in speaking (until age 3) and he was often in trouble at school. Before his remand, he required reminders to shower and tidy up. Margaret managed his money because otherwise he would spend it all straight away. He is often teased by other boys in town and is quite withdrawn and socially isolated.

Educational records reveal that teachers had concerns about him in late primary school. He underwent an educational assessment on entry to high school where he showed delays in literacy and maths as well as behavioural problems and an FSIQ score of 64. A vineland (teacher form) ABC score was completed by his teacher in Alice Springs was extremely low (52).

17

How does the historical assessment make you feel about your own interpretation?

0%	0%
More confident in reliability	More cautious of bias

18

19

The Neuropsychology 'Cowboy'

20

What is cross-cultural neuropsychology exactly?

21

How to define 'culture'?

- Many definitions!!
- International Handbook of Cross Cultural Neuropsychology
  - "…the set of learned traditions and living styles, shared by the members of a society…includes the ways of thinking, feeling, and behaving"
  - 'the specific way of living of a human group' (minimalist)
- 3 dimensions of culture
  - Internal, subjective or psychological representation of culture, including thinking, feeling, knowledge, values, attitudes, and beliefs;
  - Behavioural/relational dimension (relationships, behaviours in different contexts, festivities etc),
  - Cultural elements/physical elements (e.g. clothes, ornaments, houses, instruments, weapons, symbols etc)

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How to define 'culture'?

- Concept of relative distance between 2 cultures
  - E.g. mediterranean cultures relatively closer with Anglo-Saxon cultures and relatively distant to Amerindian cultures
- Inclusion of 'subcultures' within the dominant culture
- People are adaptive and dynamic and therefore 'nationality' and/or 'cultural affiliation' may not necessarily be reliable predictors of cultural values and social beliefs (Fernandez & Evans, 2022)
- Education remains one of the most powerful variables influencing performance on neuropsychological tests (Fernandez & Evans, 2022).

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Theoretical Orientations to Cross Cultural Neuropsychology

Absolutism	Relativism	Universalism
• All human behaviours are basically the same in all cultures • Cultural environment contributes little to meaning of human behaviour	• Performance must be evaluated within the specific cultural context of the individual (avoid making invalid cross-cultural comparisons) • Little interest in group similarities of differences • Context-free concepts and their measurement are impossible	• Human characteristics are common to all members of the species • Culture affects the development and display of these characteristics

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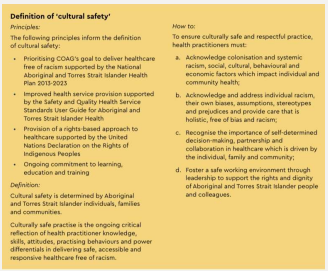
Cultural Safety in the National Scheme



Definition of 'cultural safety'

Principles:

The following principles inform the definition of cultural safety:

- Prioritising COAG's goal to deliver healthcare free of racism supported by the National Aboriginal and Torres Strait Islander Health Plan 2013-2023
- Improved health service provision supported by the Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health
- Provision of a rights-based approach to healthcare supported by the United Nations Declaration on the Rights of Indigenous Peoples
- Ongoing commitment to learning, education and training

Definition:

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

How to:

To ensure culturally safe and respectful practice, health practitioners must:

a. Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health;

b. Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism;

c. Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community;

d. Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

- The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025
- An updated version is due for release shortly.
- Embedded in Section 2 of the AHPRA Code of Conduct

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Cultural Safety in the Code of Conduct

Respectful, culturally reflective practice requires psychologists to have knowledge of how their own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community, other practitioners and colleagues. Psychologists should contribute to a respectful and safe culture for all, communicate with all clients in a respectful way and meet their privacy and confidentiality obligations including when communicating online.

The Code, Principle 3

- Broad definition of 'cultural safety' as applies to 'all Communities'
- Use the principles of reflexive practice to be aware of and address any of your own biases, stereotypes, or prejudices related to aspects of a client's identity.
- Ensure that your services are not used to discriminate unfairly.
- To support the development of competence, consider the importance of consulting with individuals, organisations or peak bodies that represent specific client groups. Such consultation is particularly important when colleagues with relevant experience cannot be easily identified or located.

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Elements of culture that affect test performance

Education (Level and quality of)	Culture /Acculturation	Language (English proficiency)	Economics (socio-economic situation)
Communication styles	Test Environment (comfort/motivation)	Intelligence (conceptualisations of)	Context of Immigration

- *ECLECTIC Framework (Fujii, 2018)*

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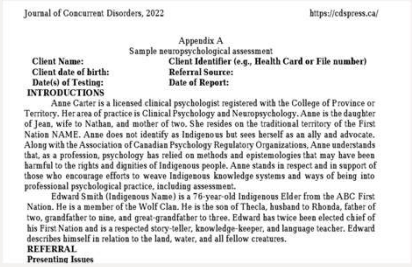
Sample Report – Gale et al (2022)



Journal of Concurrent Disorders, 2022 https://cdspress.ca/

Appendix A

Sample neuropsychological assessment

Client Name: **Client Identifier (e.g., Health Card or File number)**

Client date of birth: **Referral Source:**

Date(s) of Testing: **Date of Report:**

INTRODUCTIONS

Anne Carter is a licensed clinical psychologist registered with the College of Province or Territory. Her area of practice is Clinical Psychology and Neuropsychology. Anne is the daughter of Jean, wife to Nathan, and mother of two. She resides on the traditional territory of the First Nation NAME. Anne does not identify as Indigenous but sees herself as an ally and advocate. Along with the Association of Canadian Psychology Regulatory Organizations, Anne understands that, as a profession, psychology has relied on methods and epistemologies that may have been harmful to the rights and dignities of Indigenous people. Anne stands in respect and in support of those who encourage efforts to weave Indigenous knowledge systems and ways of being into professional psychological practice, including assessment.

Edward Smith (Indigenous Name) is a 76-year-old Indigenous Elder from the ABC First Nation. He is a member of the Wolf Clan. He is the son of Thecla, husband to Rhonda, father of two, grandfather to nine, and great-grandfather to three. Edward has twice been elected chief of his First Nation and is a respected story-teller, knowledge-keeper, and language teacher. Edward describes himself in relation to the land, water, and all fellow creatures.

REFERRAL

Presenting Issues

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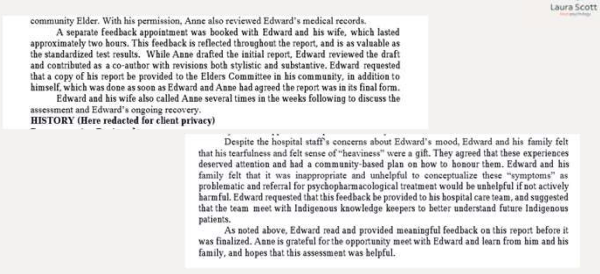
Sample Report – Gale et al (2022)



community Elder. With his permission, Anne also reviewed Edward's medical records.

A separate feedback appointment was booked with Edward and his wife, which lasted approximately two hours. This feedback is reflected throughout the report, and is as valuable as the standardized test results. While Anne drafted the initial report, Edward reviewed the draft and contributed as a co-author with revisions both stylistic and substantive. Edward requested that a copy of his report be provided to the Elders Committee in his community, in addition to himself, which was done as soon as Edward and Anne had agreed the report was in its final form.

Edward and his wife also called Anne several times in the weeks following to discuss the assessment and Edward's ongoing recovery.

HISTORY (Here redacted for client privacy)

Despite the hospital staff's concerns about Edward's mood, Edward and his family felt that his tearfulness and felt sense of "heaviness" were a gift. They agreed that these experiences deserved attention and had a community-based plan on how to honour them. Edward and his family felt that it was inappropriate and unhelpful to conceptualize these "symptoms" as problematic and referral for psychopharmacological treatment would be unhelpful if not actively harmful. Edward requested that this feedback be provided to his hospital care team, and suggested that the team meet with Indigenous knowledge keepers to better understand future Indigenous patients.

As noted above, Edward read and provided meaningful feedback on this report before it was finalized. Anne is grateful for the opportunity meet with Edward and learn from him and his family, and hopes that this assessment was helpful.

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Scenario 2 – 'AZ'

You receive a referral from an NDIS support coordinator who is assisting an ethnically Hazara family from Afghanistan (a couple and their 2 sons). They arrived in Australia in 2019. Both sons have significant cognitive impairment but neither has been diagnosed with any relevant cognitive disorder.

The elder son, AZ, is 19 and his family are seeking to make an application for Citizenship. However, they are seeking an exemption from completing the Citizenship Test on the grounds of his cognitive impairment.

The referrer has given the family the strong impression that you are there to 'help' them and that your report will convince the assessor from the Department of Home Affairs to support this application for exemption.

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Scenario 2 – 'AZ'

The Decision Point: *Do you accept the referral, and how do you approach the initial consent process?*

- **Ethical Considerations:**
- **Competence:** AZ has limited English proficiency and low acculturation to dominant Australian models of testing and health. Can you deliver a culturally safe assessment? Can you find a Hazargi or Dari-speaking interpreter?
- **Informed Consent/Independent Report:** How do you explain the highly specific role of a neuropsychologist, the limits of confidentiality (the report will go to the Department of Home Affairs), and the potential that your findings might *not* support AZ's application?
- **Financial vulnerability:** This client has limited funds and an expectation that this assessment will help them. Does this assessment represent value for money for this family?

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Scenario 2 – 'AZ'

You clarify your independent role and this is accepted by the clients. You arrange additional supervision from an experienced colleague before and after you see this man.

The client presents with a highly complex range of comorbidities. He was born blue in an unassisted home birth. He took several minutes to breathe. He was hyperactive as a child. He attended 3 years of school but was often absent. He fell from the roof at age 7 and was changed afterward in demeanour. Around that time he witnessed the brutal killing of men from his community. They fled their home and were transient for several years. Lately, he has been getting angry and paranoid. He sometimes calls out to people in his room. He laughs for no reason but then can 'snap' and get aggressive.

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Scenario 2 – 'AZ'

The Decision Point: *How do you differentiate between organic cognitive impairment, effects of trauma and a potential emerging psychiatric condition? How do you communicate this to a government agency knowing the risks?*

- **Ethical Considerations:**
- **Integrity/Honesty:** AZ's diagnostic situation is very complex and there is little objective information to rely on. There is a high risk of bias on assessment. However, there also seems to be clear evidence of genuine underlying impairment. An overly cautious report could jeopardise his application for exemption. However, it is inaccurate to overstate your confidence in a diagnostic conclusion.
- **Safety vs Need:** It is immediately clear that this man is either severely impaired and/or very uncomfortable and unable to engage optimally in assessment. Do you stop the assessment to prioritize his immediate psychological safety, even if an incomplete assessment jeopardizes his application for exemption?

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Scenario 3 – 'MK'

You have received a request from Child Protective Services to undertake an assessment of MK, a 51 year old, profoundly deaf woman who is seeking permanent custody of her 5yo granddaughter (whose mother has ongoing addictions issues).

MK was previously in an abusive relationship and her GP raised concerns of possible TBI during a recent consultation.

You consult with a colleague who has worked with deaf clients in the past. She connects you with an AUSLAN interpreter who provides lots of useful information. As you prepare, you begin to worry about the potential applications of your findings in this matter.

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Scenario 3 – 'MK'

The Decision Point: *How do you formulate any impairments that may emerge on testing and what implications could this have for MK and her grandchild?*

- **Ethical Considerations:**
- **Minimising Harm:** You need to balance your responsibility to your client with your responsibility to the involved child. If you overestimate MK's impairments she may lose custody of the grandchild. If you underestimate her impairments it could place her grandchild at risk.
- **Assessment Modality:** Since AUSLAN is a very different language to English, it is not easy to translate conditional phrases (e.g. what would happen if…). Is it enough to have an AUSLAN interpreter? Do you need to explore more concrete or visual avenues for examining abstract reasoning and problem solving?

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Concluding remarks

- Our work is really complex and challenging
- It is an ongoing process of learning across your psychological career
- Reality is highly nuanced and that's OK! (that's the job…)
- Do the best you can to educate yourself on your responsibilities with reference to the AHPRA Code of Conduct, the Australian Privacy Principles, relevant state legislation and organisational rules
- Keep striving to do the very best you can within the guidelines and framework that we have by:
  - Seeking consultation with those who have expertise
  - Keep your network of supervision going
  - Keep up to date with training and education
- Be compassionate and kind to yourself and others
  - It is through experience that we learn to navigate these challenges

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How do we *know* that we are doing more good than harm?

When should be seek feedback and from whom?
How do we seek accurate feedback?
Is anonymity important (how to manage with small cultural groups)?

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