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Transcript:

Providing Culturally Relevant Crisis Services (Part 2)

Presenter: Dr. Michelle Evans
Recorded on April 17th, 2020

ANN: Hello, everyone and welcome to our webinar Providing Culturally Relevant Crisis Services During COVID-19. This webinar today is brought to you by The Great Lakes ATTC, The Great Lakes PTTC, The Great Lakes MHTTC, and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by the Substance Abuse and Mental Health Services Administration, otherwise known as SAMHSA.

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And again, thank you for joining us. We have just a couple of housekeeping items. Today's webinar is recorded and is available on the Great Lakes ATTC web page and the Great Lakes Current YouTube channel. There will be no CEUs or certificates of attendance available for this webinar. And please send any general questions you have regarding online resources or recorded webinars to The Great Lakes ATTC.

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ALFREDO CERRATO: Thank you, Ann. Hi. My name is Alfredo Cerrato and I'm the senior Cultural and Workforce Development Officer for the Mental Health, Addiction, and Prevention Technology Transfer Centers at the Center for Health Enhancement Systems Studies, otherwise known as CHESS, located at the University of Wisconsin in Madison.

Today, I have the privilege of introducing to you Dr. Michelle Evans. Dr. Evans is a licensed clinical social worker, a certified alcohol and drug counselor, and a licensed sex offender treatment provider with experience in individual and family counseling and in developing therapeutic groups. She has worked primarily with Latino populations throughout her career as a bilingual and her bicultural social work. She is currently the hospital administrator for Elgin Mental Health Center in Elgin, Illinois. She is also a private practice practitioner at Nickerson and Associates as a bilingual therapist where she treats adults, adolescents, and mental health issues with substance abuse and sex addictions.

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She also teaches on these topics at Aurora University and at the University of Chicago. Previously, she was the assistant dean for health professions and public service at Waubonsee Community College. And she has held other positions within private psychiatric hospitals.

Throughout her career, she has worked to increase equity, justice, and cultural awareness to these institutions. Michelle Evans has earned a doctorate of social work and a master of social work degree from Aurora University in Aurora, Illinois. And she is with us today to help us understand, as providers, how to help ethnically diverse communities during these times of crisis.

Dr. Evans, thank you so much, and welcome.

MICHELLE EVANS: All right. Well, thank you so much for the welcome. I am so excited to be here today. We are in unusual times. And when I was thinking about coming and doing this webinar, it just struck me that the things that we are considering now, the issues that are coming in front of us, are truly unusual and unique to this time of life. And so I'm really happy to be able to be here to share with everybody that's listening different things that have come in front of me, and also how we can use evidence-based practice and some things that we do know to guide us as we go forward.

And so during today's webinar, my goal is that by the end of this, you will be able to describe how cultural factors impact the experience of crisis, describe the benefits and challenges of telehealth, which I know many of us have moved towards using, identify cultural idioms of distress, and apply the Cultural Formulation Interview to effectively use in telehealth.

And so to start out here, I would like to give you just a kind of peek into my experience. Because as we know, our personal experiences do inform our perspective. And so currently, I am seeing this crisis, as many people are, on a very micro level in terms of looking at it from the eyes of my clients, looking at it from the eyes of my family and friends in addition to my own perspective as a health care provider.

I also have the advantage of being in a position where, as a hospital administrator, I'm looking at things on a macro level as well, and being able to see how there are so many different levels one thing that I have found. And that this current crisis, COVID-19, is really impacting us in two ways. The first way, of course, is physically. But the second way is psychologically. Never before have I seen a disease, a virus, that has impacted our psychology so much just because of its impact on our economic status, the unknown of how it impacts us, the symptomology, the treatment of it, and how it impacts our social relationships.

And so as we look at providing mental health services during this crisis, there is an additional element that comes from not being able to walk away from it. Typically, I've worked with the Red Cross in the past as a disaster mental

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health volunteer. And when you have someone with a house fire, at least at the end of the day, they can walk away, go to a hotel. They're still in a state of crisis. However, they're able to go somewhere safe where they know that it's going to be OK. The next day, they can work toward rebuilding. But this is a long and sustained crisis that really is requiring another response.

And so just as a short review here, just to talk about the impact of a crisis in general, the impact of a health crisis may include, of course, home or environmental stressors, school or work stressors, social or emotional stressors, isolation and loneliness, mood deregulation, reduction in the ability to use coping skills or self-soothe successfully, and the exacerbation of factors of oppression and discrimination.

As we look at the current crisis that we're in, this crisis is affecting all of these areas, which when you're working with someone who either has a previous diagnosis of a mental health illness or perhaps they don't have a previous diagnosis or previous struggles with mental health but now are dealing with all of these stressors which are just pushing them over the top, we can see that individuals who normally may be able to use coping skills or self-soothe successfully, things that worked in the past may not be working today, especially as they, themselves, may be working to care for others, children in their family, or partners, or even co-workers and others in their community.

As we look at the additional stressors of a pandemic like this, we see that people are really experiencing frustration, boredom, or anxiety related to isolation or changes in their usual routine; inadequate supplies and access to regular medical care, food, clothes, masks, and medication; fears about becoming infected or infecting others; financial loss; and also stigma from others.

So I had an unusual experience in the grocery store the other day. This was before, in my state, we were using masks even to go to the grocery store. And I ran into a couple of early adopters of the public mask, as I'll call it. And even as I would pass them and watching our different levels of anxiety at the time, I was a little more calm about it. But watching them pass me and instantly move away from me, instantly have this kind of recognition of almost fear. And being myself, I've never had that experience where I actively could see people stepping away from me, moving to the other side of the aisle, looking down the aisle and walking in the other direction because just of my presence.

And reversely, just recently, I started to wear a mask when I went out in public. And I saw the same thing, only it was on the opposite side. Individuals that weren't wearing masks, I was seeing almost a different look in their eye, it felt like almost ridicule. Like, oh, you're one of them. And so in watching this and watching how different people are on different sides of kind of the understanding of the need to stay safe, and experiencing my own perspective of being an individual that is taking in information that is available, trying to make decisions regarding my own safety, but being in that place of feeling stigma for whichever decision I'm making at the time. And recognizing,

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especially, when we're looking at individuals who have suffered from stigma due to other elements, whether it's disability, whether it's race, whether it's age, all sorts of different factors, how this can be increased.

And then we add, I know we've had some discussions in the news about ventilators and who it will be available to. How do we decide, when we're looking at a limit of masks, and PPE, and ventilators, and other medical supplies or hospital beds? And we're really seeing a discussion within the news and also within family and friends, of course, as to, how does society decide these things? Which, again, contributes to that psychological impact that we are suffering with this.

Typically, when there is a disaster, we like to know that we're safe. There are people out there taking care of it. But with where we are currently, there really is that added element of not being sure just because this is a pandemic. So we're seeing some of those stressors really impact mental health.

And so one of the things that has been really helpful to me in working with the individuals I'm working with both in an individual way and also in terms of leading a hospital, are using psychological first aid principles. They are evidence-based, supported by SAMHSA. And they really have provided a great basis as we're going forward and working with both individuals and small groups.

The core actions of psychological first aid are contact and engagement-- increasing that safety and comfort, just communicating safety and comfort; helping to stabilize, if needed; information gathering on current needs and concerns-- and that current needs is so important; offering practical assistance; connection with social supports; information on coping; and linkage with collaborative services.

And so in using this in a broader sense, I found when I'm working with my clients and I'm talking to them just about how COVID 19 is impacting them on a regular basis, I found it to be incredibly helpful to use these principles to really focus on the now. Now, on a regular basis, I use acceptance and commitment therapy personally, which is always very, very focused on the present moment. And even more so, I found that to fit very nicely with psychological first aid in terms of, what's happening today? What are our current feelings?

Because one day I might feel very confident and I've got this, I'm safe, nothing's going to affect me, or I know how to take care of my safety needs. And within a couple of hours, I can feel completely the opposite direction. I experience this myself. And I've seen this in co-workers that I've had of feeling very, very confident at work. And then I get in my car to drive home. And all of a sudden, all I can think about is, am I bringing something home? Do I need to care for loved ones? Do I need to look for PPE? Or am I going to find what I need at the grocery store?

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And I reflect to myself how my own personal mood changed just from two hours ago-- I was very confident, I was doing everything I could-- to just switching my environment, switching where I was or who I'm talking to. And all of a sudden, I'm not feeling as safe. And so it's that focus on the present moment. And then with the individuals we're working with, helping them identify what they can do today, what they can do now to help themselves feel more comfortable to make it to that next place, offering the practical assistance we have.

And I've found even with this, sometimes it's reminding people. Often, I find that individuals may have what they need. But when their mood shifts to not feeling as secure, it's reminding them, here's what we're doing. Here are the safety measures we're taking. Because as we know, when we're in crisis, it's hard to focus on what we need to do now. It's hard to focus on what we do have because of the overwhelming emotional response and move response that we're having. And so moving through these are very, very helpful. And I'm going to use this in a little bit to show you how we can use those in incorporating it with our culturally relevant response.

So looking at how cultural factors impact the experience of a crisis-- now I mentioned a little bit about this a minute ago. But one of the big highlights here is just the disparate impact of COVID-19. In many of the large cities-- and I highlighted some statistics that were put out by the surgeon general. Black people accounted for more than 70% of all COVID-19 related deaths and more than 50% of total cases in the city of Chicago while making up only 32% of the population. Louisiana and Michigan report similar figures.

African-Americans are more vulnerable to COVID-19 due to health disparities and historic racism around housing, education, and employment. And so when we're looking at the individuals who are being impacted disparately just because already they face more poverty, lack of technology, lack of education in terms of health practices, sometimes, lack of access to rainy day savings funds that can help them economically, we're seeing that individuals of color are definitely suffering more through this. And when they start becoming sick, they have less resources to be able to help them through the illness.

Additionally, we see communities of color-- and I mentioned some of this-- are more likely to suffer from the following disadvantages that are exacerbated by COVID-19 such as the lower socioeconomic status, less access to sufficient health care. If I'm in a city and many of the doctors in the area are already overwhelmed or many of them are becoming sick themselves-- doctors, and nurses, other health care providers-- that is going to impact my ability to access care. They're more likely to work in the gig economy or rely on a job that does not pay for benefits or health care.

They're more likely to live in urban communities with less ability for social distancing. When we're looking at high-rise living, public housing, there isn't the ability to avoid the individuals in your home. If you're living in a one- or two-bedroom apartment, staying away from your family members that are

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working in health care as a CNA or staying away from your family members that work down on the street at the grocery store just isn't possible. And so we're seeing that they're not able to follow some of the recommended practices.

Also, there's a higher incidence of diabetes, heart disease, and lung disease already due to many of the health disparities that already exist in our society. And so we're seeing that as COVID-19 impacts some of our communities of color, already they're starting out behind what other communities have in terms of resources.

The impact on Latinos and immigrants also is great. We're seeing them disparately impacted by COVID-19. When we look at working in jobs that require physical presence and do not offer a telework option, statistics from the Economic Policy Institute are showing 16.2% compared to 19.7% for African-Americans, 30% for white Americans, and 27% for Asian-Americans. And this data was as of March 2020. And so we're still seeing that many of the jobs that are individuals of color work, they're not able to access that telework option.

Additionally, Latinos work disproportionately in the country's lowest paying jobs such as cashier, farmworker, and domestic worker. When we think about our society, our economy, and our food supply is based on factories and farms, and those individuals-- our farmworkers, our factory workers-- can't go home. They are essential workers because they are feeding the rest of the country.

And then we look at the working conditions of they're typically working close to other individuals when they're working in factories. And I know we recently had an incident at one of the largest factories in the country that provide much of our meat. They're not able to space out in the factory setting. They're not able to access health care. Additionally, taking off because they may be starting to experience symptoms can bring discipline or even the loss of the job.

In addition, often, if they don't work, they don't get paid. And so we see individuals working in the factories, in the farms, in many of our food supply areas that are going to work because they have to go to work. Because there is no backup. There is no option to stay home. And the country needs them as well. However, therefore, they are being impacted by COVID-19 disparately.

Due to documentation issues, Latinos and other immigrants may not be able to access benefit programs or may fear seeking medical care or other assistance. We already see on a regular day that immigrants hesitate to reach out for benefits programs that they may qualify for such as food pantries or other resources that are offered by the public schools to school children no matter what your documentation status. We see that often, they do hold back because of fear of being reported, for instance, if there's documentation

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issues. And so we see that they're often hesitant to go forward and get medical care because they're just afraid of what might happen.

Latinos suffer from disproportionate rates of food insecurity and access to healthy food, which may compromise their immune system. And they also disproportionately lack access to technology to continue participation in education, telework, or access to accurate information on how to keep themselves safe.

I know recently in my own private practice, I work with a large population of Latinos. And unfortunately, we have moved to telehealth. But many of even the adolescents I work with don't have access to a computer. Some of them don't have access to a smartphone or there's only one smartphone in the household. And so therefore, as we are scheduling our telehealth sessions via either telephone or via video, they may be using the only phone in the house, which is difficult. As other people in the family then can't use that phone. We have to schedule very carefully. And so we're seeing that communities of color are suffering just from that huge technology gap, which we have on a regular day within the United States.

Also, all of our other vulnerable populations are also disparately impacted. Nearly 1 in 10 LGBTQ people are unemployed, more likely to live in poverty than straight and cisgender people. LGBTQ individuals are less likely to see a doctor when needed as they cannot afford it or because of the fear of stigma. Again, we have a lot of stigma from our vulnerable populations, even in approaching both physical medical personnel but also mental health personnel.

The elderly, disabled, homeless, and other vulnerable populations also are impacted disparately through lack of access to health care and resources to stay safe. So especially as we're talking about a mental health crisis, these are already populations that we often struggle to get into the door to see a therapist. It's already difficult to get them signed up with therapy, to get them to continue in therapy because of stigma, because of difficulty by, often, the clinician of offering culturally relevant care. Or stigma within their community, within their family of what it means to receive mental health care.

And so these are individuals, also, that because of this situation, are being encouraged to stay home. Don't leave your house. And so that also may impact their willingness to reach out-- if they don't already have a mental health provider, reach out to a mental health provider. Or even-- many of these individuals, schoolchildren, are seeing their mental health providers in the schools.

And so because of, now, the lack of school, they may not be able to reach out to the individuals that normally provide them with mental health care and that normally help them access some of the benefits programs and social services that normally they would be engaging in. And so we see that especially these

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populations, their vulnerability is being doubled and tripled if not more just based on how this particular crisis is impacting this population.

In working to provide mental health services to the population, one of the things that I have seen wonderful things happen with is we are moving toward offering telehealth. And so it bears some mention here because I know many of us are now offering telehealth through Zoom such as this webinar, through other modalities that have been really, really effective. I know many of us, if we're older, some of us are looking at it a little sideways going, OK. I wouldn't normally do this. This is something I've tried to avoid for my entire career. Because it's not the same.

And so, granted, it's not the same. However, it does offer some different benefits, especially in terms of being able to reach out to people that are ill. But also meeting people where they are and overcoming some of the transportation issues, some of the infection issues, and, in reality, keeping people safe. And so I've seen more and more providers who are trying this for the first time. So many of us are, as the insurance companies are now. We see them coming aboard. We see this supported by many of our states in terms of this is a great way to get mental health services to the individuals that need it most.

And really, when we're looking at our communities of color, there are some benefits. There are some challenges, certainly. But there are also some benefits that we're being able to see.

And so when we're looking at uses of telehealth during a crisis, four ways that that kind of came to my mind-- and there may be more. But of course, inpatient hospitals, outpatient, for crisis services, and also maintenance. And so when I talk about inpatient use of telehealth, we're seeing more and more individuals-- as we watch how this pandemic is affecting us, the interesting thing of being a clinician is it is one of the first times that I've been sitting inside the exact same crisis as my client at the exact same time.

And so when we're looking at this and just having that knowledge, we really need to have an ability to kind of examine our own perspective. Because as we're looking at inpatient hospitals, whether the individual is in for COVID-19, they're receiving physical hospitalization for their physical body, or whether it's psychiatric care, we're looking at the need for clinicians to be able to meet with that individual in a safe way where they're not spreading infection. And so they're keeping themselves and other individuals safe.

Additionally, as we look at how this impacts the population, we know that our employees are getting sick. And needing to maximize the use of some of the employees that we do have that are still working. using, telehealth in hospitals has been a wonderful opportunity. Because we're being able to see that using technology, use of video, we can increase the access that patients have to treatment providers in an appropriate way.

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Of course, we also see telehealth being used in an outpatient way. And this is, I assume, the vast majority of individuals as we're offering it in instead of our usual face-to-face individual therapy or group therapy. I've been seeing actual treatment groups that are being held in a Zoom setting or another video program. We're seeing that it's different. But people are participating. They are responding. And even though it feels different for the clinician and for the group members, we're seeing that it is successful, especially in terms of staying connected, which is so important during this crisis.

Of course, use of telehealth is very helpful in dealing with the crisis of, I just need to talk to someone now. We're seeing an increase of text lines, of being able to text someone for support, being able to text someone just to talk about how they're feeling right now.

I mentioned earlier with psychological first aid, it's so important that the response is in the here and now to help the individual make it through where they're sitting and how they're feeling at the moment. And so the ability to be able to reach out via phone, via text, via video and connect more quickly, or to have an appointment more quickly, is very, very helpful. Whereas otherwise, it might be delayed until an appointment can be made in the future.

And then also, maintenance-- I work with many clients who I have been seeing them long term. And being able to touch base to make sure that they're maintaining stable mental health, knowing that this crisis is stressful for everyone. Those maintenance interactions help to make sure that they continue to stay healthy even though they, themselves, might not be in crisis at this particular moment.

And so to date, no studies have found any patient subgroup that does not benefit from or is harmed by mental health care provided through remote video conferencing. The American Telemedicine Association did an entire study. And they continue to do meta studies to look at just the impact of video conferencing or telehealth. And at this point, they've found that just about every population can use telehealth in different ways.

And so, of course, providers should consider the patient's expectations and level of comfort to determine appropriateness. I found, as I move toward telehealth in working with my individual clients, this was the biggest thing to overcome. Even the setting up of defining, OK, here's how long we're going to meet . It's not just a phone call. It's not just a check in. This is an actual session. Helping educate them as to where you should sit. Let's talk about where you're going to be sitting during our session. Are you going to be in the family room where your family's watching TV, for instance? It might not be as consistent.

Many patients, at first, thought we were just having a phone call, that they could just walk around. And so just clarifying those expectations and their level of comfort, and talking about, what are things that, maybe, they feel comfortable talking about in their house versus not feel comfortable talking

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about in their house? And how we could adjust for that was very, very important. But it took a conversation before we actually sat down to have our session.

So in terms of considerations for telehealth, some of the recommendations are that providers should consider the patient's cognitive capacity. There hasn't been any studies that have found that individuals with lower cognitive capacity are not recommended for telehealth. However, it may need to be adjusted. And it depends, of course, on the individual and where they are.

Additionally, you should assess the history regarding cooperativeness with treatment. Obviously, telehealth may not be as effective with someone that already is resistant to participating in sessions. I've had a couple of individuals that maybe aren't as happy with treatment. I have a couple of people that are mandated to see me that sometimes they answer the phone, they call me back. And it's typical. It's like, OK, you weren't cooperative face to face. So why would I expect you to be overly cooperative with telehealth?

However, I've seen other clients who previously, maybe, struggled attending in treatment because of transportation, because of family support where telehealth really has worked for them because they don't need to ask for a ride. The individual driving them isn't running late. And so there can be pros and cons regarding just helping them feel more comfortable.

I know especially when we're looking at-- and I'll talk about this in a little bit-- individuals and feeling comfortable with a professional office. I have many clients who have been more comfortable in sharing because they're in their own home. They're in their comfy chair or in their own room where sometimes they feel like it's more of a chat rather than a formal appointment. And so these are some considerations that I had when I was considering whether telehealth was appropriate.

Current and past difficulties with substance abuse may also impact their ability to participate in telehealth, especially in terms of our own assessment of sobriety. History of violence or self-injurious behavior-- again, this can be difficult. And each individual must be assessed individually.

If an individual cannot be safe or if there are not individuals that can reach out to them, that needs to be a consideration of how telehealth will happen and what sort of things are recommended to discuss. Whereas if that individual has felt that they may be self-injurous or violent, it might not be recommended at that particular time.

Additionally, the ability to gain appropriate, informed consent-- I know I have some new clients coming in. And I am requiring that they come into the office to make sure that I can give them the appropriate paperwork, to get that appropriate, informed consent. Of course, I don't know that I can do that in all cases. And so I'm really assessing how to make sure that they're fully reading the paperwork that we're sending to them via email, and having a full

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discussion before beginning treatment to make sure that they know what telehealth is and what we might talk about, especially if they're new to treatment and they haven't participated in therapy before.

Also, looking at potential for technical failure-- I mentioned a little bit ago just that many of our families may not have great technology or a great Wi-Fi connection. And so being a to anticipate that and determining what will be used, and also the backup. If, for some reason, your computer does not work, your Wi-Fi doesn't work, what are some other options that we can use? And then, of course, the ability to ensure safety and support, talking to the client about, are there family members that can support you, help you set up the video chat if that's what it's going to be? And make sure their safety regarding their own presentation of mental health symptoms.

Some of the challenges in teleheatlh in cross-cultural communication-- already, I consider every single interaction we have cross-cultural. I've never met anyone in my life that has had my exact same experiences, my exact same cultural background, my same family. And so therefore, cross-cultural communication happens with everyone. However, especially when we are working with individuals who may be from vulnerable populations or under-resourced populations, this can be very, very difficult.

And so first, if a therapeutic rapport has not been developed, appropriate assessment of physical and mental health symptoms may be difficult if the client's entire body is not visible. So I don't know if any of you out there are a little more gestalt, but it's always a benefit when I'm sitting across from the individual and able to see what they're doing with their feet, what they're doing with their hands. And often, if I'm using video, I can't see the entire person. Sometimes-- I don't know if you've ever worked with somebody doing video or talked to a friend-- all I can see is the top of their forehead.

And so being able to address that during your session is very important. And it can be a challenge, especially knowing that many of our populations that we work with may express their mental health symptoms physically. And so when we see somebody has a tense body, that may indicate a lot to us which the use of video may not be able to show that. So we have to be much more active in asking. Tell me how your body feels. Can you point to me where you might have tension in your body today? Things that on a normal basis, if the person's sitting across from us, we can tell those right away.

The treatment providers should consider the client's language capacity and the ability to communicate verbally and nonverbally using telehealth. Often, if an individual speaks a language that you're not familiar with or don't speak well, already in-person communication can be difficult. But when we add the challenges of using a video, sometimes a person's microphone-- I've had video conferences myself where one person, their microphone wasn't working well. I couldn't hear them well. And when we think about adding on a second language of them trying to understand what we're saying, it can definitely

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impact communication, just being able to hear them. And again, especially if they're also communicating nonverbally.

The treatment provider should assess a client's ability to be in a private area for the session and should clarify mutual expectations regarding the telehealth setup. Different family members have different levels of comfort. And so we have to talk to the individual, especially about their family comfort in them participating in a therapy session. This might impact comfort if they're now being asked to do it by telehealth.

I know I've worked with many clients who based on themselves, based on their own family, their family wasn't supportive of therapy. And so they're trying to go into a separate room. The family members keep entering just because they don't respect the process. So that, as well, can impact just their ability.

And so I've had at least one client who was, maybe, not responding very well or giving me very short answers. And when they were able to step away and actually talk about it, it was that they had a parent or a family member hovering around the room. And they just didn't feel very comfortable. And so we had to have a family session to just clarify with the family member of what we were doing and what was expected regarding privacy.

A consideration of the client's ethnicity, race, age, gender, sexual orientation, geographical location, socio-economic and cultural backgrounds should also be considered, especially regarding to that culture's use of technology and communication. Especially if there is an individual that doesn't trust technology, asking them now to share intimate things can impact the share.

All right. And so the next thing we'll discuss here are cultural idioms of distress, especially when we look at how individuals are experiencing this pandemic, how they express it can be unique. When we look at the impact of the concept of illness on individuals, the cultural concepts may be related to acculturation, discrimination, oppression, and a stigma related to physical and mental illness.

Now, it's important to note that every single human on earth has a culture. And so in many ways, this applies to everybody that you might see. And again, I repeat that everybody I meet, there is a cross-cultural communication that is happening. And so as we start to look at how different individuals are expressing their pain right now, we will see that it does vary based on a couple of specific concepts.

So the cultural concepts of distress are expressed through three concepts. The first is cultural syndromes. These are groups of symptoms that co-occur among individuals in specific cultural groups, communities, and contexts. Second, cultural idioms of distress are ways that symptoms are expressed which provide a collective, shared ways of experiencing and talking about personal and social concerns.

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And then the last one are cultural explanations or perceived causes, labels, attributions, or features of an explanatory model that indicate culturally recognized meaning or etiology for symptoms, illness, or distress. And all of these are in the DSM-5.

So today, I'm really going to focus on the cultural idioms of distress. Because as we look at COVID-19, the very, very unique thing about it is this is a community illness. Now, again it's impacting us two ways, physically but also psychologically. And it is being expressed. The entire community is contributing to this discussion. But when we see the smaller groups of individuals, personal racial groups, community groups where they live, and then family groups, we see some differences regarding their cultural expression.

And so I am really going to highlight cultural idioms of distress here. Individuals from different cultures may use expressions that are consistent with the culture-bound syndromes that they experience. Or they may express somatized symptoms. For example, individuals may express their symptoms in culturally acceptable terms. Nervios-- if we're discussing Latino individuals-- starts with a persistent idea that is stuck. The individual may find it difficult to think about other things, or they find their thoughts consistently returning to this idea, to whatever idea it is.

Some individuals may report body sensations and feelings rather than mental health symptoms. With African-Americans, we found some very, very similar things where often, mental health symptoms are expressed with the body. And so I found that in my work in therapy, 9 times out of 10, if somebody tells me that they have physical ailments such as heart attack, they have back pain, 9 times out of 10 I can diagnose anxiety with it. And often, they're much more comfortable talking about their physical ailments, how their body is feeling, than their mental health ailments. But it's understanding that.

When we see how individuals somaticize their symptoms, often, instead of expressing that I'm worried, I'm hurt, they'll express stomach pain. I found myself doing this earlier in the week for the first time ever. I had significant stomach pain. But all of a sudden, I started realizing that it was really just this expression that I was experiencing, and that it was connected to much more emotional things that I was going through. But it's being able to understand that and take a look at that as, also, a mental health symptom.

Research shows that often, individuals in cultures that have this expression of mental health symptoms through the somatization of symptoms, often, they're more likely to be referred to specialists. They are more likely to see the physical doctor again and again. They're also more likely to not have a resolution of symptoms. And many of these are attached to just cultural methods of expressing how they're feeling these psychological symptoms.

And so as we're talking with people that are going through this crisis, it's again very difficult. Because you're looking at COVID-19 and someone's expressing

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that, oh, I have a headache. I have stomach pain. I have these other things that are going on. Instantly, we're thinking, OK, is this someone that is having symptoms of COVID? But at the same time, when we're looking at the cultural expression of mental health symptoms, we are looking at almost the exact same symptoms, which can be very, very difficult to kind of pull apart. But recognizing that these may be idioms of distress can help us become aware, to be looking for these and to be able to refer appropriately for the physical treatments, but also to continue to keep these in mind as we treat their mental health symptoms.

The assessment of cultural idioms can be extremely difficult, especially when we're using telehealth. In addition to the assessment of culture-bound syndrome and cultural idioms, the DSM-5 encourages an assessment of cultural factors affecting self-coping and past help-seeking behavior. And so it can be incredibly effective, when we're looking at the difference between physical symptoms and mental health symptoms, to talk about what the individual has experienced in the past regarding crisis or even their mental health. Being able to reach back and discuss how they coped previously, and also look at their normal presentation of symptoms can be extremely helpful. However, it's important not to assume that the crises that they've experienced in the past weren't medical health regarding their physical health. It might be the same. Often, people do express symptoms differently depending on the crisis that they're experiencing.

The more assimilated the individual is to the local culture, the more likely he or she is to seek help from a psychiatrist, or psychologist, or another treatment provider. And so if there is-- I've worked with many clients that felt very comfortable reaching out to the mental health providers in the school because it was the norm. That community really recognized it, embraced it. Traditionally, if there is a mental health facility in the area that people know and people trust, they will be more likely to reach out for services rather than if it's an individual who lives in a community or a population that's very separate from the mental health community.

Individuals with different levels of acculturation may have multiple models of distress and help-seeking. Each individual must be evaluated based on their individual, communal, and national culture. As I've mentioned before in terms of cross-cultural communication, all of us are very, very different. And there is no one like the other. And so therefore, we have to talk to the individual just regarding themselves but also the community around them, their personal family, and also their national culture to look at how this individual may be expressing stress, especially when we're talking about individuals who may have had trauma regarding immigration, may have had trauma regarding stigma, and discrimination, and prejudice already. They may be experiencing this particular crisis much differently or even much more severely than other individuals who haven't had those previous stressors.

So some challenges in assessment within telehealth-- many cultural idioms are expressed through physical symptoms. It may be difficult to assess these

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through telehealth. As I said before, many individuals express their mental symptoms through their body. And these are extremely difficult to assess through telehealth unless we directly ask.

Clients that are unfamiliar with telehealth may not be as open with symptoms. Again, they may feel uncomfortable because of family members on the other side of the door. I have a client where the one place he can talk is in his apartment stairwell. Now, he says that there aren't a lot of people that walk in that stairwell. But he's like, I'm not comfortable talking about these things in my house, so I'm going to go outside, and that's where I'm going to sit. And he feels more comfortable with it that way. But that can hinder his comfort in expressing symptoms that he's currently experiencing.

Many vulnerable populations only go to the doctor when something is unbearable, which may reduce preventative care. And so already when we're looking at vulnerable populations who may have a stigma about seeing a mental health provider, already they might only come to us once their pain is absolutely unbearable. And so we don't have that opportunity to provide preventative care and help them before it gets overwhelming.

Many clients expect to include family members in the relationship with the provider, which might be a challenge with telehealth. On the other hand, this is one area where it may be a challenge in some ways. It may also be a strength in others.

Yeah, I know. Recently, I was working with an adolescent. And we were talking about bringing their mom into the session. And he stood up, went to the other room, and brought her in, which was actually a benefit of telehealth where she was able to stop in just for a short period of time to discuss some things and then leave. And so this can be either a strength or sometimes a challenge depending on your client.

We do have tools to help us assess culture so that we can understand individuals in crisis. The DSM-- to start at the beginning of how the DSM-5 presents it, the DSM-5 defines culture at the values, orientations, knowledge, and practices that individuals derive from membership in diverse social groups such as ethnic groups, faith communities, occupational groups, veterans groups, for instance. The influence of family, friends, and other community members, their social network, may also have a large impact on the individual's illness experience.

Now, when we look at that and we think about COVID-19, when we think about that, all of a sudden, we see how values could significantly impact how someone experiences this. If you think about your own values regarding health, we have some individuals who are very, very attentive to their health, and others that aren't. We look at individuals and their knowledge base regarding health practices. I've talked to so many clients who just really weren't sure about how the virus spreads. When people say contact

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precautions, they didn't really know what that even was. And so that can impact their perception of the virus.

Additionally, being in the influence of family, friends, other community members-- when people see people in the community that are dying. I know recently in my community, there were some religious leaders who were impacted by COVID-19, which significantly impacted how the community saw this illness very, very quickly. These were leaders that were some of the first people to be diagnosed.

And all of a sudden, it spread very, very quickly in the community that this happened to these leaders who otherwise were healthy individuals, didn't have practices that would put them in danger. They didn't have some of those stigmatized behaviors. These are individuals that became sick. And that really impacted the community's perception of COVID-19 as something that anybody could get. And so these factors can impact each individual's experience of this illness.

So the DSM-5 provides an outline for a cultural formulation to supplement the diagnostic assessment. This allows the provider to assess the effect that cultural issues will have on treatment. And so I summarize them as follows. The DSM has a cultural formulation interview, which is provided the back of the DSM-5, looks at the cultural identity of the individual, the cultural explanations of the individual's illness, cultural factors related to psychosocial environment and levels of functioning, cultural elements of the relationship between the individual and provider, and overall cultural assessment for diagnosis and care.

So if we pause for a moment and we think about everything we've already talked about in this webinar, looking at how the individual's identity, their explanation of illness-- is it because it's bad people do it, people that don't wash their hands get it? Does it just happen to anyone? Like I said, it happens even to religious leaders and political leaders. Why do people get sick?

When we're looking at the cultural factors that impact psychosocial environment, individuals that are currently working at home, teleworking, and they are at home with their kids, they're experiencing different than the individual that has to go into the factory and work. Because if they're sick a day, they won't get paid. And they're living check to check. And so these factors can impact that.

Cultural elements of the relationship between the individual and provider-- do you know me? Is this the first time you're seeing me? Am I seeing you in an inpatient location where I'm just coming in to assess you? Or do we have a long-term relationship?

How about-- is the school involved? Is that where the connections happen? And then looking at the overall cultural assessment for diagnosis of care in terms of how expression is happening, the cultural idioms that might be

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involved here. All of these things can be impacting how each individual perceives and experiences this virus differently.

And so the cultural formulation interview can help us. It provides us with six questions that providers may use during an interview to assess the impact of culture on key aspects of an individual's clinical presentation and care. Now, 100% of the time when I ask individuals, hey, how are you assessing culture in your work? Usually, if they haven't been in a lot of cultural training, they say, I don't have time for that. I barely have time to get my work done.

And so one thing I always emphasize is assessment of culture is not done on top of your work. It is your work. And so if you take a look-- and I'll show you briefly in a second the question. You're going to see that they're just the same questions you ask in any intake. However, they're written a little bit differently and they're focused on specific things.

And so it highlights these four domains of assessment-- the definition of the problem; cultural perceptions of cause, context, support; cultural factors affecting self-coping and past help-seeking behavior; and cultural factors affecting current help-seeking.

And I gave you the pages. So if you can only look at your DSM-5, you can find it. So those are the questions. There's a couple of questions on each of these domains. So let me show you the questions here.

And so when you look, the question is like, what brings you here today? When we look at how these questions in the cultural formulation interview are written, they're all open-ended questions. And they all speak to those past help-speaking, looking at, what's your understanding of the cause, context, and support that you have? Looking at why this might be an issue for you today.

So when we think about assessing someone that is struggling with handling the virus, the change in their lives then the impact that this has brought upon them, we're seeing that these questions can be extremely helpful. But a lot of it is not just, what is your experience? It's also, tell me about your family, your friends. As you talk to your mom, what does she think is happening here? How does that affect your perception? And really looking at how these individuals are affected by more than just a kind of single view. This is so important so that we can understand how their entire culture is influencing their perceptions.

One of the beautiful things about this-- and so putting it all together, when we look at those cultural formulation interviews, those four domains of assessment. And I just showed you those questions that fit under there. And we look at psychological first aid, which is an evidence-based treatment, we see that they all fit together. And this is the beauty of it.

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It's looking and going, OK, how do you define the problem? How is the virus impacting you? Is it financially? Is it socially? Is it emotionally? Tell me what is coming up for you. And we're looking at working with that. We're connecting with them. We're engaging them where they are that moment. We're talking about-- if right now, you're going, you know what? The thing that's really panicking me is I don't have a check coming in. It's talking to them about, OK, let's talk about safety. Let's talk about this. Let's stabilize you if needed. Do you need a referral somewhere? Do I need to link you with collaborative services to help you if that's your problem today?

When we're talking about cultural perceptions of the cause, context, and support that they have, we're information-gathering on their current needs, concerns, people in their life looking for that practical assistance. Cultural factors affecting self-coping, past help-seeking behavior-- it's helping us connect them with those social supports that have worked in the past and we might be able to bring back again.

And then the factors affecting current help-seeking-- who is not available to you right now? Normally, for instance, you talk to your mom. But right now, you can't see her as much. You can't go over to her house. And so let's talk about practical assistance. Let's talk about helping you feel safe and gather that information on your current needs. And so the cultural formulation interview can really help us apply psychological first aid to make sure that we're doing it in a culturally relevant way that can meet all of our clients' needs, especially if, looking at this virus, it impacts us so differently depending on where we are.

So in summary, when we're looking at the impact of COVID-19, what is needed is a very culturally relevant response as it's impacting all of us-- our clients, but also us-- in such different ways that as we go forward, this is a need for right now in terms of dealing with the crisis. But as we go forward, we're looking that this is going to be something that we're going to be working with for more than a year after this just as we look at people that have gone through a current trauma based on where they are now, but also those after-effects, the ripples of trauma afterwards. And so using the cultural formulation interview and psychological first aid concepts can really help us meet the needs of the individuals that we serve.

ALFREDO CERRATO: Dr. Evans, thank you so much for your insights. I am sure that the information you shared with us will assist us-- and particularly our behavioral health workforce-- navigate the new and the unknown for themselves and for their clients during these times of crisis.

I would also like to thank you, our listeners, our behavioral workforce. Thank you for your services during these times. This concludes our webinar presentation. Thank you very much.

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