Ep. 38: Cultural Diversity and Mental Health

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Good day, gladiators, thank you for listening to another episode of the Sword and Shield Podcast. It's Francis Martinez, Director of Psychological Health for the 960th Cyberspace Wing, here with a guest from San Antonio Counseling and Behavioral Center, Melody Montano LPC. So, thank you so much Melody for joining us this morning. - Thank you guys for having me, I'm really excited to be here today. - So tell us a little bit about your background. - Sure, so I'm a licensed professional counselor in the state of Texas. And I've been practicing approximately for about nine years, but I've worked in the field of mental health and social support for about 13 years. Currently, I'm working on my Ph.D. in clinical psychology, where my specialty is social justice and minority health disparities. So I consider myself a qualitative researcher, which basically means I evaluate psychological constructs through the stories and narratives that people tell me. - Well, that actually fits perfect, right? Into what we're going to talk about today. So our topic for today is cultural diversities as it relates to mental health. And you know, why such a big disparity and kind of challenge some of those thoughts and theories today. - Right, yeah, definitely. Definitely an important topic. - Yeah, and so I think people, you know, everyone knows the United States is such a melting pot for different cultures, right? I mean we have so many different types of people, even in their same, you know, Asian community or black community, Hispanic communities. There are so many diversities within those individual communities as well. - Right. - And so I think I wanna focus, you know, talking about, you know, where are we with mental health as it relates to like the different cultures and how do we talk about like those disparities and challenges that we're facing. - Yeah, absolutely, so first of all, I think it's really important for people to understand that traditionally, mental health providers have been trained from what we call an ethnocentric perspective. And basically, that means that we are trained from the get-go to view disorders and experiences, basically the human experience, from a specific lens. And basically what we've been doing for several years is pathologizing what are actually cultural norms, cultural expressions of distress is what the DSM five calls it. And so what we're shifting to in the mental health field is what's known as cultural relativism. And basically, that's the idea that a person's beliefs, their values, their practices, basically how they live their life should basically be understood from their own cultural perspective and not necessarily judged by a certain criteria or even our own worldview as practitioners. - And I know there's so many different challenges because some cultures, right? They don't believe in mental health altogether. - Right, yeah, so, you know, that's an issue because one of the things that people are not

aware of is the research in the world of mental health is actually not technically generalizable to ethnic minorities. Mistrust the nature of clinical trials, even researchers, in general, are not representative of minority or underrepresented groups. So what happens is that these norms, these ideas, the knowledge about what it means to be mentally ill, doesn't resonate with minority groups. And so there's this sense of mistrust, or there's a disconnect between connecting with the ideas of what it means to have mental health. And that's really what the cultural sensitivity phenomenon or dynamic is shifting towards. How do we define mental illness? How do we explain what's not normal? What is a health condition versus a cultural expression? So that minorities are not, or don't continue to be disproportionately impacted by disparities, just like mental health disparities. And I think it's important for practitioners to really learn about how to communicate in a culturally sensitive way. So that people can really, and I don't want to use the term buy-in because we're not really trying to convince people that they have these mental health disorders, but really helping them learn from their own cultural perspective of what they may be experiencing, that's inhibiting them from living as their optimal selves. - And I like that you said the buy-in piece, right? Or helping people to really learn and understand, you know, the diagnosis that they may be given. And I know from, you know, experience that there are lots of people, that, one are going to challenge what you're telling them, right? Because, "What are you talking about "I have major depressive disorder, "that's not a thing, you know?" And from the Hispanic culture, the Asian culture in which I'm part of both, you know, that's not a thing. We don't talk about that, we don't, you know, do anything with that, that's, you know, weak. And I think, you know, breaking the stigma is so difficult, especially in these cultural settings. - Absolutely, yeah, I think that you hit the nail on the head. I think that people have a worldview. Basically, that's what we call post-modernism if you haven't ever heard of that. It's basically the idea that our reality and how we see the world and even what people tell us is based on our own lens and our own cultural experiences. So if you've been told your whole life that crying or having inability to function as you normally would, or go to work or even get out of bed is considered weak. You're going to subscribe to that narrative. And when somebody comes in and tries to pathologize that you are going to be defensive about it based on your cultural lens. And, you know, I think it's important for practitioners, again, I'm going back to the importance of this, to use language, to meet the client where they're at. To help them understand their experiences from their own perspective. So that we can lead them to the path of understanding how to get well and how to move out of their particular condition. - Yeah, and I think when we talk about, you know, culture itself, it's far more than just your ethnic background, right? We have to look at like the religious background or faith-based background, any socioeconomic factors, right? Because even again, like in the Hispanic or Asian or black cultures, or communities, there's a wide range of people in those, you know, from poverty level to, high socioeconomic levels. And then they're going to have different views in addition to just the race or the ethnic background. - Absolutely, and, you know, those are what we call subcultures, right? So they're kind of like, we can go down the funnel of subcultures all the way down to like small groups that you can find on the Internet or something like that. But I think that you're right. So that's a whole new

world that is called intersectionality in the world of mental health. Where instead of looking at people as like, "Oh, you're Latino or you're African-American, "or you're a part of the GLBTQI community." We start to look at people on somewhat of a grid, like where do you fall? How many risks are associated with who you are as a person and how you identify? How can we incorporate the reality of the social impact that you're experiencing because of who you are. Not simply because of your culture, but because of your religion, because of your gender, because of all these other factors that make your experience what it is? And really, I think it's so important for people to not only look at themselves culturally, from one perspective, like your ethnicity but also, you know, their class, also their gender. You know, there's a lot of research out there that shows that there's still disparities in the workforce that go against women. And so what would it mean if you were a multi-cultural female who identified as lesbian, you know, that would all be impacted differently than if you were just identifying as a female alone. Or a Latino without being female or a part of the GLBTQ community. - Yeah, and that goes into further, you know, with the sexual orientation and so forth. So I'm glad you brought that up because, you know, especially in the military, right? We're trying to include and be diversified and have that sense of inclusion. And we're trying to do that through multi-layers of, you know, different facets, right? Like we're it's a female versus male or female and male, you know, changing that script or that narrative. And I think with the mental health it's the same thing. We're trying to change that thought process and make sure it's okay to have that sort of inclusion. - Yeah, it's really hard, you know, and I always come at everything with some kind of compassion and empathy. Because it's really easy to get upset depending on what side of the spectrum you stand on with change, especially this kind of social change. You know, systems work and totally don't work anymore. And anything in the world that is alive, even the human species evolves over time. And so we just have to understand that, you know, things have to move along with the development of society. And it doesn't always mean that things are going to be perfect at first, growth is a painful and uncomfortable process, even in the world of systems and policies. But I just think that people who are experiencing the impact of systems and policies need to learn to voice their experiences and their thoughts and how they're personally being impacted. Because like I said earlier, the knowledge and the data that is out there about people is not generalizable to the very people that are being negatively impacted by systems and policies. So if we don't really know how people are impacted, especially underserved or minority groups, then we don't really know how to build your change systems. - And I'm going to throw in another culture, the military culture, right? And that's who our listeners generally are right now, our military counterparts. And then that just adds a whole other layer of stigma, right? As it relates to mental health and challenge, and how do we overcome those different challenges as it relates to the military culture. Because again, you know, it's the perception of, "I'm weak, I'm gonna lose my job, "you know, how am I gonna feed my family," and so on and so forth. And so that's another challenge that we're facing here in the military sector. - Right, yeah, actually I do a weekly group with veterans who have PTSD. Through an organization called the Birdwell Foundation. And it is a faith-based organization, but ultimately the aim is to remind veterans, wounded

soldiers, emotionally and physically, that they don't have to heal alone. And that's part of what you were alluding to earlier, is there has to be a movement towards eradicating stigma, especially from military culture. Because there is this kind of like notion that you just have to deal with it. "You just have to learn how to embrace the suck," is the famous saying. And in reality, what that does, especially with conditions like depression and PTSD, the more you internalize your symptoms, the more exacerbated your symptoms become. And so it's very important for us as either mental health providers or people working with military populations to just throw it out there. Like, you know, there's spring sources, there's things you can do, so you don't have to go through this alone. And even if you get the yam, good, thank you for that. At least it's a seed that you planted so that the person can later if needed cultivate that idea. - Yeah, and I liked that you talked about like group settings, right? Because when we talk about different ideas or support groups, right? People are a little bit more liberated because, okay, I'm not alone. You know, this other person feels the same way as I do. And it kind of normalizes it, versus, you know, making, "Oh my gosh, I have this disorder "and I'm going through, you know, nightmares and flashbacks "and things like that." And so you know, finding again, a culture, right? If people that have the same experiences that you do. - Absolutely, the term we use in mental health is called universality. And it's basically the notion that you're not the only one in the universe experiencing this hardship. So connecting with peers or other people that are having similar experiences is very healing. And I think that that's something that, you know, military personnel or veterans can relate to. There's kind of like a brotherhood in surviving when you're active duty. But then there's also a brotherhood that can be experienced or a sisterhood that can be experienced in the healing journey. As they assimilate to civilian life, or as they try to learn what it means to redefine their identity outside of military culture. And that's really difficult and hard, and the burden can be eased by joining, you know, these groups that exist, there's so many. But I just fell in love with the Birdwell Foundation because, you know, they throw barbecues they're out there in the gym together as a group. And it's just really an experiential process that I think is important for veterans. - Yeah, that's a great resource. We appreciate you sharing that with us because you know, some of our listeners might be able to reach out to that organization for assistance. So, thank you for sharing that. I do want to talk a little bit about you know, again, as practitioners, we're kind of faced with the obstacles, right? Of helping people who are, you know, completely set on. "There's nothing wrong with me. "You know, I'm just, you know I'm going to be weak, right? "If I'm sharing my thoughts and feelings, "'cause I grew up not doing that. "You know, we don't cry, we don't you know, "talk about our feelings." And so walk me through what that looks like and, you know, breaking down those walls to help someone, you know, really live their best life. - Yeah, I think it's important. So there's actually a lot of research that has been done on what's called the five-factor model. And basically, what they've done throughout the years, that psychotherapy has been in existence, is they wanted to find out which approach is the best approach, right? So we have the psychodynamic, like the Freudian and people fighting against the cognitive-behavioral people, my treatment is better. And so then we have the existentialists and the humanist saying all people have the potential to be great. And

so everybody wants to claim that their treatment approach is the best. So we have a famous researcher called Wampold, who said, "Let me really get to the bottom of this, "and let's find out, you know, who's the winner, "who's the champion." And what they found out over a span of 20 years, doing a longitudinal study, there really is no difference in the particular strategies or treatment approaches used. But rather there were five factors that were very important in treatment. And this is, I'm getting to your question. So one of them is the therapeutic relationship, okay? So that means that when you're working with somebody who doesn't believe in mental health and doesn't believe in conditions like major depression, you really wanna focus on building that relationship. I know with Latinos, it's super important to be relational, like how's your family, how are your kids, How's it going? And you're really building that trust that I said earlier. The minority community does not have trust in the medical community, which includes mental health providers. So we're building that relationship and we're working the relational aspect, okay? The second part is the person has to see you as somewhat competent, okay? This goes back to my idea about providers carrying kind of like an ethnocentric perspective. If a provider who is not culturally sensitive, kind of takes this like authoritative approach, the patient is not going to see them as competent. They're going to see them as a threat. They're going to see them as that person doesn't know what they're talking about, they don't understand me. And the second thing that needs to happen for effective treatment is the person needs to believe that the person helping them is competent enough to do so. And that doesn't always look like having, you know, enough degrees on the wall or having the right credentials behind your name. It looks like for many ethnic minorities being able to relate and being able to understand their personal experience, okay? The third thing is really difficult, is actually the buy-in, like we were talking about earlier. This is where you start with psycho-education. You have to start teaching people at some point, like, you know, "I know like I'm bilingual, "so I do a lot of Spanish speaking treatment." And one of the things that a lot of Latinos come in with is this notion of what they call nervios. And nervios is actually diagnosed many, a times as anxiety. So what I do is I'll start to help them make the connection by educating them that in English, in the medical world, having nervios is actually a condition that you can work through and it doesn't have to bring you to your knees. What would it mean if you could, by thinking certain things or practicing certain things? Control your nervios and not have an attack in the nervios, which is the panic attack in the middle of HEB. And so when you start to link and you start to learn about the language, you can start to make the connection with the actual disorders that they're having to help them with the buy-in, okay? The other thing that's really important, the fourth thing is them having to really follow through. That's one of the hardest things to do in any type of medical intervention, not just with mental health. But the follow-through the medical compliance. - Oh yes, that is, yeah, that is one of the biggest challenges, right? Because we can give them all the tools in the world, but it's, you know, on them to actually utilize what we give them. - Exactly, so one of the things that we get trained on when we're learning and doing like social justice and minority health research, is the importance of checking in. So, you know, as a practitioner, you're getting somebody that doesn't believe in mental health and you're trying to use

their language and you're building rapport and you're helping them, feel confident that you can help them. But then you never really check-in to see if they got what they're supposed to be doing. In many cultures, it's disrespectful to disagree or to counter what a doctor or a practitioner is telling them. So they'll just kind of give you the, like, "Okay, yes, yes." And then you think as a practitioner that they understood what you were saying. And then they go home and they don't do anything that you ask them to do. And so checking in is actually a culturally sensitive practice for those practitioners or people who have experienced dialectical behavioral therapy known as DBT. Checking in is a very important part of the process because one of the most non-compliant population is people with borderline personality disorder. So, Edna Foa, who did research on how do we get people to comply, realize that checking in was a super important part of getting people to follow through with treatment. So as a practitioner, you have somebody you're not really too confident that they understood you. Maybe doing a follow-up call, maybe having your personnel, you know, check in on them to see if they filled out the forms, the assessment forms that you're trying to get back to really get a scope of their pathology. And really just trying to make sure that they understood and that they're doing beyond what is normative of a client that's not an ethnic minority. - Well, thank you for sharing all that. You know, we face a lot of challenges and it's really an uphill battle, right? To really break the stigma and break down the walls and help people to do what they want to do, right? Because it's all, you know, therapy is all in the person's own control, right? We can't force it. We can't make them do anything that they don't want to do or meeting them where they are. And, you know, again, helping them in whatever aspect or area of life that they really are asking for the help. - Right, exactly, so essentially at the end of the day and the bottom line is building that relationship. I think that that goes for, military personnel. They want somebody that gets it. You know, they want somebody that understands the struggles of what it meant to experience, you know, whether they were deployed or whether they were wounded or lost somebody they were close to. And then even the aftermath of assimilating to civilian life and like letting go. I think one of the biggest struggles I find is also the letting go. Like the grief that comes with like letting go of who you thought you were for so many years, and now you're retired and you're supposed to just figure it out. You know, there's a grief that comes with that process that a lot of practitioners don't get. And I think it's really important for us to see that as a cultural phenomenon. Because even with, like, for example, I do political asylum work with refugees. And even though they're here to seek asylum, there's still a grief about missing their culture and their, you know, their home life. And I think that we need to nurture that and not pathologize that as practitioners. - Yeah, thank you so much for sharing that. And, you know, being in the military culture, right? There's tons of transition all the time. There's a lot of adjustments for family members for, you know, the military members themselves. And so you know, that's what we're here for. So our gladiators if you are, you know, needing assistance, please reach out, you know, we can point you in the right direction. And you know, if you are interested in meeting with Melody, you know, you can contact me and I can put you in touch with her. So, Melody, I wanna thank you so much this day for joining us and sharing all of your insight. It was a really

great conversation and helping to understand, you know, all the disparities as it relates to mental health and different cultures. I do want to wrap up with, you know, our gladiators, you know, if you or someone you know are contemplating suicide. You know, contact the national suicide hotline at +1 800-273-8255. Again, that's +1 800-273-8255. Thank you again, Melody, for joining us today and gladiators, thank you again for tuning in to this episode of the Sword and Shield Podcast. Gladiators out. - Thank you, bye-bye. - Bye. (Bright instrumental music)