EXPLORING CULTURAL IDIOMS OF MENTAL HEALTH
EXECUTIVE SUMMARY

A Foundation for the Promising Practices Program for Culturally-Effective Stigma Reduction

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In order to reduce racial and ethnic mental health disparities - providers, communities, friends, and family members must have a greater understanding of what it means to be culturally competent and provide culturally competent services.

CULTURAL IDIOMS PROJECT OVERVIEW

The Cultural Idioms Project is implemented by the Center for Dignity, Recovery & Empowerment at the Mental Health Association of San Francisco, funded by the Mental Health Services Act and administered through the California Mental Health Services Authority (CalMHSA). The Cultural Idioms Project was launched to better understand how different cultural communities across the state of California made sense of and conceptualized personal and social distress. The objective was to highlight how culture influenced the understanding and development of mental health and wellness within specific diverse cultural and ethnic populations. We relied on a strengths-based approach to further investigate resilience, well-being and culturally-responsive practices.

UNDERSTANDING CULTURE AND WELLNESS: AN OVERVIEW

Culture is an integrated pattern of human behavior which includes: thoughts, language, beliefs, values, manners of interacting, and expected behaviors of cultural, racial, ethnic, and religious or social groups transmitted across generations. We can develop a better understanding of how culture and mental health interplay by examining how diverse communities express psychological distress, attitudes towards mental health and treatment seeking. The language, concepts and beliefs about mental health used in different cultural communities can inform best practices in care management, access and mental health service delivery, and how to address stigma as a significant barrier. Therefore, to promote recovery and effectively reduce stigma, it is necessary to first understand the cultural concepts of mental health distress within communities of interest. This report will provide a culturally-specific understanding of mental health distress in three culturally diverse communities.

The primary goals of the Cultural Idioms Project are to:
1. Better understand how individuals and communities within three ethnic groups define and experience mental health distress,
2. Learn more about the mechanisms that can reduce mental health stigma,
3. Provide culturally-specific prevention and early intervention recommendations for service providers.

WHAT ARE CULTURAL IDIOMS?

Cultural idioms are expressions used by specific cultural groups that have unique phrasing and features. Cultural idioms can be used to describe and understand culturally specific perceptions that lead to a shared recognition of experiences. Idioms of distress, according to social scientists, are terms describing distress that can be religious, medical, or political in nature (Kirmayer 1989; Nichter 1981, 2010). Cultural idioms of distress are “shared, culturally distributed sets of symbols, behaviors, language, or meanings that may be used by people to express, explain, and/or transform their distress and suffering” (Hollan 2004:63). Exploring cultural idioms of distress can also reveal generational, regional, and varying types of diversity within cultures.

In order to reduce racial and ethnic mental health disparities - providers, communities, friends, and family members must have a greater understanding of what it means to be culturally competent and provide culturally competent services.

METHODOLOGY

Setting

Researchers established relationships with three community-based and population-focused organizations in the state of California. Our three community partners included: The African American Mental Health Coalition (San Bernardino County), Community Advocacy Coalition (Ventura County), The Center for Lao Studies (San Francisco County), and The Latino Commission (San Mateo County). The Idioms study was conducted in collaboration with trusted community partners aiming to reduce mental health disparities, not specifically mental health service providers. The African American Mental Health Coalition (AAMHC) is an outreach program connecting community members to mental health services. The Community Advocacy Coalition (CAC) is an advocacy and engagement organization grounded in social justice and the transformation of Black people and people of African American descent. The Center for Lao Studies (CLS) is an organization advancing knowledge...
and engagement in the field of Lao studies and holding partnerships with mental health agencies. The Latino Commission (TLC) provides direct mental health and substance abuse services utilizing a culturally-specific model emphasizing cultural affirmation.

**Methods and Data analyses**

Our study involved twelve months of ethnographic fieldwork using participant observation, focus groups with community leaders, and interviews with 114 participants to explore concepts of mental health and stigma. A minimum of thirty hours of participant observation occurred at all three partner sites. Focus groups consisted of 8-12 community leaders, service providers, and outreach workers that reflected the cultural community. Questions were finalized collaboratively with the directors of each partner agency to ensure rich and meaningful focus group discussions.

Discussions focused specifically on understanding service providers’ perspectives and methods used to promote mental wellness with each community. The Cultural Formulation Interview (CFI) - a validated instrument to assess idioms of distress was used to conduct 75 semi-structured interviews (22 with Lao partners, 26 with African American/Black partners, and 27 with Latino partners). At all sites, half of key interview participants were community members who identified with having mental health challenges, while the other half consisted of family or friends of these community members. All data were transcribed, line-by-line. Using Atlas Ti software, the data analysis team coded these data using an open coding approach, allowing key themes to emerge directly from the perspective of the participants, rather than using an a priori approach that assumes to know findings before the research is conducted.

**DISCUSSION AND RECOMMENDATIONS**

**African American Community**

In the African American community, results indicated that historic “collective traumas,” wherein all members were exposed to similar potentially traumatic experiences, specifically slavery and segregation, combine with current stressors created a unique environment through which mental health challenges arose. Additionally, racism and structural barriers such as lack of access via insurance, cost, or location of treatment have deterred many in the African American community from seeking help. In regards to stigma, participants emphasized the need for mental health literacy owing to the stigma and shame attached to mental health care. Therefore, mental health education and services need to be more accessible and through diverse venues. Lastly, the notion of “community” is particularly important. For some, community-level support and isolation had more profound effects on mental health over and above family support. Our findings suggested that within African American communities this notion was not always connected to biological ties, but rather something that is consciously created with like-minded “kin” from one’s neighborhood, peer group or church.

**African American-Specific Recommendations**

Drawing on those findings, we developed community-specific recommendations that encourage policy makers and service providers to:

a. Broaden the conceptualization of “family;” Friends and family members are important ties to that can be significant support systems and sources of strength and coping.

b. Consider the ways that racism and structural inequality shape the experience of personal and social distress, as well as how these entrenched societal forces contribute to stigma, when it comes to social service provisions. While some of our participants associated seeking mental health services with a position of empowerment and strength, many described how services that are heavily rooted in the biomedical model seem to create further marginalization, may enforce colonialism, and feelings of isolation.

c. Recognize the historical traumas and deep mistrust from this community about the quality of care provided to African American community by mental health professionals. Participants shared experiences where service providers only seek to give medication without seeking to understand
concerns and stressors.

d. Incorporate the concepts of “community” and family-level interventions by bringing together the vast network of churches and faith-based institutions with community-based organizations that may or may not have an explicit focus on mental health.

**Lao community**

In the Lao community, sharing one’s own mental health challenges was the biggest barrier to seeking treatment. In addition, a Lao person may not seek help because the services are not culturally-responsive or they are “timid” and would not want to burden others with his or her problems. Furthermore, the Lao community described themselves as “underprivileged,” feeling that their refugee community was underserved across a number of dimensions in California. As a result of participation in the Cultural Idioms Project, community members themselves reflected on the ways their own cultural values both enhanced wellness and resilience, and how they might sometimes further entrench their community into a marginalized position. Some participants observed that because they are historically a “non-confrontational” culture, this may only further their vulnerability and tendency to be overlooked. The findings associated with the Lao community could potentially lead to novel and innovative approaches to culturally-salient mental health services.

**Lao-Specific Recommendations**

When engaging this community in advocacy or service provision, providers and policy makers should bear these cultural dynamics in mind:

a. Participants articulated that voicing their mental health complaints was very uncomfortable at the personal level, but perhaps less so at the social level. We recommend that these cultural stances toward debriefing or processing personal details be considered. It may be that while members of this community would like support, they are uncomfortable with the American style of very direct and authoritative communication.

b. Mental health services tend not to frame personal or mental distress in a way that is comparable to how Laos may understand their challenges. Therefore, discussing spiritual beliefs, cultural stigmas, and personal experiences should be respectfully engaged as discussion factors during service delivery and treatment planning.

c. We also wish to draw attention to our findings around the significance of cultural values, such as generosity and making offerings. As with our other recommendations, focusing mental health services on generosity—and important cultural construct for this community—may be an innovative approach to cultural competence within service provision. The value of “generosity” was a core value that supports cohesiveness and personal and social well-being.

d. Participants expressed that the ability to use their language would be important to them in a mental health setting. Language barriers or the need for younger generations or strangers to translate prevent many older generations from accessing mental health services and literacy. Thus, a more culturally diverse mental health workforce is needed to address concerns for the Lao community and in particular experiences of distress by newly arrived refugee groups and elders.

**Latino Community**

Within the Latino community, members who used substances and women who had experienced trauma both appeared to be of high risk of developing mental health challenges. Barriers to seeking treatment included cultural stigma, language, and financial hardship. One broad theme was the notion of “cultural competence” within mental health services. Participants emphasized that misdiagnosis was a major problem in their community because of a lack of cultural competence. Lastly, many participants discussed how the Latino population, regardless of age, tended to identify strongly with their particular ethnic/cultural background. Thus, religion and family support were two of the most widely endorsed coping strategies.

**Cultural idioms of distress** are “shared, culturally distributed sets of symbols, behaviors, language, or meanings that may be used by people to express, explain, and/or transform their distress and suffering.”
Latino-Specific Recommendations

The findings of the Cultural Idioms Project with regard to Latino communities lead to a number of culturally responsive considerations and advocacy focuses:

a. Moving beyond merely offering Spanish language services (although this is needed, as well), participants emphasized that there is a serious misunderstanding of cultural values and practices that can lead to misdiagnosis. Cultural sensitivity is critical when providing mental health services to the Latino community. Cultural stigma towards mental health services and not wanting to talk about emotions can lead to providers diagnosing Latino clients without understanding what is causing the client mental distress. Providers should not only try to answer “why are you here” and “what’s wrong” but also “what happened to you” and “what are your needs”. For example, using respectful engagement and even reframing mental health services like therapy into more culturally acceptable descriptions like talking can result in better responses to services. Especially, for youth who feel isolated and not understood, since there are very few programs accommodating for them. Many participants described how the Latino population regardless of age, identifies strongly with their ethnic group. This relates to, for example, faith, superstition, and local healing methods that are important to consider and respect when devising culturally responsive intervention.

b. Religion and spiritual traditions held more promise for resilience and recovery than did those services that are purely biomedical in their approach. We recommend that the vast network of churches and faith-based organizations partner with existing community organizations.

c. Among the Latino community members, individual therapy (or remaining alone during treatment) was perceived negatively due to this lack of felt presence and support of family members and partners. As such, remaining aware of the importance of the family unit must not simply be addressed in therapy, but respected as well in order to ensure treatment success for this population.

d. Psycho-educational approaches and techniques would greatly benefit family and community members to both increase illness knowledge and improve their ability to sympathize with, care for, and support their family. In addition, providing psycho education on medication will create more comfort, reduce the stigma around medication, and prevent people from not continuing treatment.

CONCLUSION

In order to reduce ethnic and racial mental health disparities in diverse communities providers and communities must have a greater understanding of culturally-responsive care and become trained on best practices in its delivery. The recommendations outlined above are suggestions and may help create a framework for working with these underserved ethnic and racial communities, but by no means a “recipe” for success. Each community – and each individual within that community – is unique and must be treated as such. Through cultural awareness, sensitivity, and cultural knowledge providers can understand how expressions of psychological distress can surface and explored further in service delivery.

Our data showed that discrimination, lack of linguistic services, and lack of culturally-responsive services needed to be addressed to reduce current disparities in health care seeking and delivery. Our findings supported our hypothesis that culture influenced the construction and conceptualization of mental health and wellness. In addition, sociocultural beliefs and social environments supported, as well as, hindered help-seeking and treatment use.

Community-wide efforts aimed at creating supportive social environments (employment, safe housing, and culturally-responsive services) lead to healthier communities and more help seeking efficacy. These findings and recommendations suggest that there are numerous avenues and innovative approaches to reducing ethnic and racial mental health disparities. More community-based participatory research with diverse communities and implementation of strategies is needed to build on this work.
African American Community Quotes:

1. “Historically, because of how things were run in our family [mental health] wasn’t approached. It was the elephant in the room … many of the families, even today, they don’t approach it. They just leave it in the back room.” -Focus Group Participant

2. “When you talk about wellness you are talking about the community and the family.” -Focus Group Participant

3. “Our depression is different from others’ depression, you know as far as the experience, you know, it’s because it’s cultural.” –Focus Group Participant

Lao community Quotes:

1. “We don’t take part in controversial issues or activities, we don’t take risks, we like to keep quiet and keep to ourselves, prefer a simple life” -Focus Group participant

2. “When you are worried, you think about your tradition. Any man will become a monk and stay in a temple from a day to years. Anything religion keeps you mind calm. Tradition keeps your mind calm” –Intervieewee

3. “I think it’s still very important to keep your culture, to practice the way that you used to do. That will help us to be happy, to feel like we are still doing the same way that we used to do, that our parents and grandparents used to teach us to do over here. If we can keep, if we can practice, we feel happy, we feel alive” -Focus Group participant

Latino Community Quotes:

1. “It’s taboo. (agreement in the background) You know because right away they are going to be labeled as being crazy, you know, and you know the latino culture you don’t really want to be talking about stuff that are happening at home and stuff so it’s hard to get them the help, plus when you do refer them to some of these mental health places they can’t get in or something or there is some kind of obstacle.” - Focus group participant

2. “my family members, they have helped me so much right now with my addiction, with my mental problem, with all this, and so I am like is it all worth throwing away? And I am like no! I will not make them go through this.” - Interviewee

3. “The difference for me is being able to express myself in Spanish more..and being able to feel better, speaking my language” - Interviewee
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We want to thank our community partners who made this project possible:

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