Wellness in Color: Looking Beyond the Pathology of Culture
Interview Guest: True Thao
Interviewer: Amy Wang and Mai Yee Chang
Hosted by: Caroline Ludy
Produced by: NAMI Minnesota (namimn.org)
Recorded: February 28, 2019

True:

And I have to often remember to say, what does this mean in your culture? What, what does this mean? And so I have to say oops, don't forget, your thinking like a Hmong person. And so it's hard. So, I think we have to be humble and have the humility to say that we don't know much; and join that process with our client and allow them to also educate us to.

Intro – Brian: Welcome to Wellness in Color on the Mental Health in Minnesota podcast produced by NAMI Minnesota, The National Alliance on Mental Illness. Wellness in Color is a podcast series that explores perspectives on mental health to reshape the cultural language of mental illness. Visit NAMI Minnesota online at namimn.org Subscribe to the podcast and listen on the NAMI Minnesota website or wherever you get your podcasts. This interview was conducted by Amy Wong, and Mai Yee Chang, who are both volunteer members of the NAMI Minnesota Multicultural Young Adult Advisory Board. And now here's your host, NAMI Minnesota staff member Caroline Ludy.

Caroline: Welcome to Wellness in Color. Today's hosts are Amy Wang and Mai Yee Chang with guest licensed clinical worker, True Thao. True talks to Wellness in Color about his Hmong heritage and clinical work in the mental health field. For twenty years, True has provided bilingual and bicultural mental health services to adolescence and adults and has experience working with organizations in the areas of employee mental health, refugee issues, and Hmong culture. Understanding the complexity of Hmong lives, and the issues affecting Hmong families and community, True currently works with clients at his practice True Thao Counseling Services based in Saint Paul, Minnesota.

These efforts were supported by the National Center for Advancing Translational Sciences of the National Institutes of Health Award Number UL1TR002494. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.
Welcome True, welcome Amy and welcome Mai Yee. I'll let you guys take it from there.

Mai Yee: We would like to start off by asking you can you tell us more about your background, and how you came to be a therapist.

True: I am a clinical social worker. I've been in the field close to about thirty years. I've been mostly been a frontline staff working as therapist. I have had few positions where I am the manager of a mental health program. And in my last position, I was running a program that recruits and trains second year Master's students to become licensed mental health professionals. But pretty much in my career, I set as a bilingual mental health worker in Rhode Island where the state provided money to a hospital to provide mental health program for refugees; Southeast Asian refugees actually. And I found mental health to be interesting so I went to school. And I've been working in the field since.

Amy: From your training and experience, what stops cultural populations from seeking help?

True: There are some that I think are generally true for everyone. Those are affordability, transportation, time. People who may need mental health (treatment) and do not have babysitting (help). People may not have the knowledge to get help or know how the mental health systems are organized. I think generally everyone have those. People in the inner city I have those. But I think from a cultural standpoint, I think most refugees and a particular more understanding of the broader mental health systems is a barrier. Again, like the other any other people, transportation, certainly language, certainly affordability, but I think a key distinction about the Hmong is that I think Hmong view wellness much more physiologically and spiritually. And the Hmong are not very psychologically minded. So I think it's a barrier for them to come to get help because health and wellness is defined more physiologically if they are experiencing a mental health condition. They often say they are not well, but they don't see themselves as sick either. And so that then prevented them from that perspective of who do I get help from and when do I get help from the other thing. I other thing that I think is that the Hmong have a lot of traditional remedies to help, so they tend to explore that and exhaust that before they turn to Western medicine treatment systems.

The other complication is I think that people always question about particular for psychotherapy, whether talking cure is really (helpful). Are we able to cure a sickness with talking? We are certainly not shaman. We are certainly not herbalists where we have tangible and are aware of a superpower. I often joke when people come to my office they see a 5x7 certificate from the board of Minnesota board of social work licensing. So I don't have these magical alters. So I certainly don't have significant magical power. Finally, I think in terms of therapy is that I think because culture and language differences. I think we often don't realize how much that the therapy process does not have the shared meaning by both the therapists and the clients. These are often things that we overlooked, but have significant power, in terms of the effectiveness treatment and longevity of people's commitment to stay in treatment. So I think there are a number of issues that can be potential barriers to people like the Hmong to come and get mental health services.

Mai Yee: So you share about your professional background, but I would like to hear more about your personal background, like your experience. What led or inspired you to also become a therapist?

True: Well I came to America when I was eleven. I'm the baby of 8 siblings. Growing up I help a lot in terms of translating for my folks. I remember as probably a sixth grader, I used to take the bus and take Dad to work and translate for Dad with the supervisor and then come and go back to school. So I think the feel of how people have been, I think that draws me into that. And so when I was in Rhode Island, actually the family resettled in Rhode Island Providence on the east coast. As I said my first exposure to mental health there was a program that was established by the state to provide mental health services for the South East Asian refugees that was led by a psychiatric nurses. So because I speak a little bit Laos, they hired me to work as the bilingual metal worker for the Laotian community and Hmong and there was a Cambodian worker. That really exposed me to the mental health and I was really intrigued by reading some of the evaluations. I wanted to know more and so that got me into it. I was actually enrolled as engineer. I got accepted to engineering school, but I did not go to engineering school. I went I was kind of floundering on the sociology and liberal arts stuff and I got my hand into mental health, and I found that fascinating about the mind and body, and that's what drove me into mental health.

Mai Yee: Do you feel like it connected to you personally, because you also see mental health going on with your home life or your personal life?

True: We don't have anyone in the family that have mental illness. There was a brother in law, who's is a brother in law of my, my older, brother, who's also a social worker. He had schizophrenia early on in his life and he came to Rhode Island. But, you know, without the training, we don't have much understanding about what's really going on. When I think my first real exposure to mental health was when I work in the program that I was hired as a bilingual worker and began to visit people in hospitals and was consulted by people, more so on the cultural sign vs the clinical side. That got me really intrigued about mental health and the human body and mind.

Mai Yee: How does your cultural and racial identify infuse with your clinical work with your clients?

True: When I read that question I think there are two parts to that. I think the cultural and racial side allowed me a context to understand when people come and present a situation. I will be talking about few scenario here. Then I think the clinical side allowed me to see the signs and develop the skills to be effective in helping them. So I think my role as a therapist has two sides: the arts and science. And I think the arts and sciences is the cultural and racial side that allows me to have a perspective that I think allows when you do therapy you have to have engagement. You have to have trust and rapport. And I think that allows me to have meaningful engagement with my clients with trust. They feel like I can relate to them. So I think for me the, the racial and culturally specific part are the arts/science where it allows me the cultural context to process the clinical content of wellness for the disorder.

So what I meant by that is it that allow me to, for example, I would go into the community and I can see that someone based on what they describe in, in my mind as a professionally trained, therapist that this person may be experiencing schizophrenia or depression or anxiety. But when my Hmong colleague or Hmong family member who is not trained they may think it's because the person is possessed or that person maybe (Hmong translation) which means loss of the soul. For me I have a template because of my training to kinda understand what's happening. And so then on the flip side I get a lot of consultation from mainstream therapists. To say for example, I got a call from a therapist, who said a woman who's have been relationship difficulty with her husband, she had been folding a straw figure and put it under her pillows. The therapist found that…the therapist was questioning whether she had some delusions or whether she was having some sort of hallucination. I said absolutely not. When Hmong people do that, then what they are doing is the straw figure is the protecting figure for her from dreams and all of those. And so, I think my cultural, racial side allows me a perspective and context, that a person who is not of the same ethnic background may not fully understand. They may pathologize that situation more than it needs to be.

I remember in my early early days as a bilingual worker we visit a family and this Dad sits with me and this nurse and we are going through the process and he's holding a baby. The baby has a bottle next to him and picks it up. He often picked the bottle up and sucked on the nipple. And she would point to me and say " Did you see that? You see that? That's really weird." I said "Why is that so weird for you?" I don't see that as anything that's weird at all. I mean that just we come. But no, right. I mean just like that. Just something they, they do without realizing that you're reading more into that than it is. So, so it allows me to see things that my fellow Hmong may not see because I have the training.

And I can see that it's much more complicated and sophisticated than they think it is. Or the minimizing. Or I can also see that there are things that people over pathologize that it is not. I just got a consultation a few weeks back. There's a Hmong women who was seeing a therapist and after her husband died for Hmong a women's social identity is attached to her husband. And so, when the husband died, the family talked to her in ways that she felt like they stopped loving her and she felt very much abandoned. And when I listened to story more, I said, hmm I'm not sure. I would ask because when your husband passed away, if their relatives, particularly the men, if they talk to you too much, it maybe perceived they have bad intentions. If they are respect you too much you may be feeling that you're abandoned. So I would get more deeper into that. So I think that when we do have a racial and ethnic background, I think there are some advantage to us to see certain perspectives. And so I think that for, for me, has been an important journey to try to help recruit, train and support people from different ethnicities because I think that, that's a perspective that you have to live in and you have to be a part of to fully appreciate some of that. Also be a negative factor for us to see too much. And we over read in certain way too. But I think that's what's the beauty of cultural diversity and racial diversity is to be able to see those perspective and not over pathologize, but also when people don't have the training they minimize it and so you can push it for more services.

So, so I have been involved with relative in town, when they are very delusional and are not going, and they will call me to the house. They want us to do magical things right away. And I said, no. This is not something we are going to solve with one meeting. This is something we need to get professionals involved, and we need to be patient. We need to support the family. And so I think the clinical side allow me to understand the science and the skill and the racial diversity. The cultural side allow me to see certain perspective that sometime people over pathologize and people minimize it.

Amy: In many communities, I think especially Asian, there is that disconnect where the older generations may not know the correct terms or understand mental health in the way that we do in today in modern days. I think that a lot of a lot of that has to do with historical trauma. So how do you think that historical trauma impacts your client's mental health?

True: You know, I don't I don't think I see historical trauma, in that perspective, though. I think for me universally in the last three year as I become more and more involved. I think universally symptoms are very universal. I have worked with Haitian. I have worked with Dominican, Puerto Rican, Hmong, Somali Cambodia, Karan. I think universally symptoms are the same. No matter where you are from. If you're depressed, you have all the symptoms that everybody has. If you have post traumatic stress people have the same thing. What is different culturally is that the manifestation of the disorder is defined very culturally. Instead in, in now, we call schizophrenia. Schizophrenia in the old day when we don't have (a word for) schizophrenia, wWe call it for the Hmong "you're possessed" or (Hmong translation). Right, so something came and you're possessed. And so the defining of the disorder has a very cultural base, but symptom wise, I think is universal. So I think we have to be careful how we use these term about historical trauma, or trauma, is that I think people experience the same in terms of symptoms. Then they define and receive support from the families is very different. If you look at mental health compared to physical health, mental health is severely impairs a person's function. But people if you have a broken leg or you have cancer, people do things for you. And when you're depressed, that you are severely impaired, people may not have the same sense of empathy because we're not visible

outside. And so, I don't think it's because of historic of trauma, but is because of language precision. For example, when Hmong moved to America there are a lot of vocabulary that Hmong don't have. We are not a scientific culture, where we have science. We live in the mountain, so when we look at computers, we don't have the soft part of the computer. The brain, the heart, where we don't have the language precision and you develop language based on what you need. And so there are certain words certain term that we do not have. So that, I think it takes time for those of us who, who educate them, we need to be able to take very complex concept and be able to make it in a way that people can understand. So when I do training and supervision with my students and my staff, one of the challenge, I always have is you learn very complex, very sophisticated words too. When you around your colleagues you look, so sophisticated, but the question is, can you explain that in such a way that your client can engage with yo and understand, for example, the word trauma. We talk so much about trauma, and trauma is so often overused, but a lot of clinician cannot explain trauma in a very simple term to their client. And so you have to find ways to explain.

So how do you explain trauma to the Karen or the Hmong who just come from the mountain? When we build house, we build alarm system. And when the alarm goes off, it tells us to be careful because something's not normal. Wen God built humans or our creator built humans we have fear. Fear is our alarm system. And when you're fearful your body goes off, and your heart starts pounding to get blood, to get ready to go. Then you are afraid because you don't have the medical training. And you think something is completely wrong with your body, that you're gonna die and that feeds into that. So if we can take very complicated and very complex concepts and make it where the client can take parts and find meaning in that process, then they will stay. I find that a lot of these young clinician who are brilliant in school cannot explain these concepts in ways that make sense to their client. And so they say the client are very resistant and don't take part. But really the issue is really is the clinician. And so it is important for us to make sure that what we do what we say we do. We know what we're talking about. Otherwise it's a process to get paid but they (the client) don't get anything out of that process. And so it's important to, to be clinically trained and to know what we say.

Mai Yee: What language words or phrases to your clients, use to describe their mental health condition and wellness? (21:00)

True: For the Hmong I live in the east coast for a very long time before I moved to Minnesota in 1995, so I have to learn how to do diagnostic assessment because mental status assessment as, as you know, have many complicated words from a language precision standpoint. We don't have those. If you look at Hmong, Hmong use the liver (Hmong translation) as a center to describe emotions, personality traits, and our actions. So for the Hmong when you say (Hmong translation) if the word (Hmong translation) is used before an adjective, then it describes a personality or action. If you say someone is (Hmong translation) then it means that person is very temperamental and very quick. But if you say (Hmong translation) if you use an adjective preceding the word (Hmong translation) then it describe emotions. And, and so the is important to understand because Hmong words are very limited. That's why psychological testing or psychometric testing is very difficult because when we do questionnaire to design the psychometric testing, we use multiple angles to measure validity and reliability. So they may ask you about depression and anxiety from a different angles using words in a very different and subtle way and they both come back to the same. But for moment, because we don't have those subtle changes in language, the subtlety of how we measure reliability and validity can easily be missed. Because for Hmong (Hmong translation) means a lot of things. And (Hmong translation) means a lot of

things. And (Hmong translation) means rotten liver. (Hmong translation) means you're kind of chaotic and kinda feeling out of control. (Hmong translation) means you're depressed and very worried. And (Hmong translation) means you can't. So this is important for Hmong or people who work with Hmong if you use the Hmong language is to understand the complexities of these words and what kind of connotation do they carry. When Hmong come to see me they normally don't talk so much about psychological terms. They come to talk more physiological. They come to wait and come when their physical functioning is so impaired they cannot work or go to school. The teacher say this person I am referring to you because he or she seems like they are not here. Only then when Hmong come and then when Hmong come and they say I went to see my doctor,my bloodwork is ok. Physiologically I am ok but I still don't feel well but I don't feel sick. You do your assessment you find out, lots of family problems, lots of financial problems, lots of parenting difficulty. There are lots of different issues. You say do you think this caused that? They say " no, no I don't think about that. " It's because they are not connecting their spiritual wellness and they are not connecting their psychological minded. It's something we then continue to do psychoeducation. So when I work with the Hmong client or new refugee, whether I talk about depression, anxiety, or trauma, I have a lot of pictures and a lot of illustrations and it takes time for me, for a long time to do that. And I will say to them when you go see the doctor, the doctor give you a pill. When you have a stomach ache and you take the pill, right? Yes. So we talk about what's happening when you have a trigger by something that reminds you of a very bad experience. Then you ask, "did you take my pill?" The pill I gave to you is to understand that yes, the brain is recording all of these memories and when something that might have triggered you were there, your brain is telling your body to activate and that's when you remember my pill. My pill is remember my face, no remember I am in America and I should breathe because I am not going to die. It's not real. It's just thinking and a memory. It's very painful but I am safe.

You have to distinguish being safe from painful for them. I say since you were scared this past week, how many times did you remember my face? If they remember my face almost everyday then I know they are transitioning from therapy to home. Something is happening. I asked them. I know if they have no clue what we talked about last week then I know that therapy was a hollow process for me. I go back and look at my note and this is what we did, then I know that he/she doesn't remember anything. Then I had to say, okay, what do I do differently? And so even a very basic step like this it takes a lot of time. And so because I know that if they cannot get something concrete to help them in a matter of time, they are not gonna come back to see me. And so I, I had to really make sure there that it is meaningful for them. It is not something that I get paid every time but they come back in for weeks. When they don't have anything then they don't wanna come back.

Mai Yee: So when your clients, they come seeking help from you, are they like aware that they're struggling mentally? And that's why they're seeking for your help or because you talked a lot about they talk aloud about their physiology.

True: When they do arrive at my place, normally, they have seen their medical doctor. They have seen their herbalist. They have seen their Sharman. They have seen their Reverend if they go to church. They have exhausted the traditional remedies before they normally get to me. And so they, you can look at, you know, one thing that we do for longtime when someone's extremely depressed they come to your office, it doesn't take the DSM V to see that they're depressed. You can see right away. They're very depressed. When someone's very scared and you talk to them out loud and do something. I had a client that I just started seeing last week and I was telling her about trauma, and I keep say this (bangs hands

on table) and I banged the table. And she said, can you stop that? And she starts to cry. Then, you know, they have PTSD. The simple fact, that we ask a lot of questions that they may not think of the question we asked they are confirming what they're experiencing inside. That is one of the reasons they come back because they know that there is something. It gives validation that we're professionally trained. We know something that people haven't asked them. That we ask them, when you have nightmare what happened? When you're depressed, what happened? What's happening to your thinking? What was happening to your body? And I think them it validates to them that this person knows something because they ask me and they will tell you, you asked me something that people never asked me. And so they know we know. With my American client you start out with a question: What bring you to see me, right? For my Hmong client it takes many session for them to answer the question: Why are you coming to see me. They'll say: Oh, I'm not well. What does that mean? So it takes a long time, maybe three or four sessions for them to say that's why I come and see you come because we do an assessment. We present to them, this is what I know about you. Is this true? And they're saying that's why I come to see you. They need you to help frame that for them. Where an American client will say: you say what bring you to see me? They're familiar with the process. So this is the process when I work with the Hmong, it takes time for me to redefine to them how to shape that question.

Amy Wang: And I think you briefly touched on this, but how do you think that mental health services can be improved for people of color. In particular, the Hmong community?

True I think it needs a lot of work. Ummm I think we need a lot of education. And this is where NAMI is wonderful. I've been partner with NAMI to do the Mental Health First Aid (training). I am a big user of NAMI's phamplet's because I think that we need constant education. As I was talking earlier, in the late 1990's to early 2000's there were a series of murder suicides in the community by couples and we were shocked. We were not sure what to do. So a group of us got together. We believe that we need more education because when you do workshops and townhall meeting, the people who always come are the people who already have some information. It is the one that who never comes. So, you know back then is only maybe about sixteen, seventeen years ago but, the technology back then now is completely different. So at the time, there's only one Hmong radio station. So we proposed to do three things. We went to the state and got a grant from the Health and Disparities grant and we launch a magazine and has some materials about depression, and suicide because the young people don't necessarily listen to the radio. And at that time you had to listen Hmong radio you had to buy a special radio. It's not like now where there's a million Internet radio. So they can do that now. And then we also launch a case consultation to train, the provider, if we're gonna go and do these outreach through the radio. If the Hmong people come we want the provider to be ready. So I along with another colleague had a case consultation for professional, and then we went around to different providers to talk to them to do more training to get them ready to do outreach. And it was very successful because we believe that if people have enough information to self-reflect, then they kinda have a gauge about where they are. So what we did we invite a lot of guests to come talk about what is depression. Where do you go get help? What is family therapy? What is couple's therapy? What is suicide? What about parenting? What about civil commitment? What does that mean. So we talk in Hmong, and I think it was very successful. I did that for a little bit. I will. I did not host that.I helped to manage and supervise two people who did that. And then maybe in turn, in 2010, I went to work for another agency and we got a grant and I ask for a portion of the grant to continue the radio show. So we continue to do education. And you know in 2016 and 2017, I heard from people from far away as North Carolina, sending them right now because if

they go to internet and the radio station archive, there are programs online, so people can relisten. We should have this program long time ago because there are small communities of us who live in North Carolina and (some) who live in very small communities in Alaska and Wisconsin. We don't have access to these things. And so one of the thing that, I believe that's important is to continue to provide education to the community so they can self reflect. So they have the knowledge to understand about what they're going through because people go who are not trained have a lot of symptoms but they cannot piece it together. And when we talk about this it allow them to kinda piece them together, and they can listen to that, and not feel shameful alone or vulnerable in the home. And the second fact is that we don't have access to the people who are in the factory. They each have a radio and listen to all day and all night. If we can get the information to them and so they can listen without feeling they're being identifiable or singled out, then they would feel safe to go and get help. That's one part.'

So I think we need to continue to make sure that we have affordable service for people. Those who we see people… we see two type of people come: the people who come. The people who come to get a lot of help or those who have public assistance and insurance.

Mai Yee: How have you seen your clients practice mental wellbeing after seeking mental health. Like what has been the most successful?

True: Well, I think there are some that you can see those who are very, very depressed or actively exhibiting trauma symptom. You tell them, they tell you, they say before when the storm come and hit, I see branch and I hear brance I hear a knock on my window. I see the flood and I go in hide in the blanket (over me). Now, I'm not so scared because you told me in America we have code, this building had code. So we are not going to fall. So I'm able to withstand that. And when my heart starts to pound, I remember your face. I do breathing. So I'm still scared, but it doesn't stay the whole day now. So they will tell you the increased their function. So you look at this is one of the hardest question for me as a therapist. How do you measure your outcome? Do we do what the medical model where we reduce symptom? Is it a symptom reduction? Or what about those (people) that successfully are able to understand how the mind and the body are able to self manage from those symptom, but they're not functioning. Well as you look at the ACES score? They're not really functioning, well. They still do nothing all day long or very impulsively do things.

Well we know people who are very highly traumatized and it's very hard for them to be focused and be able to do things. And so their life may not be scared. Before they mainly know how to manage the body a little bit more, but they're still not very functional. They're not able to go to work. They're not able to live a meaningful life. So you have to do a lot of different things. There are certain thing when you talk about growth is a little bit harder than we talked about it three month or four month where you intensely teach them to focus on the skill to manage so they don't feel it. They're gonna die. So I often say to then the goal is not, you'll never be scared. The goal is when the scare come you know what to do so you don't stay home all day. You know, so people do tell you. And you do see the changes. Those that you see for years, and you don't see that changes then I really question what's their motive for coming to therapy. So we do see some very dramatic changes. We do see that people are able to go back to work and live a more meaningful life, And they're able to. Some people are so scared of, of even using the oven because they've been (exposed to an) explosion, but they were to help their children cook and do things. So that's a functional improvement. Yeah. Some are very tangible and some they can tell you what's happening. And so they…they're able to demonstrate back to you. So.

Mai Yee: What is your personal definition of mental wellbeing?

True Thao: Why I think for me it is that they have a meaningful life. You know, they understand themselves. We all have limitation. Is for them to feel it. They have gained some way of changing and feel that they can function. You know, I can never be like you, you can be like me. So the standard is not for me to be like you. But standards for me to be able to do things that I feel I'm doing to the best of my ability. So mental wellbeing is a very complex, very personal definition.

Mai Yee: You as a professional working and hearing all these challenges from people, how do you maintain your mental wellbeing?

True Thao: Very hard. People say that they leave it at office, but I'm not sure how they do it. So. You know, I work very hard. Every Friday, I don't go home until ten thirty because this is my most crazy day. So I try to play sport. I try to do things to help me. I try to listen to music. I try to do a lot. But, you know, it's also hard to not be compassionate because these are… days are. You don't know them just their story you begin to understand their children and who they are. And so it is very hard to forget their story. So I think people might do differently for me. Sometime, you know, we have all kinds of goals to train and people to tell us all kinds of way to help ourselves. But for me, I try to go home and play music, so loud that may be my other part of the family may not have good mental wellbeing or I go and golf. I go do something for me. But, you know, we each carry something inside, even though we don't share because these are very sacred story that people trust you. They don't they tell people tell you. They don't tell their husband or wife. And they tell you that no one in their family has ever known. And so you keep a lot. You tell your client your brains recording all of these things. You have all these memories (you keep) too and so it's very hard.

Mai Yee: How often do therapists, psychologists or social workers also seek help?

True Thao: I know that a lot of people do, do seek help. Because remember, we are not just therapists. We are human before, we are therapists and we are not perfect. We have our own issues. So I do think that people, you wouldn't be surprised to see a good number of the helping professional also getting help so.

Mai Yee: Thank you very much

Amy Wang: Our last question, any final words that you'd like to add to the conversation about mental health and the future of mental health?

True Thao: Well I would say cross culture mental health, whether you talk about Hmong or any other ethnicity, cross culture mental health is hard. It's hard. It's tedious. Because we have to make sure that the process is meaningful to our client. We are very well trained, or we think we are. But if the training are not translating to something that's meaningful for them then we have many factors to, to face. You have to have two sessions and then you have to get a diagnosis in order to get paid. You have to have three sessions so you can get a treatment plan developed. So they if they come audit they think you have a focus. Then you have a person sitting in front of you with lots of pain, and they tell you lots of story, a lot of facts, but you have the piece to say what does this mean? What's the impact. What's the functional impairment right now? And what do I do in a way that is not a talking cure, but it is a meaningful process that's real. It's nice. But it's also real. Sometimes we do therapy that people are so nice, but it's not real. It's not helping at all. It's just so nice, but it's not effective. So you have to wear

many hats. Sometimes you have to make it harder. You challenge people. But sometimes you challenge people in a way that is really nice. When you take people to exposure of their trauma, and the before you have five minutes before they gotta go and you feel they're really active. You don't want them to go home that way. That way that you extend the time, and that means you extended your transportation waiting for that client and their interpreter. You push. So we have so many things to do, but cross, cultural mental health is very hard. It's very tedious. I think you have to be clinically well-trained. You have to be culturally well versed, and you have to be humble. You have the humility to say that I don't know what to say. But in the last five six years, I've been working alot with the new refugees, the Karen. I saw one recently saw a women from Iran. And so I'm trying to be as humble. Because my hat as a Hmong man is a hat I have all the time. And I have to often remember to say, what does this mean in your culture? What, what does this mean? And so I have to say oops, don't forget, your thinking like a Hmong person. And so it's hard. So, I think we have to be humble and have the humility to say that we don't know much; and join that process with our client and allow them to also educate us too. But I want to thank you for inviting me for this opportunity to talk.

Amy Wang and Mai Yee: Thank you so much for sharing.

Caroline Ludy: True, Amy, Mai. Thank you so much.

Outro – Brian: For additional resources related to this episode please check the podcast show notes and visit NAMI Minnesota online at namimn.org You've been listening to the Wellness in Color on the Mental Health in Minnesota podcast produced by NAMI Minnesota.