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Sandra Mattar: [00:00:00] You cannot possibly, you know, uh, work on evidence based practices, for example, for trauma or, um, major depression. If you don't address the context. And this is something that psychology has been missing for awhile. This is what in multicultural psychology. We've been trying to address to bring up with mainstream psychology, but, uh, it is hard to come.

Diana Hill: [00:00:25] You're listening to Dr. Sandra Mattar on Psychologists Off the Clock

We are four clinical psychologists here to bring you cutting edge and science-based ideas from psychology to help you flourish in your relationships work and health.

Debbie Sorensen: [00:00:46] I'm Dr. Debbie Sorensen, practicing in Mile high Denver, Colorado.

Diana Hill: [00:00:50] I'm Dr. Diana Hill practicing in seaside, Santa Barbara, California.

Yael Schonbrun: [00:00:54] From coast to coast. I'm Dr. Yael Schonbrun, a Boston-based clinical psychologist and assistant professor at Brown University.

Jill Stoddard: [00:00:59] And from sunny San Diego, I'm Dr. Jill Stoddard author of Be Mighty and The Big Book Of Act Metaphors.

Debbie Sorensen: [00:01:05] We hope you take what you learn here to build a rich and meaningful life.

Diana Hill: [00:01:09] Thank you for listening to Psychologists Off the Clock.

Debbie Sorensen: [00:01:14] We've talked a lot about sleep on the podcast and as mental health professionals, we know that having quality sleep is really important to mood and mental health. And that's why we are excited to pair up with Manta Sleep. They offer innovative sleep masks and other accessories to help you sleep better.

Diana Hill: [00:01:30] I am a dedicated sleep mask wearer, my sleep mask is a lifesaver. When my husband's up late reading or on these bright summer mornings, when I want to sleep in and not only does a sleep mask, provide me with the dark environment I need for a deeper sleep. I have become classically conditioned to it. Getting out. My sleep mask is a cue for bedtime and like Pavlov's dogs. As soon as I put that thing on my body remembers that it's time for bed.

Debbie Sorensen: [00:01:53] Well, I'm newer to sleep masks and I've never used one before until I tried this one. So I was really excited to try it out and see what the hype was all about. And the Manta mask is really light and comfortable. And before I tried it, I don't think I realized how much the light in my bedroom was waking me up in the morning. So now I feel a lot more refreshed when I wake up.

Diana Hill: [00:02:12] So here's what you can expect with Manta sleep masks. There are six different versions to choose from. They all offer a hundred percent blackout for a deeper sleep are infinitely adjustable for custom fit. They're soft breathable. Have zero pressure on your eyelids or eyelashes and are made with durable snack green materials. You can choose from the original sleep mask or a slim sleep mask with barely. There feel you can also go deluxe with a cool mask

to see their eyes and sinuses a warm mask with natural steam, a lavender robot Roma mask to target your set vents or weighted mask. So check them out @mantasleep.com. Join their social media at, @napwithManta and @Mantasleep and get 10% off by entering the coupon code OFFTHECLOCK.

We are also sponsored by Praxis Continuing Education, Praxis offers online and continuing education in ACT, CBT, Compassion Focused Therapy. Some of their on demand courses right now, our ACT Immersion with Steve Hayes, which you can. on your own timeline? Matthew Boone is offering, A CE workshop on ACT 1. And Louis Hayes is offering a workshop on the DNAV model, which is great to use if you're working with teens. And for those of you that are interested in some online courses, there's a great course coming up on Wednesday, July 22nd with Anthony.
on commit to act evolving a society that works for everyone. So check them out at Praxiscet.com. Or if you go through our website, which is offtheclockpsych.com we have a discount code there for their live online courses. for those of you that want to learn more about contextual behavioral science, the ACBS World Conference 2020 is online this year and the program is happening from July 16th. To July 19th, registration is available and we'll put a link to that in our show notes. And two of her podcasts, co-hosts Jill Stoddard and Debbie Sorensen. We'll be speaking on a panel on the imposter syndrome so check them out on saturday morning and we hope to see you there.

Today we have Dr. Sandra Mattar on the show. I'm really excited for you all to listen to her. She is an expert in immigrant and refugee mental health, and also a, a professor and teacher in how to, be ethnio culturally responsive in our approaches to psychological treatment. And she weaves in story, her personal examples as well as really what is the current and most cutting edge approach to providing culturally competent care.
Debbie Sorensen: [00:04:50] Yeah, that's a great episode. I learned a lot and I think she's doing amazing work,
Diana Hill: [00:04:54] Debbie and I wanted to expand on something important that she talks about and she weaves throughout the episode, which is the tendency of Western psychology to focus too much on the individual without focusing enough on the context, whether that's the context of the strengths and their culture and their community, or it's the context of oppression, racism. limited resources that we really often miss those important areas. In this episode, Dr. Mattar talks about how it's not enough to provide mental health treatment for trauma. If the ongoing traumatic context isn't addressed. For example, systemic racism and other forms of opression can turn into a blame, the victim mentality, or pull yourself up by your bootstraps, where the individual is expected to adapt to harmful situations.

Debbie Sorensen: [00:05:40] Yeah, I think in general, Western psychology really does focus on the individual issues and it's at the expense expense of neglecting bigger systemic issues that are really, really important. And that can just get overlooked, I think, in psychology and in therapy, because a lot of times we look

toward changing something about the individual, right. Helping them adapt or adjust or accept something. But sometimes that's just really barking up the wrong tree. And I think. We see this in so many different areas in psychology.
Diana Hill: [00:06:11] I think a lot about this in terms of my very favorite episode of all time was Debbie's interview with dr. Erin Andrews, who talks about disability rights and about. That the, the struggles that individuals have, or is often not the individual adjusting to the disability, as much as the stigma and lack of access that are really the problem. She really gives some eyeopening examples of that. And I looked a lot at my own life and my own ways in which I participate in not, um, Providing access to individuals with disability,
it's similar with sexual orientation and gender minorities, which were considered disorders in the DSM for a long time and of this caused, a lot of harm, uh, and ignored the stigma and hostility that people face that contributes so much to mental health concerns.
Debbie Sorensen: [00:07:03] Yeah. And, and I think that as women, we see this too all the time, right?
because we have sexist structures in place. And we have all these expectations with that without enough support. So for instance, women who are trying to have a successful career and they face things like workplace culture sexual harassment, lower pay, you know, sexism, limited opportunities, and really even just workplace culture, that's just oriented toward a more male perspective. It's these systemic barriers that are the real problem.
Diana Hill: [00:07:38] I think that it's, this is all complex, right. And part of what I'm trying to do is do more learning and listening and. I just feel like over the last couple of weeks, there's been just so much to download and shift in my perspective taking. And, um, that's why I think an episode like this with Sandra Mattar is so helpful because it gives views in different perspectives, um, that can really shape our work so that we can do a , a better job as mental health providers.
Debbie Sorensen: [00:08:14] Yeah. That's really important. I think another area that, that we see this a lot is when we talk about things like burnout and work stress, and a lot of the conversations are about like, Oh, you have to take better care of yourself and practice mindfulness and all these things, but people are working. Here in the United States in environments that can be really toxic. So where they're expected to work all the time, a lot of pressure, not enough support they're working maybe in isolation and on screens. And we're in workplaces where people do it, experience things like sexual harassment, you know, microaggression, racism, . And so often when we're looking at. These types of treatments for burnout, where we're really not addressing the underlying problem, which is more about worth workplace culture and systems within organizations

Diana Hill: [00:09:07] And I think that's why we need to ask more questions. We need to listen, listen more. we need to dig for strengths. look at cultural influences, and this bigger system when doing our clinical work.
Debbie Sorensen: [00:09:17] That's right. I think a lot of clinical tools that we're used to using from including some perfectly good ones that are helpful in a lot of

ways, but these evidence-based tools often just don't do a good job of this. Right? So even something that came from Eastern traditions, like mindfulness practices get kind of westernized and co-opted into this. Point of view, right? So I read this book. McMindfulness how mindfulness became the new capitalist spirituality by Ronald purser. And he writes about how a lot of the traditional elements of Buddhism that were really focused on helping people and changing systems and making the world a better place through. right. Actions have been kind of taken out of context and have become about the individual and about making people happier and this sort of self fulfillment, and it really gets lost. And he advocates that teachers of mindfulness need to get back to acknowledging that that personal stress is often caused by societal problems.

Diana Hill: [00:10:19] There's a wonderful book by Larry Yang. That talks just about that. He, , is a Buddhist teacher who wrote the book awakening together, the spiritual practice of inclusivity and community. He talks about his own experience, , in terms of racism and his own personal spiritual practice of really, um, looking more at community and, , systemic influences.

I think that in moving forward, this is the time for us to continue to listen and learn, and, um, really hope that you enjoy as much as we did this interview with Sandra Mattar.

Dr. Sandra Mattar is an assistant professor at Boston University School of Medicine, Department of Psychiatry. She is a founding member of the Division 56 Trauma Psychology of the American Psychological Association. And as a past chair of the Committee on Ethnic Minority Affairs at APA, she is currently a member of the APA Race and Ethnicity Guidelines Task Force.

And as a graduate of William James College and the Universidad CatÃ³lica AndrÃ©s Bello in Venezuela and has done field research around war trauma and in Lebanon. Dr Mattar's research interests are on the intersection of psychological trauma and culture, immigrants and refugee, mental health, mental health disparities, multicultural, and international psychology, cultural considerations, and disaster, mental health, culturally sensitive education and training and mindfulness and spirituality.

She is currently an associate editor of the Journal of Psychological Trauma. Dr. Mattar is bilingual in English and Spanish and speaks conversational Arabic and French. And she has a yoga teacher certification, which I'll be excited to talk to her about. So welcome. Thank you so much for coming on our show.

And it's such a relevant time to have your expertise to talk to us about immigrant and refugee mental health and mental health disparities. You'd really? Yeah. And you've really dedicated your career to this area. Can you talk about what the personal and professional relevance is for you?

Sandra Mattar: [00:12:25] Absolutely. Well, I am the daughter of immigrants in Venezuela. My parents are originally from Lebanon and so I was born in Venezuela and then became a, an immigrant here, myself in the U S and my kids were born here. So, uh, I've always been really interested in the psychology of immigrants and immigration.

And when I came here to the United States, I started working with refugees and immigrants. And, uh, I discovered that that was my field of interest. That that was what I was really interested in doing. And it was an area where I really wanted to

help, because I would say the, the experience of coming here thrusted me into becoming the other.
I was very privileged in Venezuela. I was seen as a white woman, a privileged woman, um, because in the scheme of things of race racial, uh, understanding, I was seen as a white woman being the daughter of Lebanese immigrants. And, uh, when I came here, I realized that I became the other with my accent and with, um, the.
The country that I came from Venezuela that, uh, so that put me in, into a social category that I had never experienced before becoming the other. And that, uh, that really created that, um, not only was painful, but, uh, it also was a great learning experience for me that has helped me throughout my career.
That just that sense of what it means to be the other. And, um, I believe it has helped me connect, empathize, be more compassionate with my patients and that also growing up, speaking several languages made me very interested in, uh, in different cultures, in, in, in cultures in general, and how to see the world from the other's perspective.
I think that every language is. Reading much effort. Um, when you speak a different language, it puts you, it makes you see the world in a different way. There are all these nuances that if I had only was like monolingual, I would have not noticed before. So that's how I was thrusted into this field. And it has again become it's my passion.
It's what I, uh, what, what I've center might work. And now at the. Uh, at the Boston center for refugee health and human rights, which is at the BU school of medicine and at Boston medical center, that's a, it's a sort of a culmination of my career because I work there with, uh, immigrants, immigrants, and refugees. And I also work with trauma. Which is the other interests, my other interests, um, many of the asylum seekers and the refugees that I work with, there are trauma survivors. They are survivors of torture. So this is a great place where I can bring my understanding of the psychology of immigration and exile, the psychology of exile.
And with. My knowledge of the psychology of trauma and my knowledge in multicultural issues and cultural anthropology, which has been my dissertation was, uh, around a very much a cultural topic. It was called the self revisited and multicultural perspective, and it was a critique of the notions of the individualistic notions of self that dominated the language of psychology.
The narrative in psychology. And, uh, it was sort of providing another option and sort of trying to, I guess my goal was to try to persuade people that it was important to use not only an individualistic approach, but also to incorporate a more collectivistic approach in their work.
Diana Hill: [00:16:05] I love how you highlight both the resiliency of the immigrant experience and all of the strengths and resiliency and positive outgrowths that you've personally experienced. And, um, as well as the challenges and , I'm. Wondering if we can talk about specifically some of the mental health challenges that show up both from immigrating to the United States and the process of immigration, but also the process that you talk about in terms of acculturation and feeling other and, and oppression, that happens
Sandra Mattar: [00:16:39] sure. Sure. I mean, I could speak about some of the

experiences I've had, but I know that I am a PR even, even if I am a Latina immigrant and I've been discriminated against and I've experienced that, I think I'm still a very privileged woman here in the U S because of the way I look because of my, uh, socioeconomic level, because of my, um, educational level. But I can tell you about my. Patients, I've been working with immigrant populations for 20 some years now. Um, not only at the Boston center for refugee health, but also in California. When I lived there, I worked at the center for new Americans and, uh, the experiences are. They are devastating in terms of what they go through.

They're very difficult. We, we talk about them having to assimilate into a new culture, but it's not only about learning that the social Moors of the new culture and knowing how to take a bus, how to go to the library, how to apply for social security. It's, it's so much more than that. It's it's the. For many of them it's for the first time they experienced racism and they don't know how to deal with that. Interestingly enough, uh, I have patients from Africa, the majority of the patients I see at Boston medical center are from Africa. And, uh, when I, uh, it is imperative that I talk to them about what's happening right now, because they all suffer from PTSD and they are black. And so I, I talk to them about. I asked them.

So what do you think of everything that's happening with the black lives movement and all those videos that have been, uh, we've been watching, uh, out there. And, um, they said interestingly enough, that they had never experienced racism. They, they are learning about it now because in their countries they experienced political discrimination, uh, political, um, uh, harassment, also tribal. They were D w w because they'd belong to one tribe or the other, that's how they experienced harassment and eventually got them in trouble. And that's why they applying for asylum here, but, uh, leading, uh, working with race and knowing what to, how to teach their children to deal with race. That's a very new thing for them.

So that's one thing. And another issue that they have to deal with is, uh, a sense of lack of control. Uh, and I'm talking mainly with, uh, the asylum seekers right now, things are very different, very difficult for asylum seekers in terms of, of the laws and on the, on the, um, Oh, laws that regulate to the asylum seeking process.

It's been very complicated. Um, but parents, it's very hard to raise your kids in another country. It's very hard in many cases to raise your kids without a community. And yes, many immigrants find communities here and yet they, they don't have the, the help of parents and grandparents and community in general that they had before.

So there's this sense of isolation. There's this sense of a lack of control. There is a sense of a misunderstanding that they are being misunderstood. There is a sense of going, uh, always uphill because they are not familiar with. The educational system here, they, they make mistakes. The problem with language skills, the difficulties with language skills, it's all an uphill battle for many.

And yet they also recognize the amazing amount of help they get here in the U S in certain areas at the refugee clinic, we provide all kinds of help. We provide legal help. We provide, um, food, um, We, they, they are able to, to obtain clothing and they're able to get medical care, dental care. So in this, in most of it,

because we're a public hospital is for free for many of them, even though they have, uh, insurance too.
Um, so yes, it is. It is not easy. The, the psychology of the immigrant is, um, and then the psychology of acculturation. We have to talk about it. It is. How do you acculturate and what kind of trajectory do you follow? Because we'll see that people follow different trajectories depending on where do they live.
Is it mainly a white neighborhood or a different Brown, mixed neighborhood? Is it, what kind of resources do they have when they arrive here? Who sort of sponsor them? Uh, which schools do they kids go to? What, what's the, did they leave their country where they forced to leave their country? Or was the, was it a choice that, just that in itself, Can change the whole psychology of acculturation and psychology of immigration, um, who was allowed to make decisions to come here, where they sponsor when they arrived here.
Were they by themselves when they arrived? Did they come with a family that all changes the trajectory of the mental health for these immigrants?
Diana Hill: [00:21:47] There was two Supreme court decisions that came out in June that shows sort of the. Uncertainty, , sort of the unpredictability of current administration and its impact, , and R and, uh, on immigrants and asylum seekers. And I'm wondering if we can speak about the mental health implications of that.
So the first, , Supreme court decision was. In blocking concurrent, administration's attempt to end DACA, which is deferred action for childhood arrivals, and it helps , protect undocumented immigrants who were brought to the U S before the age of 16. And I'm wondering how the impact of DACA. On undocumented children and young adults, as well as the potential reversal of that and that that sort of back and forth impacts that again, that sense of safety, not only for individuals that are recent to the us, but individuals that have been here living here for years and years and years going in schools in universities.
so I'd love to talk about, mental health implications of DACA, as well as the, then the Supreme court decision that came out. That blocked, um, asylum for, refugees .
Sandra Mattar: [00:23:01] Yes. And I, I, um, you know, I was so thrilled to hear about DACA and that it's a decision that they finally understood that these kids were born. Many of these kids were born here, or these kids came here very young and some of their parents are not with them. Some of them don't even. Speak, for example, I'm thinking of many of the Mexican or central Americans that have come here that are under the DACA program.
They don't speak Spanish at all. They were, they grew up here and this is, this has been their country and this is where they went to school. And, and so going back and not, not having anyone, if they go back. Uh, I mean, can you imagine how devastating it is and how isolating and scary it is for a 13, a even eight year old, nine year old to think that they would be sent back and they don't have anyone there to be with them, or they cannot move with their parents or they don't have any options.
So it's other helplessness. Um, to be going back and forth in terms of the government's decisions about their program. I'm sure that right now they are, they feel temporarily safe, but if you're thinking about trauma and many of these

kids live, uh, in, in dramatic circumstances or have had, uh, Families with traumatic histories, they've experienced themselves, uh, histories of trauma, but they also experience a major depression and, and this back and forth of the government.
I can see very clearly how it has produced many cases of major depression, anxiety disorder, uh, inability to sleep nightmares. I mean, it is, they don't feel rooted at all. And I think that, um, if you think about mental health, Feeling rooted in one community is what gives mental health. It's a, it's a major promoter of mental health and they don't have that.
They have now that temporarily, but it is, uh, they know that tomorrow, next week the government can come up with another regulation and all the law that will sabotage what, uh, the court, even though it's the Supreme court, uh, there, there are so many ways to sabotage this process and this population.
Diana Hill: [00:25:11] And that the, um, oftentimes trauma treatment is done as something that happened in the past. When, when, when a client comes in, who has a sexual trauma or it's okay. We can work on work through your trauma when the trauma is ongoing. I'm just so curious how, how you work with that with
Sandra Mattar: [00:25:30] And thank you for bringing that up because we are, we tend as psychologists to be sort of, uh, isolated sometimes from the context, you know, we're looking at symptoms, we focus on the symptoms and we want to make sure that we're helping them with the symptoms that they are showing in our therapy rooms.
And sometimes we, we work sort of in a vacuum and this is something I teach. I also teach courses in multicultural, psychology, trauma, psychology, and social justice. And, um, I try to help my students understand that whatever is happening out there, it's important to bring it up in the therapy room. And how can you treat a DACA person?
So for example, uh, treat their, their symptoms of PTSD or major depression and not talk about the fear and the uncertainty not talk about the implication of the law and the, and the decisions in their lives. This is in terms of, if you were to have sort of a Maslow hierarchy, that would be first on the list.
So talk about You cannot possibly, you know, uh, work on evidence based practices, for example, for trauma or, um, major depression. If you don't address the context. And this is something that psychology has been missing for awhile. This is what in multicultural psychology. We've been trying to address to bring up with mainstream psychology, but, uh, it is hard to come.
It is, there is a reluctance because there is, um, The idea that the psychologist is there to treat the individual, but not to treat the context. That's how we are trained in clinical psychology. In general, there are programs, obviously counseling psychology is a field that has paid a lot of attention to the context.
Um, But it's important that, so it's important that we address the context in terms of where you just mentioned. Yes. Recently I just found out about the what's going to happen to the asylum seekers when they come to me. Most of my, uh, asylum seekers. They asked me what are what's gonna happen to me? Uh, what's gonna happen to my life.
Doctor is my life ever going to be the same. And when I started working with them, I would say, you know, you will never forget what happened to you. But,

um, there is a way that you become the author of your own story. Once you CA you are here in the U S there is, uh, like Judy Herman says in trauma and recovery, you can, you can gain a sense of agency of your own memories and your own stories.
You won't forget them. But you can be in control somehow. And that's what we do at the clinic. We provide, um, all kinds of services so that they can feel that sense of control, but then what I, what am I going to tell them? I'm next week when I go back and tell them that the, the option for hope is closing down, uh, it is hard to work that way before I was able to tell them the, you know, the, the, the.
We write affidavits for our patients all the time clinical affidavits. So we, we, I just finished writing one for someone who went through, um, work, um, forced labor here in Massachusetts, and he's seeking asylum with his family. But now that the criteria to grant asylum is becoming, uh, it's it's. Basically, it's getting smaller and smaller and smaller in terms of the, of the options that we can use.
Right. And, uh,
Diana Hill: [00:29:03] But window of
Sandra Mattar: [00:29:04] the window. Exactly. So, what do you tell them? It's, it's hard for me and I have to be honest with them. So I started, uh, recently a few months ago. I started telling them that, well, you're right. I mean, it's not, it's not easy. We're going to try to do our best to help you and support you.
Your immigration law attorney will try to do the, his best or her best to, to help you. Um, but, but the options are becoming very limited. And, and now even more so, so it is hard. It's hard to offer hope, which is the main culprit to recovery from major depression and PTSD is once you offer offer that they, um, they have a different outlook, it's sort of a cognitive riff, any emotional reframing of, of their lives when you give them hope.
And they want to hear someone, someone in a role of authority to give them hope. And I don't know if I can do that anymore.
I'll try. I'll try.
Diana Hill: [00:30:07] How, how do you hold that as, as a therapist, you, you know, go home and spend time with your family. And I think one of the things that keeps psychologists from learning and growing , uh, is willingness to enter the discomfort
Sandra Mattar: [00:30:25] absolutely.
Diana Hill: [00:30:27] and you're doing it on a day to day basis.
How do you manage that for yourself?
Sandra Mattar: [00:30:31] You know, interestingly enough, my spiritual practice, I became a, just a short story. I used to be a Catholic. Uh, I grew up Catholic and I, at some point even started as thought of becoming a nun. So that's how Catholic I
Diana Hill: [00:30:47] Oh, wow. Yeah.
Sandra Mattar: [00:30:49] And then, uh, fast forward, 28 years later. And I, um, through a big life crisis, uh, I became, uh, I decided to start doing yoga and yoga led me to more of a spiritual path, which I've always been interested in.
Obviously a spiritual path path has always been interesting. So I'm exploring more ideas of, um, Buddhist psychology and the idea of compassion. And has been very helpful to me. And I think this is a term that I know it was, I started, it

was brought up, um, initially by some of the Buddhist psychologists in the seventies, like Ron baths and others.
But, uh, now with the ideas around mindfulness, It's sort of people are talking more about, about open up your heart, being self compassionate, being compassionate with others. And, uh, and that's, uh, as Buddhist psychology teaches you, it's, it's limitless. There's no limit to how much compassion you can give.
Even though we have a term called compassion, fatigue and trauma psychology, right. And disaster psychology. Um, Yes, you can, you can get compassion, fatigue, but at the same time, my own practice of yoga, mindfulness meditation has helped me a lot to open up my comfort zone and, uh, expanded and just sit down with the pain and the suffering and not become, uh, way down by it.
It's become positive and always hopeful. And I think I brought that in, in my, in the therapy room.
Diana Hill: [00:32:22] I also wonder about how taking values based action on such a daily basis may also contribute to the feeling that you're doing something. And part of compassion is, is both feeling and feeling and experiencing the discomfort and then taking action too. Make change and alleviate suffering, and you're doing both.
And, uh, it's, it's really incredible, uh, that, that you're, you're in the trenches and you're, you're, you're doing a podcast interview and not like crying, you know, the whole, whole time.
Sandra Mattar: [00:32:56] It teaches you to be, uh, to reside in equanimity. Really? Uh, yes. I had my training, my psychology training to become, to be empathic and to try to keep, um, boundaries, but I, I I've read the fine the way of, uh, um, The idea of keeping boundaries is I just simply open up my heart. Um, and this is the language that I had never used before.
And trust me, I, if you had asked, if you had told me four years ago that I would be doing yoga and taking a spiritual path today, I would have told you that you're crazy that I'm a scientist, that I'm a psychologist, and that does not belong in the world of psychology. And here I am, it's enriched, reached my, enrich my practice and become a much better practitioner by including this.
And I am very, very clear and strong about it. I, I, it's very clear that he has enriched and improved the quality of the work, uh, with my trauma patients. Absolutely.
Diana Hill: [00:33:54] another current experience. For immigrant and refugee population has COVID and I, and you're working in a hospital
Sandra Mattar: [00:34:04] Yes,
Diana Hill: [00:34:04] setting here, and I'm wondering what you're seeing in terms of COVID impacting a refugee population and immigrant population. And then also how it's changed your practices as a mental health provider.
How are you, how are you doing this?
Sandra Mattar: [00:34:16] did a seminar, a webinar with APA on that very topic last week. So, so, uh, yes, the minute we found out about the. The COVID, uh, the implications that COVID brought with it, we immediately turned us, uh, started offering the option of tele-health. So then we were asked all the clinicians were asked to go home and work from home.

Hopefully we have all the technology to access the records through Epic and the hospital records. And we were able, and then through, um, programs like, um, apps, like Doximity. That are encoded in and protect privacy and confidentiality. We were able to do therapy. And so I've been, I've been doing therapy from home telehealth, both a phone and video through Doximity, uh, since March. And we will, we are not going to the hospital, hopefully. Um, uh, let's see, I believe until the end of July yesterday, they announced that we might go back at the end of July. So, uh, it's been very interesting because we've realized that we can reach out more people in a more effective way. If you think about it, my patients use to pay around.
They live, uh, in outside of the box. Scenario. So it takes, it's very, uh, it takes them a while to get to our, to the hospital. They would spend between 25 and $30 to between buses and trains and to get to the hospital. And now we just call them and they are there. And so we've been able the rate of no shows for all the clinicians has dropped significantly.
So the show in right, was we used to be on average for 60% for all the clinicians. And now it's 90 to 95%,
Diana Hill: [00:36:05] It really highlights that contextual barrier,
Sandra Mattar: [00:36:07] absolutely. Absolutely
Diana Hill: [00:36:10] Yeah. To
Sandra Mattar: [00:36:10] not only that. Um, absolutely. And, uh, and so it's sort of a discovery. Wow. We can, we can reach more patients. We can be more effective by doing this. And this has completely shifted the way we think about how to provide therapy.
Another, another issue that we've encountered that's wonderful is that we're able to talk to the patient's family. I was trying to also as a family therapist, so one of my, uh, uh, internships were at a family therapy Institute and, uh, To me, it's very natural. So I come from a kimono communalistic culture and it's very natural to do family therapy.
And it's not that I'm doing family therapy, but yet, but I am able to meet the family. I'm able to speak with some of them, I'm able to even encourage some of them to seek therapy because they're struggling. And so just, um, it's been wonderful. It makes all the difference in terms of the quality of the work and for the patient. There's a high level. They report back a high level of satisfaction that we're able to talk to their kids, to their partners. Uh, yes. So
Diana Hill: [00:37:20] Or even just a window into people's homes. And then I've been finding it so valuable for people to pull off things from their bedroom and show me objects and meet their paths and look outside what they have outside their window. And it's just, it's like this whole world that you don't see, or you don't enter into as a therapist that now we're being exposed to

about the human yeah.
About. Like you said, like talk about the whole concept context in which the individual is, which is really starts in the home and what are their living conditions
Sandra Mattar: [00:37:49] It is, it is, it is wonderful. And it's also a reminder to me of, of my own privilege when I have patients talking in the bathroom, you know, because there's only one bedroom in the house and only one bathroom and they

have to, they're six people living in the house and they have to go in the bathroom
Diana Hill: [00:38:05] Yeah. Or the car conversation
Sandra Mattar: [00:38:07] the car or, um, or that they, the connection is really bad or that they don't pick up the phone because, um, for two weeks in a row, because then I find out that they didn't have enough money to pay for the phone plan, all these things that, you know, they just come to your office. And you never think about those things, uh, or you might do think about it sometimes, but it's not in your face.
Right. And that's also a reality also what COVID has shown. Um, many of our patients are home health aid. And so they have been working since the pandemic started and they have been in, in ground zero basically. And so it's been with, we've had to deal with a fear of contracting the virus, which has been a fear for all of us.
Right. But in their case, it's even more because they, it triggers. It triggers symptoms of PTSD. It's also how they make their livelihood. They have to work with people that either have COVID or, uh, most of them work in nursing homes. So it's been a very big issue for our population. And, uh, they, if, if they con contract the virus, they, they, they lose their jobs there.
So it's, it's been a source of, of a big source of stress for them and triggers of PTSD, anxiety disorders, panic attacks, major depression, uh, even dissociation for patients that are, that had already sort of gotten a handle on it. They go back, they revert to PTSD to having showing PTSD symptoms and other.
Sometimes.
Diana Hill: [00:39:43] Yeah, I think what, um, what you're really highlighting. And I I'm reading, we had just talked about reading this, this book called the undocumented Americans by Carla ho via the Senseo. And she writes about in the book, how. The second responders are often undocumented people. So after nine 11, when all the first responders came in, it was all the second responders that came in and did a lot of the cleanup and the physical health impact of that and the mental health impact of that.
And then the lack of services. For the individuals that are doing the really important work of keeping us safe, keeping everyone safe. And I think that showing up at the time of Colbert. So yes, there's all the doctors and nurses, and there's also the people that are cleaning the offices and the spaces and that are exposed in Tacoma at high rates.
And may also not have the healthcare, um, and resources and
Sandra Mattar: [00:40:44] Absolutely. Yeah. I, you know, I just started teaching a class called social justice, psychological trauma and social justice. And I was just mentioning that to my students last week about. I mean, if you imagine what these workers have to see and smell, and on September 11, when they were on, on ground zero, when they were there, I was more, a little bit more specific with my students.
I'm not going to do that here, but I am. I'm very familiar with what they had to experience and imagine the trauma and not being able to get help for that. I just, uh, it is, it is a human rights issue. Actually. It becomes a human rights issue. If you think about it, How can we put them in that situation and then not offer help

to them.
And then here you have the same thing. You have Mo many, most of our patients have a herd, but multiple loan losses in their building. In their neighborhoods in their community. And so there's this grieving process. So they're not only activated and being triggered by the memories from being back home when they had to hide.
For example, social isolation has brought up ID, uh, memories of having to hide in order to avoid being caught by the government or being imprisoned by the government. Also the Ebola virus. They also, many of our patients went through that that were so many people died back in Africa. Um, and that this is also a reminder to them.
It's a painful reminder of what could happen and how many losses can be. And, and so, yeah. And so your team, you're trying to work with trauma with PTSD symptoms or anxiety disorders, or major depression with them. And then they also have this very sort of traumatic grief process that they have to go through compounded grief.
Um, I have a patient from Iraq who, a woman who has lost already five relatives, not only here in the U S but also back in Iraq. And she already was. A very symptomatic in terms of PTSD symptoms. So imagine trying to contain that, and now all this pain that she's having, that she's going through and then having to do that over the phone, I've tried to convince her to come to the hospital and I would meet her there because that's what we're doing with the more complicated cases.
And she refuses to come to the hospital because of fear of contracting the virus. So it's a, it's a very difficult situation as a therapist. I'm, um, sort of my hands I'm trying to feel trapped. I mean, my, I told my hands are tied because I cannot help her enough. So I'm resorted to calling her regularly just to check on her, to work with her son who lives with her, who also have probably he's not my patient, but probably has symptoms of PTSD from what I gathered.
And, um, And he is having such a hard time. He feels so isolated, but in, in talking to me, sort of on a side, sort of a side therapy, I've been able to help, uh, help her because I sort of coached him to try to support her. And it's been, it's been quite difficult, quite difficult doing trauma therapy over the phone.
It's quite a challenge. Many of our patients don't have the video capability.
Diana Hill: [00:44:09] Yeah, well, you're doing trauma therapy over the phone, but you're also doing this culturally centric trauma, which is like, I've got it. I mean, gone getting the son involved, , I'm not just, talking with this one individual and individualistic. Perspective, but it's really a different type of trauma therapy that may be what a lot of therapists are trained in and the more individualistic trauma therapy model.
And I'm wondering if you could describe, or kind of break that down in terms of what it looks like for you in your, in your therapy office?
Sandra Mattar: [00:44:44] Yeah, well, you know, the issue of religion, for example, I have, um, through my training, I was rarely trained in how to use religion and spirituality. Um, and for our patients, either they, whether they are from Africa or from central America, which is also the majority of the second half of my caseload.

Religion and spirituality is such an important issue for them. It's such an important coping mechanism for them. And so I was trying to leave it outside of the therapy room, right. Because we don't want to get into political issues into values into, well, I guess what it's become the most important resource.
I have to work with them in terms of coping mechanisms. So they tell me about, they even play their gospel music to me in the session, because that's what they are using when they're being triggered, where they are, when they are hyperventilating, when they are being, uh, when they're feeling anxious. What do they do?
They don't go to the calm app that we now use. They go to the gospel music, they play a video either of their pastor, uh, some sort of speech, um, gospel talk, or they listen to their music and we spend a lot of time talking about that. And so that's something I really, I knew it was important, but I didn't fully do many, many years ago.
I didn't fully do. And now I do it more, uh, more frequently. Um, I, there are also things that I do that you would say, well, that, that could be a caseworker that would do that. Why would you spend your time doing that? Um, and for example, I go in, um, sit in front of the computer with them when they're in my office and I teach them how to access, um, Um, the, the train, how to, how to take the train. I teach them how to, how to get a library card, because I know these are things that are, that drastically change the quality of life in their lives. If you think about it, many, many patients that don't have a job permit in the U S what do they do? They have PTSD. They are survivors of torture. What do they do?
They sit there in their homes. Uh, not, not their own homes, but, uh, sponsors people that have sponsored them and have taken them under their wing and helping them. They sit in their bedroom all day long with the windows closed because they don't want to be triggered. They're afraid of people. They don't speak the language.
Uh, and w by the way, we have a lot of interpreters. We use a lot of interprets, although. Many of the African asylum seekers speak English. Let me just clarify that. But so they are afraid. They don't know the system. They don't understand. They have never been outside of their village, outside of the communities in Africa.
Many of them, others are on the other. On the other side of the spectrum, I have a judge who was in the high court, in his country. And he's now applying for Dunkin donuts. Um, and among other things, I'm helping him right now. And yeah, it's, this is how life changes when you, when you move to another country and you're seeking asylum,
the things that I do. Yes. So getting a library card, I've been here, I've been able to help them get a library card and guess what they are able to get out of their rooms. They walk to the library. If they are able to do that, or even they take, they can take a bus w a I help them finding this, and this is not what I was trained.
I didn't, I was not trained this way. And yet I realized that this would be much more helpful for them to treat their trauma is to get them out of their room, to, to go to the library, sit there, pick a book that they like. And so have them. Engage interact, reach out that is trauma treatment. That's what you do, right?
You want to, you want to treat avoidance symptoms of the clusters of PTSD. You,

this is a perfect way of treating trauma. So this is a good example that I'm giving you as to how you have to think culturally contextually, and then whose needs are you working on? Are there the needs that your own needs? And the way you were trained or are the actual patient's needs.
And that's something that we constantly have to revisit. Is it my need and my way to, I need to just offer the offer this treatment because I, when I know that this is evidence based and I know this is gonna work for them, or can I eat, can I, uh, Make variations of this treatment. How do I make variations of very evidence based practice?
And I'm working with the postdocs to now ask her who is, uh, his wishes is on, um, Cultural, uh, accommodations of AOL cultural variations of evidence based practices. And I think it's wonderful that he's working on that. There's a camp that says, well, you know, you're still using a method that was developed mainly with using white populations was validated and white population.
So are we perpetuating sort of colonial thinking here and why do we have to adapt that treatment culturally? Why don't we, uh, change it completely? And then there's the other camp that says, well, who gets the grants? And, and, uh, um, these treatments have been validated. There's no research money that the same amount of research money to do the cultural work that that some researchers want to do.
I don't think that NMH and IHR still there in terms of expanding their, their understanding of what we search needs to be funded. And this is, I hope that this movement that's happening today in the U S becomes a window of opportunity for some of these organizations to revisit. Uh, what is it that, what, what kind of research they consider valuable and why?
Because there's a huge health disk. There, there are all these health disparities out there and people don't think these, uh, fun, uh, uh, people that ran these funds don't think that these are, uh, the health disparities could be connected with the idea related to the idea that some of this research might not be relevant to these populations.
So let's think more about that.
Diana Hill: [00:51:03] And thinking more about also the number of individuals in the United States that are immigrants. And I think for me, it was really helpful to just look at some of the statistics in terms of over 40 million of us residents are foreign born of these 18 million are naturalized citizens, 11 million are authorized non-citizens and 11 million are undocumented.
Sandra Mattar: [00:51:27] Okay. Thank
Diana Hill: [00:51:27] are millions, millions of Americans.
Sandra Mattar: [00:51:32] And we also forget that, that, uh, the people, the pilgrims were immigrants too. We don't wanna, we don't want to see that way, but they were immigrants too. Yeah. Yes. Yeah. And so, so we are a nation of immigrants. Yes. Some, some came later, some came earlier, some came later, but we, and it's hard for some people to wrap their heads around that the fact that we are a nation of immigrants and also that we have inflicted a lot of pain in people.
And that, that is something that is very much present in the social agenda and sociopolitical agenda right now. But yes, we as a country has, uh, we have

inflicted a lot of pain and that, yeah. Well, I started talking about this and this might take me into outside of your question, but,
Diana Hill: [00:52:19] . I actually think it's important to go into that. If you want to talk about the pain inflicted, I think it's important.
Sandra Mattar: [00:52:24] Absolutely. I, you know, I, I think I used to tell my students, even before I taught trauma and having more of an observer, I'm not outside perspective, being an immigrant here that the United States will not fully become the, the country that it is. It has to, that it can be until we deal with the legacy of slavery.
And now it's. It's out there. I mean, you have all the, all black people and African-Americans trying to show the world that this, uh, the way that, that, that slavery is still perpetuated today, that systemic racism perpetuates the, the, the practice of slavery. And it might look different today. But it's, uh, the dynamic is the same. Their lives are still, they still have their health disparities. And look at, uh, who, who are the communities that have died in bigger numbers from COVID African Americans has to have, uh, Americans have died at a rate of three and four and five times more than whites, also Latinos. And that is a good example of being invisible, how they are being invisible in society. The S the wages that, uh, African Americans, in terms of, of salaries that they, uh, yearly salaries that they make compared to the average white population, that this parody is huge. And, uh, and that's how slavery still keeps showing up today.
Diana Hill: [00:54:01] the imprisonment and
Sandra Mattar: [00:54:03] And the imprisonment the yes, yes. Uh, absolutely. And who's on death road and that we can not talk about the level, the rates of imprisonment, of African American men, especially men.
We can't talk, we can't stop talking about that. It's important to bring all that up. And how about the conditions of public schools in, in, in black neighborhoods? We can't, we have to talk about that. Why are we treating them as second level citizens? Why does that still continue? So now that I'm teaching this, um, that just started again, teaching the social justice and psychological trauma class, I'm trying to.
Help students see the connection between taking down the comfort Confederate monuments and recovering from trauma. Right? That's not written in many trauma book, but it is, you know, um, Ken doctor candy, Abraham candy, who was just hired by Boston university, my university, uh, to, to lead an Institute of the study of race and ethnicity.
Um, he mentioned, uh, in a conversation in, on a college wide conversation or university wide conversation we had yesterday, he said something like the final act of violence is the denial of violence. So when you treat about trauma, when you think about trauma and violence, and Judy Herman said that in her book, trauma and recovery, she said that the.
The survivor of trauma needs to have witnesses to their trauma. It's important to have a witness and someone that will validate what you went through. Otherwise, it's, it's very difficult to process the trauma because you don't have the social support and someone outside of you to validate what you went through.
Diana Hill: [00:55:58] The denial of trauma is part of the trauma and
Sandra Mattar: [00:56:01] Absolutely.

Diana Hill: [00:56:03] the trauma and prevents. Yeah.
Sandra Mattar: [00:56:04] Absolutely perpetuates. Yes. And so what does that mean? That they are taking those Confederate people say, well, they cannot erase history. Well, you know, I was trying to think, what would it, how can I explain to my white friends and colleagues? What does that mean? Oh, my white students. What does it mean to take down a comp and why would they do that? And then I thought, okay, let's say that we would put out a Harvey Weinstein statue up there. Well, yeah, about walking by it every day. When you go to work. Okay. How would you feel about you would, you would probably have a faith, you would image the man, an immediate removal of the Harvey Weinstein statue from your neighborhood.
You would do all kinds of things. Well, those statues, that's what it means for them in terms of the trauma you, and some people might say, well, this happened so many years ago. No. If you know about intergenerational transmission of trauma, Rachel Yehuda has wonderful research on the, how even, uh, your genes change after being exposed to intergenerational transmission of trauma. I mean, uh, after, uh, grandparents great grandparents, they can transmit those, those, uh, changes. Um, so. It is, it is, uh, it's in the body. Uh, I, you know, the truth is that yes, it's true that the body keeps the score, that, that trauma stays in the body. And, uh, until you not only work in the body, but also talk about it, both, uh, and, and society talks about it.
We are not gonna recover from this. Um,
Diana Hill: [00:57:48] Yeah.
Sandra Mattar: [00:57:49] Um, problem with slavery. I, problem is a very kind word. We are not going to recover from that as a country. And I think that that it's, uh, it's long do to talk about it. We'll talk about it and process it. Yes,
Diana Hill: [00:58:05] Thank you. Thank you for speaking to that. you've mentioned some hope, some little threads of hope throughout our conversation today. Hope in terms of changing of our trauma treatment, changing our approach and, and just the, the change. That's so positive change that's happening in our country right now.
And I'm, I'm curious for you personally, where, what is your hope for. For the future.
Sandra Mattar: [00:58:31] Yes. I, you know, I am seeing this as a, as a window of opportunity for, uh, as I said for our country to move forward, it is a window of opportunity because, uh, we have a legacy of amnesia in, in, in terms of the U S history. We talk about things and we forget for many years that we go back to the last time we really, we were talking this way I understand was in the, uh, during the civil rights movement, even though I wasn't, I was not here.
. So, so that we're having again, those conversations, but now we're having it at another level because thankfully we have, um, people of color now in, in, in positions, uh, quote, unquote of power, where they can, uh, share that message even, uh, to a wider audience.
We also have videos that we can capture what many people denied so many times. And it's right there in front of our faces. I mean, we are seeing that and, and in a way it's very traumatic to watch those videos, but I am happy that we have that medium because otherwise many of us would have not believed.

We would have not believe all these, all these, uh, accounts of, of, uh, abuse and, and lynching, but, uh, I am, uh, hopeful. So I'm hopeful. I'm hopeful that we'll, we'll keep the conversation, but it's not only the conversation. I'm hopeful that we are going to start making actual structural changes, systemic changes. And I've seen that I've seen in removing of the statutes and changing the symbols of the flags in the funding, police in naming more faculty of color, to higher up positions. But we still have a long way to go this morning. I read an article about the, how many editors of color, as you know, I'm associate editor of the journal, psychological trauma, which is an APA journal.
The, how many editors, white editors are as compared to editors of color and the percentages remained sort of 90% of white editors. And what does that mean? I mean, we need to share the resources. We need to, uh, start changing the narrative. Of how things are, and in the field of psychological psychology in general, we can't change the narrative until we have people in those positions that will be able to speak to those narratives.
And so right now there is mainly one narrative dominating. Let's engage and bring more people into positions of power, more people of color into positions of power, so that we can all have all these different narratives and be more inclusive to those. That is extremely important and I'm hopeful that that's going to start happening more and more,
Diana Hill: [01:01:10] Thank you. Thank you, dr. Matara. I feel like an hour with you, uh, has been such a rich experience and that has really impacted my own thoughts of, you know, just moving forward as a psychologist. And I am so grateful that you're doing this work in academia and also in the, um, feet on the ground work that you're doing and appreciate.
You so much for your offerings? I,
Sandra Mattar: [01:01:38] so much. Yeah, go ahead.
Diana Hill: [01:01:42] we will link to some of the, some of the resources that you have. Some of the books you've mentioned other resources. Um, I'd love to link to some resources for mental health resources, in the show notes of this podcast and, um, as well as, uh, you as an individual.
So thank you.
Sandra Mattar: [01:02:00] Thank you so much for giving me a platform platform to speak. Uh, yes. And to talk about all these issues. I'm very grateful. Thanks so much.

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