

1.17 Mental Health and ESOL Learners

This section provides:

- Background information on mental health in the U.S.
- General information on the stresses and adjustment challenges experienced by many ELLs
- General information on post-traumatic stress experienced by some refugees and other ELLs
- Suggestions for creating a class environment that supports learners who are experiencing stress related to resettlement, acculturation, or trauma
- Suggestions for lesson content to prepare learners for U.S. views on mental health and treatment of mental health challenges
- Information on different cultural views of mental health

Case Study: Lina

Lina, a woman in her 60s, appeared to be having a hard time getting into the groove of her multilevel ESOL class, appearing scattered and confused a lot of the time. Her teacher attributed this to Lina's newness in the country and, maybe, the challenges of beginning to learn a second language at her age. One night a guest speaker came to the class and spoke with learners about health care in the United States. As part of the presentation the speaker asked learners if they understood the term "mental health." The class talked about different terms like stress, depression, anxiety, and trauma. The speaker explained trauma as something bad that happened in your past that stays with you in your memories. Lina suddenly sparked to life. She told her class in English, which the teacher previously didn't know Lina could speak, that in her native country "bandits" had killed her daughter and grandchildren. Lina said that every day she is depressed and anxious and that she doesn't know what to do. She came to the U.S. to live with friends and escape the memories of her native country but she can't forget. The class was in shock to hear all this from Lina and offered empathy. The guest speaker was able to refer Lina to a counselor specializing in trauma who spoke her native language.



Case Study: Eduardo

Eduardo is in his early 30s and arrived in the U.S. three months ago. In his native country, he was a pharmacist. He hopes to do that job in the U.S., but for now he spends his days at home watching TV while his relatives are at work. Then, they drive him to English class at night. He has tried to find an entry level job at a local pharmacy, but they won't even consider him since he has not worked or studied in the U.S. For a few days, he did some lawn work, but he wonders what his family would think if they saw him doing this menial work. At home he feels frustrated, needy, and alone. He can't sleep at night and feels panicky every time he tries to go anywhere by himself. He always had a hearty appetite in his native country, but here the food tastes bland. In class he tries to keep up but he sometimes feels overwhelmed and has trouble concentrating. Back in his native country, it seemed like such a good idea for him to come to the U.S. and create better opportunities for his family, but now he wonders constantly if he made the right choice. He misses his family, friends, and a special girlfriend that he left back in his home town. His one highlight of the week is a phone call to her on Sunday evenings. But, soon after, he begins to worry that she might find someone else.

Case Study: Fadumo

Fadumo, a refugee, was in her 20s and sometimes appeared to be a giddy, lighthearted member of her ESOL class. Other times, she appeared to be spaced out and overtired. She came from a country where women often did not have the opportunity to learn to read, and literacy appeared to be a big challenge for her in ESOL class. Sometimes her teacher would struggle to be patient with Fadumo's lack of focus, and the teacher wondered if Fadumo had some sort of learning disability. Then, one day, Fadumo's refugee services case manager shared that Fadumo had been struggling with post-traumatic stress disorder and was starting on some medication to help ease symptoms like nightmares. Suddenly Fadumo's demeanor in class started to make sense to the teacher. With medication for PTSD and a better understanding of her situation by the teacher, Fadumo was able to focus better in class and the teacher was able to be more patient and supportive of Fadumo.

Learners with background stories like Lina, Eduardo, and Fadumo may well be sitting in your ESOL class. You may be aware of their emotional challenges, or perhaps their symptoms are mistaken for shyness, beginner's adjustment to ESOL class (which may be accurate in Eduardo's case), or an undiagnosed learning disability. What can you do to help make their classroom experience and language learning more comfortable for them?



What basic pieces of cultural information can you teach them to help them get the support they need for their mental health and adjustment needs? The following information will provide some helpful information and suggestions.

1. To discuss mental health in class or not to discuss?

There are no easy answers to this question. Discussing mental health and mental health services in the U.S. is uncomfortable for many. One option is only discussing mental health in class if it comes up from learners. However, newcomers are susceptible to mental health challenges from the stress of immigration and cultural adjustment, as can be seen in the case of Eduardo above. Arguably, they can benefit from learning about U.S. views and supports around mental health. There are not many sources of information available on this topic for ELLs.

PROS:

- Awkward as mental health can be to discuss, it is important for ELLs to understand how mental health is viewed in the U.S., to have basic vocabulary to discuss it, and to know what help is available should they or a family member need it.
- The immigration and cultural adjustment process can be **very stressful**. Some ELLs may, quite understandably, experience depression or anxiety in this period of their lives.
- Some refugees and other immigrants may have **histories of trauma** that still cause them emotional pain. Some may have Post-traumatic Stress Disorder (PTSD). Says Isserlis (2009), an expert on trauma and adult learners:

“Because victims of violence are disproportionately represented among the ranks of adult learners, it is critical that adult educators understand how people cope with trauma in order to understand how to assist them in attending to learning.”

- There are ways to teach about mental health in the U.S. that are impersonal, brief, and solution-focused.

CONS:

- If someone is in the throes of a mental health crisis, discussing mental health in class can make them feel more stigma or shame and may exacerbate their symptoms.
- Some teachers may feel ill-prepared to answer questions that learners bring up about mental illness.
- Some teachers may feel ill-prepared to respond to any insensitive remarks about mental illness made by learners.
- Discussing mental health takes time in an already overcrowded agenda.

2. Talking about Mental Health with Learners

If you choose to address mental health in the U.S. with your learners, here are some helpful guidelines.

- Stigma** around discussing mental health is universal, with varying degrees of stigma in different cultures.
 - Stigma in many other cultures when talking about mental health is stronger than in U.S. culture.
 - Normalize stress as part of everyone's life and as part of the immigration experience.
 - Be sensitive to stigma by keeping all discussion and practice impersonal.
 - By this writer's observation, beginner and intermediate level ELLs in the Northern Virginia Health Literacy Initiative (2011-2012) were *much* more open to talking about mental health and asking questions about care resources than ELLs in the same region in 2003. This stands to reason as other parts of the world become more "Western" in their understanding and approaches to mental health.
- Different cultures** and languages look at mental health differently.
 - Many cultures don't use the diagnostic categories (e.g., depressive disorders, anxiety disorders, psychotic disorders) that the U.S. uses to discuss mental health.
 - In some cultures, you are simply crazy or not crazy.
 - In some cultures, what the U.S. considers emotional symptoms are experienced and described in physical terms.



- In some cultures, symptoms considered pathological by U.S. psychiatry are not considered pathological at all.
 - In some cultures, saying aloud that you are “stressed out” is viewed as an admission of mental illness.
 - Western is not necessarily “better” when it comes to treatment for people from different cultures. U.S. mental health treatments are heavily influenced by the U.S. conception of self and individual responsibility, and by the biomedical disease model for understanding mental illness. Some other cultures place a higher value on kinship, define the self in relation to the kinship system, and see mental illness as externally caused, thereby reducing stigma of illness as personal biological defect. Studies have shown that these variations in kinship and external vs. internal cause of illness can positively impact how people interact with and support people with mental illness. This can sometimes lead to better outcomes for people with what the U.S. considers severe mental illness, such as schizophrenia.
 - When explaining mental health and mental health treatment, avoid using terms that pathologize stress, other mental health challenges, and treatment. It may help to describe treatment providers with more universally accepted, less clinical sounding terms such as a “counselor” or “social worker” (rather than, say, psychologist or psychiatrist), “someone who can help you fix problems you are facing in your life.”
- Try a narrative approach.** Using impersonal stories can minimize stigma, shame, and stress around a mental health lesson. Many cultures have storytelling traditions, so this may be familiar and comfortable to learners.
- **Picture prompts** can be very helpful at lower levels. For example, see the picture stories ["Stressed Out"](#) or ["Depressed"](#).
 - **Start where your learners are.** When feasible, start a lesson by eliciting learners’ own explanations or examples of “stress” or “mental health.” This will help them focus on the lesson’s relevance to their own lives and beliefs, honor their cultural perspectives, and help you understand the different views of these concepts in your classroom.
- Be trauma-sensitive.** See the trauma section below for more on this topic.



- **Have referral resources on hand. Make connections and develop relationships** with social services available in your area.
 - [Multicultural Human Services \(Northern VA\)](#) from Northern Virginia Family Services
 - [211 Virginia \(English and Spanish\)](#): social service referral
 - [CLAS Act Virginia: Culturally and Linguistically Appropriate Health Care Services](#) from the Virginia Department of Health
 - [Multicultural Resources in Virginia](#): list from Virginia Department of Social Services
- [Keep your boundaries. Don't try to be a learner's counselor.](#)
For an excellent list of suggestions for setting boundaries while still being there for a learner dealing with trauma, see Jenny Horseman's tips at:

3. Migration and Mental Health

Some Stressors of Migration and Acculturation ELLs May Experience

- **Loss:** People experience many losses when emigrating from their native country – professional and social identity, possibly possessions and wealth, social connections, way of life.
- **Nothing is familiar:** Activities of daily life all are suddenly unfamiliar in the new country.
- **Inability to express themselves:** Newcomers are frequently unable to express themselves or get needs met in the new language.
- **New bureaucracies to tackle:** Newcomers need to figure out the new bureaucracy to get their needs met.
- **Becoming dependent:** Newcomers may be suddenly dependent on others for most things in life.
- **Generational role reversal:** Children acculturate faster than their parents, which can create intergenerational tension. Parents become dependent on children in some cases.



Stages of Cultural Adaptation

- **Honeymoon:** may be characterized by excitement, idealization
- **Culture Shock:** may be characterized by depression, demoralization, frustration
- **Initial Adjustment:** may start taking more realistic steps to adjust and adapt (getting a job, studying English, etc.)
- **Integration:** begin to feel a part of society, functioning more independently

How long one takes to pass through each stage is different for everyone, and not everyone goes through every stage.

Spring Institute (1999): [Cultural Adjustment, Mental Health, and ESL](#)

[This cultural adjustment timeline](#) (based on Lysgaard's 1955 U-Curve of Cultural Adjustment) has been used successfully as a springboard for ESOL lessons on acculturative stress. Here is a link to an illustration of a slightly more detailed timeline you could adapt to use with learners:

4. Trauma

- Trauma and Post-traumatic Stress Disorder (PTSD) are often mentioned in relation to refugee populations.
- Traumatic stress can occur from many kinds of experiences, such as living through war, rape, domestic violence, childhood physical and sexual abuse, armed robbery, car crashes, torture, or neglect.
- Non-refugee immigrants may have traumatic histories as well as refugees.
- Being a refugee or immigrant is *not synonymous* with being traumatized.
- The term "trauma" may not have an exact translation in all student native languages. Many people understand "bad things that happened in the past." Counseling services for people with trauma could be described as "a place to go where people help you feel better about bad things that happened in the past."



Symptoms of Post-traumatic Stress

Some common symptoms of post-traumatic stress include:

- Flashbacks, nightmares
- Anxiety, heightened startle response, irritability
- Difficulty concentrating
- Feeling isolated
- Feeling emotionally numb
- Trouble sleeping
- Somatization – physical symptoms of stress stored in the body
- Depression

It is helpful for teachers to reflect on how any one of these symptoms – and the energy expended trying to hide these symptoms – might interfere with classroom learning efforts. For more information on PTSD symptoms and treatment, see the [National Center for PTSD](#).

Be “trauma informed” in lessons related to mental health. It works for everyone.

- Create safety and build trust in class before any lesson relating to mental health.
- Be aware of and avoid potential triggers to trauma (e.g., if you suspect a learner is a victim of domestic violence, don't do a lesson on domestic violence).
- Let trauma survivors feel power and control throughout the lesson.
- Let learners know what to expect to happen next in classes.
- Allow dignity and respect to learners throughout lessons.

What might this look like in your classroom?

Having a trauma-informed approach to teaching need not create more or different work for you. A trauma-informed approach can benefit all learners in the classroom.

- Just by being a regularly scheduled event in a new arrival's life, the ESOL class provides structure in the chaotic life of the new arrival. By imparting English language skills, it creates productivity and future orientation. Attending ESOL class can allow new arrivals to begin to create their new post-migration identities, reassuming control of their lives.



- Provide structure (e.g., write agenda on board, take a regular breaktime, build patterns of activities).
- Set ground rules for the class on speaking respectfully, taking breaks when needed, and not having to share personal information when it feels uncomfortable.
- Keep discussion impersonal, general, and indirect. Consider a narrative approach for potentially difficult topics. See the picture stories and lesson plans for "[Stressed Out](#)" or "[Depressed](#)" for impersonal narrative prompts and step-by-step instructions on how to use them.
- Allow individual learners to take breaks and leave their desks or leave the room as needed. (This could possibly be made easier by setting up a comfortable area in the back of the classroom with a soft chair and an electric kettle where learners can retreat to make themselves a cup of tea.) If a person with trauma issues is sitting in class and can't concentrate, or feels distressed by a topic, getting up and stepping out or away from the desk can help him or her decrease stress, refocus, and feel more control over the situation.
- *Normalize* stress, anxiety, and depression. Let learners know that these are common reactions to difficult things that happen in life.
- Indicate when appropriate that, in the U.S., we see mental health treatment for common issues like depression and anxiety as giving hope for a better future.
- Consult these helpful resources for additional awareness on trauma and adult learners:
 - [Learning and Violence](#)
 - [On the Screen: Women, Learning, and Violence](#)

At a program/system level, learners who are experiencing post-traumatic stress may need to be looked at with flexibility. For example, maybe more lenient enforcement of attendance policies is warranted while a learner works with services to stabilize their situation. Maybe a learner's mental health would benefit from taking time out of the classroom doing distance learning for a semester while she or he works on symptom stabilization. Because of the frequent turnover of teaching staff in adult education, programs need to make sure that new instructors are educated on the mental health challenges and life stresses adult ESOL learners may face.



Culture and Mental Health Web Resources

[Mental Health and the ESL Classroom: A Guide for Teachers Working with Refugees](#)

This guide was produced by the International Institute of Boston and Immigration and Refugee Services of America with support from the Office of Refugee Resettlement.

[Trauma and the Adult English Language Learner](#)

Janet Isserlis wrote this 2000 digest made available by CAELA, the Center for Adult English Language Acquisition.

[Trauma and Learning – What Do We Know, What Can We Learn?](#)

This article (pages 42-51) by Janet Isserlis is included in the 2009 proceedings of the LESLLA Conference, published by Bow Valley College, Calgary, Alberta, Canada.

[Talking about Mental Health: A Narrative Approach](#)

This document by Marla Lipscomb, MSW, LCSW, is made available online by the Refugee Health Technical Assistance Center.

[Picture Stories for Adult ESL Health Literacy](#)

Kate Singleton created these picture stories, along with supports for teachers, between 2001 and 2003.

[Cultural Adjustment, Mental Health, and ESL: The Refugee Experience, The Role of the Teacher, and ESL Activities](#)

This 1999 guide from the Spring Institute for Intercultural Learning was written by Mary Ann Adkins, Dina Birman, and Barbara Sample with contributions from Shirley Brod and Margaret Silver.



Mind and Culture: Psychiatry's Missing Diagnosis

This 2005 *Washington Post* series featured several articles by staff writer Shankar Vedantam:

- [Patients' Diversity Is Often Discounted \(June 26\)](#)
- [Social Network's Healing Power is Borne Out in Poorer Nations \(June 26\)](#)
- [Racial Disparities Found in Pinpointing Mental Illness \(June 28\)](#)
- [Culture and Mental Illness \(June 28\)](#)

The Americanization of Mental Illness

This article by Ethan Watters was published on January 8, 2010, by *New York Times Magazine*.



Appendix I: U.S. Mental Health Statistics

Mental Health Statistics for Virginia (from the [National Alliance on Mental Illness](#))

- In 2000, approximately 262,000 adults and 82,000 children in Virginia had serious mental health conditions.
- In 2006 in Virginia, 876 people died by suicide. (In the U.S., one person takes his or her own life every 15.8 minutes.)

According to the [National Institute of Mental Health](#):

- 28.8% of U.S. adults will experience an anxiety disorder in their lifetimes. Women are 60% more likely to than men.
- 3.9% of U.S. adults will experience bipolar disorder in their lifetimes.
- 16.5% of U.S. adults will experience major depression in their lifetimes. Women are 70% more likely to than men.
- 8.1% of U.S. adults will experience ADHD in their lifetimes.

Depression in the U.S.

(from Centers for Disease Control and Prevention report
[Current Depression Among Adults, United States, 2006 and 2008](#))

An estimated 1 in 10 U.S. adults has some form of depression. Per the report, those adults most likely to meet criteria for depression diagnosis tend to be:

- Persons 45-64 years of age
- Women
- Blacks, Hispanics, non-Hispanic persons of other races, or multiple races
- Persons with less than a high school education
- Those previously married
- Individuals unable to work or unemployed
- Persons without health insurance coverage

