The COVID-19 Pandemic: An Evolving Story. Professional and Personal Insights using Self and Culture as Agents of Calm and Healing after a Year of Co-habitation with Imminent Threat

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Being a cross-cultural systemic therapist, clinical supervisor, and educator means that culture and language are central to my work. They provide a scaffold to develop deeper understanding, increased trust, and connection between myself and my supervisees, students, and clients and facilitate a process for the latter to connect to their own selves and values. Given the fear and uncertainty generated by the COVID-19 pandemic, there exists a pervasive activation of the sympathetic nervous system in the community. In this article, I present two case studies as examples of a cross-cultural/cross-linguistic approach that facilitates two clients to find a place of comfort and calmness and consequently a balancing activation of the para-sympathetic nervous system. First is a client who, due to the overwhelming pandemic chaos, suddenly exhibited a host of signs and symptoms of a functional neurological nature, which she experienced as a lack of control and disconnection from her body, her primary language, and herself. Within a trusted therapeutic relationship that draws on the culture and primary language of the therapist, the client regains connection with language and enhances her ability to communicate and connect with her body. Second is an international student who is encouraged to use her culture of origin and primary language to induce calmness, reconnect with herself, and return to the familiar as a ‘known’ collectively inclusive, comforting, and nurturing environment.

Keywords: COVID-19, family therapy, cross-cultural therapy, primary and secondary language, psychological trauma, neuroplasticity, sympathetic nervous system activation, self of the therapist

Key Points

1. The impact of the pandemic is evident across all three-tiered micro, mezzo, and macro systems as communities deal with collective mourning from loss of lives, health, relationships, and family structure.
2. The quality of our relationships, belonging, and fulfilment determines the quality of our lives and well-being.
3. Family and systemic therapists can play a critical role during structural, cultural, and ecological change in supporting families and communities to deal with the current, evolving, and future impact of the COVID-19 pandemic.
4. There is a need to be responsive and culturally sensitive to the diverse needs of our clients, which also applies to the training of students and practitioners whether they are from, or work with, cultural and linguistic difference.
5. As practitioners and academics, we need to apply a respectful, curious, and creative approach in developing pathways to reach people and use our ‘selves’ as catalysts for connection and instruments to elicit positive change.
Background

It has become somewhat clichéd to observe that the COVID-19 pandemic, as one of the most profound events in living memory, has disrupted humanity. The rapidity and ubiquity with which our lives have been upturned has been breathtaking; the only ‘constants’ have been change and uncertainty themselves. This paper was drafted over several months between mid-2020 and early 2021, when information and regulations were changing daily. While there has been a collective impact, there have been specific impacts for each context, each life, each family. The impact is evident across all three-tiered micro, mezzo, and macro systems: the ‘micro’ level concerns the individual; the ‘mezzo’ level involves groups (the smallest being the family-unit); while the ‘macro’ level involves entire communities, states, or countries (Friedman & Allen, 2011).

There have been significant macro-level changes impacting legislation, politics, economies, education, ecology, health, and socio-cultural systems with profound implications for civil liberties and human rights. These effects are apparent in research, teaching, and clinical practice. They include the structure and function that families and individuals present at the micro and mezzo levels; the micro and mezzo issues arising for students, particularly international students; and mode of service delivery and education. Communities are dealing with collective mourning from loss of lives, loss of relationships, and loss of structure and function in families. Since physical distancing has been enforced, our ability to relate has been diminished, yet touch and social connection are necessary for us to survive and thrive (Patterson, 2012).

This paper aims to provide professional insights into the effects of the existential threat, highlighting my approach to working with families and systems. It begins by discussing the effects of the COVID-19 pandemic in Australia, and particularly Western Australia (WA) and concludes with two relevant case studies.

Navigating through Darkness

The virus

Early in March 2020, in Australia, little was known about the new virus called ‘Corona’ or ‘COVID-19.’ The fact that it was ‘novel’ led immediately to high levels of uncertainty and fear of the unknown (Amorin-Woods et al., 2020). While Australia has been spared the devastation wrought by the virus in many countries, it has not escaped totally unscathed, recording over 28,000 cases with just over 900 deaths (Ting, Scott, & Workman, 2020). In WA there have been around 900 cases, mainly from international travellers, cruise ships, and commercial vessels, with 80 community transmissions. However, none have been recorded since April 2020. Worldwide, there have been over 100 million cases and over two million deaths.

Government responses

Owing to a rapid increase that peaked at more than 400 a day in late March 2020, Australian governments acted quickly to contain the pandemic and implemented a COVID-19 emergency action plan with the information available at the time comprised of four phases. In late November 2020, Australia entered a fifth phase, which was termed a gradual transition to a new ‘normal,’ recognising that there would be outbreaks until a vaccine becomes available (Duckett & Stobart, 2020).
Knowledge about the virus has increased exponentially from intensive research findings and observation of the virus’ epidemiology. This led to Australia being in a privileged position to assess the effectiveness of the measures applied overseas. Between May and November 2020, despite the increased knowledge, we were still dealing with the unknown, and fear of the unknown often resulting from government and health authorities’ measures to curtail the spread.

Fear as a consequence
Fear is arguably the major factor resulting from the COVID-19 pandemic; fear connected to the virus, the media, and the public health measures. In fact, the term ‘Coronaphobia’ has been coined to describe the combined acute fear and anxiety connected to the coronavirus (Lee, Jobe, Mathis, & Gibbons, 2020). This leads to emotional distress, high levels of loneliness and isolation, including elevated levels of depression, self-harm and suicidal ideation, and psychological trauma (AIHW, 2020).

Psychological trauma has long been known to have emotional, mental, relational, and physiological effects that impair function. This is illustrated by the experience of war veterans from Vietnam in whom PTSD was described (Doidge, 2008). People are presently living in a constant state of stress, fear, and unpredictability. Psychological trauma can reside in the body in the form of pain or central nervous system (CNS) malfunction, sometimes for a lifetime, and perhaps even transmitted inter-generationally (Tolle, 2004).

Neuroscience and trauma
There is greater neural processing in the brain in response to negative stimuli (Ito, Larsen, Smith, & Cacioppo, 1998). Due to negative bias, stressful and problem-saturated narratives rapidly take over; humans display a propensity to use negative information far more than positive information (Vaish, Grossmann, & Woodward, 2008). Thus, the barrage of negative media takes effect when stories get repeated ad-nauseam. Consequently, we may see this as a threat and respond accordingly. Due to neuroplasticity however, the brain can be rewired to form new neural connections and pathways, leading to the development of preferred stories. This is the case for people who have suffered psychological--physical--environmental trauma (Carey, 2020). Psychological trauma is not merely a response to a past single incident but leaves an imprint on the person’s brain, mind, and body (Van Der Kolk, 2014), and like a volcano may lie dormant and then erupt, sometimes as ash, sometimes as gas, and other times as hot lava. Thus, trauma may manifest as anxiety, anger, panic, stress, or physically. This represents a constant threat, waiting to erupt at any given time.

The autonomic nervous system (ANS), composed of the sympathetic and parasympathetic nervous systems, controls everything the body does automatically. The two modalities act like opposing sides of a ‘seesaw.’ The sympathetic nervous system (SNS) is responsible for the fight--flight--freeze response, while the parasympathetic nervous system (PNS) is responsible for rest--digestion--reproduction--repair. Hyperactivity of the sympathetic nervous system is a state in which the sympathetic component of the ANS dominates and controls the person’s immediate thoughts, actions, and reactions displayed as increased heart rate, respiration, blood pressure, and perspiration. The correlation between prolonged stress and activation of the CNS is termed sympathetic dominance (Todd, 2016).
I have noted over recent times an increase in clients with SNS activation and I have observed increasingly this tendency in whole families. I believe this can be mirrored and kept alive within families, like an inherited response. Although my focus is on people, not labels, I have noticed this familial phenomenon of sympathetic dominant families which has been accentuated due to COVID-19 and maintained by prolonged lockdown. The underlying fear feeds the uncertainty, which feeds the hypervigilance. This flicks the ‘sympathetic switch on’ and keeps it on.

Since the advent of the pandemic, we have been living and experiencing a ‘new normal’ of collective panic and social disruption, thus people find themselves forced into prolonged survival mode and erratic coping styles. Thoughts and opinions become more rigid and extreme, behaviours more reactive -- and irrational -- giving rise to division and consolidation of a survival of the fittest stance. One of the frequent stories I hear from my clients along with those already discussed is intense fatigue and exhaustion. In fact, many are calling this ‘pandemic fatigue’ a significant challenge for public health running parallel to the pandemic global experience (Meichtry, Sugden, & Barnett, 2020).

The Role of Systemic and Family Therapy

Systemic and family therapists working with relationships, families, systems, and communities have a critical role in the mental health and well-being of clients that is often overlooked. Social connectedness and relationships provide us with meaning, belonging, fulfillment, health, and well-being, and can determine the quality and length of our lives (Holt-Lunstad, Smith, & Layton, 2010). Families and individuals seek our support for coping with change or managing transitions. As family therapists we direct their attention to individual and collective strengths and internal resources and help to mobilise them around their system.

The pandemic has disrupted family cycles, functioning, and rituals. This has included delays in adult launching (due to unemployment); parents unable to witness their child’s graduation; couples having weddings without family; a father not being able to witness the arrival of his child; grandparents kept distanced from their families; the inability to be with an ill parent or attend their funeral. Smooth entry between life stages requires an effective transition. However, living under persistent stress and lack of support and connection can delay, disrupt, or impair this process. Families have faced the loss of vital family processes such as important milestones, community, normative and cultural traditions, and rituals. Acknowledging transitions such as life stages and milestones is paramount in helping families adjust to change and assisting with the grieving process (Imber-Black, Roberts, & Whiting, 2003).

Families have been left uncertain, fragmented, cut off, and disconnected, experiencing collective mourning and perma-grief. This is manifested in increased signs of mental ill-health and suicidal ideation (AIHW, 2020). The pandemic has resulted in widespread lockdown and isolation, in hospital, at home, in a town, state, or country. Many people are isolated for extended periods and the absence of social connection and healthy relationships may predispose people to mental illness both now and in the future. Some of the families I work with online, who have family members located in WA or in the Eastern states, refer to family separation due to border closures as ‘relationship death.’ Our role as family and systemic therapists may challenge
us into the future, requiring an even higher degree of support to help clients deal with multi-layered COVID effects.

**My Approach as a Cultural Family Therapist: MI CVLTVRE**

We need to ‘be’ before we can ‘do.’ Authenticity is to a therapist what breath is to life. We need to be authentic with the families who come to us with hope and trust and this includes possessing heightened awareness of ourselves; hence the need to uncover the ‘self’ (Amorin-Woods et al., 2020). For each client I attempt to *transcend borders* with a mission of empathy, unity, inclusion, sensitivity, and connectedness and strive to make my interactions unique, acknowledging and validating their diversity. The sharing of stories is born organically as are the ways of sharing oneself to allow trust to deepen understanding, elicit hope, and support the creation of change and growth. This is particularly important when we consider COVID-19 as a baseline, given its complex and chaotic nature, where individuals, families, and communities feel ambiguous about what the next day will bring.

As a cross-cultural therapist, over many years of clinical practice and teaching in Australia, I have noticed a tendency for therapists to work from a monocultural perspective, while living in a multicultural society. Therapists may inadvertently assume that people from different cultures relate to the world in the same way as they do, and consequently believe they should meet the needs of their clients based on their own perspective (Raheim et al., 2004). This may involve an erroneous belief that ‘if I view it, or experience it in this manner, so will the other’ (Amorin-Woods, 2016a, 2016b, 2020; Ho, Matthews-Rasheed, & Rasheed, 2004). Cultural biases and insensitivity may often be due to therapists’ experiences of ‘discomfort’ in cross-cultural interactions with their clients, which leads to avoidance or bypassing of cultural issues (Stampley & Slaght, 2004; Utsey, Gernat, & Hammar, 2005). My real-world clinical experiences were confirmed when I conducted an informal literature review to investigate the available evidence in this space. Whilst I discovered a body of work describing this dissonance (Costa, 2010; Dewaele & Costa, 2013; Falicov, 1995), there was a dearth of Australian literature about ways to address this issue (Amorin-Woods, 2020).

Consequently, I have developed and presented an inclusive clinical model which I describe with the acronym ‘MI CVLTVRE’: ‘Meaning,’ ‘Identity,’ ‘Community,’ ‘Views,’ ‘Language,’ ‘Traditions,’ ‘Values,’ ‘Roles,’ ‘Rituals,’ ‘Religion,’ ‘Ecology,’ and ‘Environment’ to elicit trust, cultivate hope, and create change (Amorin-Woods, 2016a, 2016b, 2020). I focus on these important components of therapy through the inclusion of cross-cultural conversations. Using this model facilitates *culturally sensitivity* to the diverse needs of the individuals, couples, and families who consult me, whether they come from a different cultural background, or whether my own cultural background becomes a pathway to reach them.

The following two case studies illustrate some of the themes of this model, which allows me to connect, join in, and deepen understanding with clients, and develop a more inclusive family structure that acknowledges different cultural views and expectations. The case studies illustrate the effects of high levels of uncertainty, acute fear and worry, loneliness, and isolation as well as corona-phobia and xenophobia. They illustrate the way I use my ‘self’ and my cultural and linguistic background as catalysts for connection and instruments to elicit change.
Case Studies

Carla: Using language as a medium of human expression and connection

Carla is a 55-year-old Australian-born woman, a survivor of complex trauma whose primary language is English. She is a long-term client who had previously attended family sessions but moved to individual face-to-face sessions when her children moved abroad. Following a couple of months during which I had not seen her, we made contact soon after the emergence of COVID-19 in WA. She informed me she had developed some unexplained symptoms that included difficulty with her speech and mobility. At this stage our contact was brief while she was in hospital for investigations, the results of which were inconclusive. Consequently, it was described as a ‘functional’ neurological condition (Cock & Edwards, 2018; Stone, 2016). As weeks went by Carla’s symptoms worsened and she reported further lack of mobility, particularly on her right side where she would lose balance easily with her ability to walk reduced. Carla’s speech became slow and hard to understand and as she was unable to drive, she couldn’t attend face-to-face sessions.

As we were transitioning into telehealth, I agreed to provide online sessions that increasingly became more frequent. Given Carla’s history of complex trauma, establishing trust was particularly important and fortunately she had developed a trusting therapeutic relationship with me over time. One point of connection was Carla developing an affinity toward the Spanish language as I am also a multilingual psychotherapist, with Spanish being my primary language. While it is hard to understand what may have led to her brain dysfunction, it is fair to say that the emergence of COVID-19, and the uncertainty, fear, lack-of-control, and stress connected to it may have ‘ignited’ her sympathetic central nervous system to leave her in an almost permanent survival state of fight-flight-freeze. My therapeutic intervention included mindfulness, meditation, and relaxation strategies such as diaphragmatic breathing with the aim of putting the ‘brakes’ on her activated SNS and strengthening and activating her PNS. These strategies are known to help induce the ‘wound-up brain’ into a more calm state, improve sustained attention, affect, and cortisol levels (Ma et al., 2017).

As Carla had started to take Spanish lessons online, which she practiced every day, I decided to incorporate language as a helpful therapeutic tool, increasingly including Spanish content as well as Spanish mantras. Consequently, my primary language and I became a source within which positive change could take place.

Carla had found that she would at times go blank and stay stuck in the middle of a sentence when communicating with some people, including her health-care team, particularly in situations when she felt pressured, and when others failed to understand her. She grew increasingly distressed and depressed by losing ‘language’ and her voice as her medium of communication. Carla reported that even though English was her primary language, she found it difficult to connect and communicate in it. Having survived a history of complex trauma, and now with the extra trauma of COVID-19, ‘trauma’ had become encoded in Carla’s mother tongue, English (Costa, 2010). Spanish presented an alternative medium with a protective function and an accessible route to communication and self-expression. Curiously, as Carla learnt Spanish she found that whenever she was stuck, she would ‘organically’ access Spanish to trigger her memory, to get her back to the present, and allow communication flow, as she explained in the following transcripts:
When I’m speaking to my rehab team and carers, particularly because they have a lot of expectations on me, how I should be, how I should communicate, I become anxious, stressed, and worried. I freeze, my mind becomes blank and I lose my speech altogether... if I think or speak in Spanish that triggers my memory back, I connect with my speech, and then I can communicate again.

When I attempt to speak English, it comes out with stress, and I am also left with stress, but when I speak Spanish, it comes out ‘easier.’ I feel more relaxed, and at peace. It comes from a calming place and leaves me feeling calm.

Carla had reported feeling more ‘unified,’ like her mind and body felt ‘one and whole.’ This was especially important for her given she had increasingly felt as though there were only fragments of her, her brain was doing one thing, her body was doing another, and she was no longer seeing herself as a collective whole.

In addition to Carla utilising daily meditation and diaphragmatic breathing when she wakes up and goes to bed, we added Spanish mantras like the following: mi mente esta calmada, mi cuerpo esta calmado (my mind is calm, my body is calm) as she was more likely to listen to and connect with it. In telling herself she is calm her brain and body follow suit. Previously she would tell herself, This is too hard or I don’t remember or I am frozen, so her brain would automatically listen and respond accordingly, by freezing or getting stuck. In a stressful situation, stress hormones including cortisol activate the SNS response which obstructs the centres of the brain responsible for memory while it activates the amygdala, responsible for emotions, such as fear (Goleman, 1996). Since Carla is saying it in Spanish and has learned to identify Spanish with calmness, this puts her automatically in a calming state. Spanish had brought on calmness for Carla and it is in the place of calmness that language is formed. Perhaps that is why Spanish can trigger memory recall even though it is not her primary or native tongue. If language is born within a stressful environment, the opposite happens. This ignites the SNS response and feeds anxiety, confusion, and stickiness in speech and in the body when trying to move. As Carla put it:

I believe it is better to have a language rather than no language, but people, including some of my care team make assumptions that I am stupid or that I don’t understand, now because “I speak with an accent”... before it was because I got stuck and couldn’t talk or formulate words.

When her speech becomes stuck due to stress or anxiety, and she is unable to form words in English, Carla uses diaphragmatic breathing and mantras in Spanish to connect with her breath as her anchor and connect with what she is telling herself. She has found this process her ‘antidote.’ Her choice of mantras and messages are those that counteract the situation whenever she feels paralysed, when she wants to mobilise or speak, and it doesn’t happen. This also extends to situations in which Carla feels like people are taking over her ability to make her own decisions; she then reminds herself that she knows herself better and that she knows what she needs and wants.

Another mantra Carla uses is: Yo se lo que quiero y escojo lo que quiero, Yo creo lo que digo cuando yo me lo digo (I know what I need and I can make the best decisions for myself, I believe what I say when I hear myself talk). Given her history as a trauma survivor from a young age, she had learned to view herself as ‘superfluous’ and as a ‘nuisance’ to others, and now as her voice and body were also giving up on her, she had come to view herself as a ‘thing,’ not only obsolete to others, but also to herself.
However, because of her ability to learn and communicate in a new language, she was able to re-write a preferred story of herself and reclaim her identity as a courageous, resilient woman, and as an able, capable, and resourceful person, who, through the opportunity to learn and communicate in a new language has been given a chance to be *born again*, leading to both the creation of an alternative identity and story line. My involvement in the co-authoring process occurred as I loaned my culture and primary language as a means for her to create her own scaffold; the curiosity, eagerness, and commitment to practice and engage was hers, thus empowering her.

Norman Doidge (2008), one of the pioneers of ‘functional neurology,’ discovered that the brain is plastic and able to develop attributes and properties to repair and rewire itself. When areas of the brain are damaged due to trauma, affecting skills like speech or movement, for instance, the brain can be stimulated by conscious habits of thought and action, leading to neural pathway development. Thus, as learning occurs, connections increase (Doidge, 2008). There is emerging evidence on the neural benefits of bilingualism and learning a second language. Through the process of language learning, the brain structure is altered, and certain neural functions are improved. Language acquisition stimulates multiple brain regions, enhances learning capacity, and boosts brain plasticity and excitation of white and grey matter. For instance, bilinguals or multilinguals have been found to have increased grey matter density and white matter integrity compared to monolinguals. Further to this, language switching also boosts grey matter volume in other regions of the brain (Olulade et al., 2015).

In Carla’s case, acquisition of Spanish as a second language may have contributed to the development of new neural pathways, which in turn provided a route for her to regain speech and movement. Also the trusting therapeutic relationship enabled me to draw on my own culture and language, thus using my ‘self’ as an instrument, to facilitate the client to regain connection with language and body. This unusual case represents a salient example, albeit unexpected, of a nexus that emerged organically.

As a cross-cultural therapist, who transcends borders I fortunately had the tool of another language in my ‘therapeutic hand’ and we were able to co-create a bridge to a more calm, serene space where Carla’s healing could take place.

**Amina: Language as a medium of transport to culture and place**

Amina is a 32-year-old international student born in Kenya. She is multilingual and speaks Swahili (primary language), Arabic, Bantu, and English. Amina had developed stress overload and acute anxiety following the advent of COVID-19, which prevented her from travelling back home. Due to the closed international borders, Amina, who only had a year to finish her nursing degree, was unable to return to her country of origin, not only because she would not have been able to return to Australia to complete her degree had she left, but also because she did not have the financial means to do so. Amina’s family had made huge financial sacrifices for her to study in Australia. She was the oldest child and because of her collectivist cultural tradition, her biggest wish after finishing her degree was to give back to her family. Amina had endured racial prejudice, overt and covert racism, which led to her losing her job and her rental accommodation. Amina was distraught and found herself for a few weeks unemployed and homeless without means of financial support. One of the characteristics of covert racism is denialism. Denial or rebuttal that a given behaviour or decision may be racist, an argument Amina encountered (Szoke, 2012):
I have always dreamt about coming to Australia, and when I was accepted to study here, I was so happy and so grateful... Australian people seemed to be accepting of me. Even though adjusting was hard, because I missed my family so much, I wanted to make friends, in the end I did, although most were African. It makes me so very sad that since the corona, things have changed so much. Everyone here is running around like robots, stressed, impatient. Other people in my classes, foreigners like me, we have all felt the frustration, the hostility, the division. When I lost my job, then later lost my rental, it was so difficult for me, I could not believe that was happening. People asked me aren’t you angry about what’s happened to you? I just tell them I am not angry, but I am very sad and disappointed, and also worried and scared, the worst thing was not being able to be with my family in these difficult times and this also meant my ability to help my family financially was delayed...

Amina became stressed, distraught, and highly anxious. She also felt drained and fatigued, unable to digest her food and experienced unexplained body aches. She was also unable to turn off the high volume of thoughts that left her in an ‘activated state,’ switching on her SNS. A person may construct around 6,000 thoughts per day, and negative thoughts can quickly create robust neural pathways (Tseng & Poppenk, 2020). I have always discussed with my clients and students the importance of engaging in a continuous reflective process. One of the suggested tools includes journaling; however, in respecting uniqueness this may take different forms, including written, artistic, or recorded verbal entries. Amina had chosen a combination of written and verbal memos as her choice of journal entry and she had been using English in her entries.

As a systemic therapist, my aim is to introduce safety, promote trust, reduce distance, and enhance connection in working with people from Culturally and Linguistically Diverse (CaLD) backgrounds (whether clients, students, or supervisees). I honour their cultures of origin and primary languages, so it is usual for me to be curious about these elements and to invite them into our space. In this vein, I asked Amina: ‘I wonder what you may find when you speak to yourself in your native Swahili?’ She gave it a try and returned with the following.

I found something very interesting. I made a point of paying attention to my external and internal self-monoogue. I found that when I talked to myself in English I came across as harsh, critical, and judgmental and felt agitated, stressed, and anxious. When I spoke to myself in Swahili, my mother tongue, I sounded gentler, kinder, and felt calm, safe, and comfortable.

As Amina alternated between written and voice memo journal entries, she told me that in listening to herself, through her voice in her ‘native primary language,’ the calmness she experienced extended to her mind and body and the comfort she experienced transported her back home as if she were being comforted by her family. Amina had experienced Australia, post COVID-19, as a place of hostility, xenophobia, and racism, where individualistic undertones reverberated, and empathy towards ‘difference’ had been lost. It was as if speaking Swahili transported her to a place of care, calm, nurture, collectivism... ‘reminding her of ‘home.’ Language switching allowed Amina to transport herself back to Kenya, to her culture, her village, and her family where she could connect with her collective and cultural-ecological roots, to a different time and place. In doing so, she could access a different part of herself and share that with herself, as well as with me (Bager-Charleson, Dewaele, Costa, & Kasap, 2017). Amina also shared that when speaking in Swahili she felt more
connected to her culture, and also felt more genuine and empowered to be ‘herself’ through all the layers; yet when she communicated in English she felt ‘fake and unauthentic’ (Dewaele & Nakano, 2013).

Amina reflected on her past relationship with a Western man and her initial concerns given their cultures were drastically different. She would wonder how she could share herself in his terms or translate what she wanted to say in an ‘Anglo’ way as what she wanted most of all was to connect with him. When she tried, she found herself overwhelmed and frustrated and, rather than connecting, she found herself withdrawing from him. She felt torn because she wanted to honour him, and in doing so, she felt she needed to be and communicate in a particular way with him. On the other hand, she recognised the importance of acknowledging herself and her culture, in keeping wholeness and authenticity and so decided to share with him information about her culture, her rituals, and her language. When she brought her culture and language into their space and their relationship, she felt more open and more intimately connected to him (Heredia & Altarriba, 2001). Amina also reported that when she connected to her culture, and expressed herself in her native Swahili, she was more likely to pay closer attention to what was going on for her, she was more fluid in her feelings, able to feel each feeling, and express the ‘rawness’ of those feelings to her partner (Dewaele & Costa, 2013). I reflected that this translates into authenticity and vulnerability and a relationship requires both these elements. We discussed how people from different cultures who may speak more than one language have an advantage of being able to connect with the self in a different language and on a different platform. This brings local primal knowledge, connecting back with the self, giving one a sense of wholeness and empowerment.

Amina told me that for the past 3 years since living in Australia, she had immersed herself in the Australian way of life. She had been communicating mostly in English and had even decided to keep the Anglo name she had been given by her Australian classmates and introduced herself as such. However, since the eruption of the pandemic, she found that when she spoke English and called herself by her adopted Anglo name, she disconnected from ‘self’ and others. With that knowledge in mind, I started to call her by her African name, which she told me she found very connecting and comforting.

Deisy: I guess your name is a symbol and linkage to your culture and Swahili is the method to get you there . . . even though you know that I’m not African, but it’s almost like when I call you by your original name, it’s almost like you’re taking me to Africa to introduce me to your culture and your people. Language is so powerful, it can bring you back or take you away, it can connect you or disconnect you from yourself and others.

Amina: That is so interesting, that reminds me of elderly people, like in the case with Italian elders who have lived in Australia for years and they may not have spoken in Italian for a while, but when they go to a nursing home, and maybe they don’t feel so happy there, they revert back to Italian and speaking their original language fluently again . . . I find that amazing . . .

I suggested that this experience took her to an earlier time, a happier, more comforting, more familiar time and place. This discussion brought Amina hope that connecting with her language connected her with her culture and even though our borders are closed it is almost as though she is taking a flight back to Kenya. So
whenever she feels fearful, excluded, or alone, by talking to herself in Swahili she can take herself back to Kenya and her loved ones whenever she needs to.

With all that is currently happening in our world with the pandemic, including in Australia, with death, fear of imminent threat to our physical health due to infection, loss of livelihoods, and threat to our mental health due to border closures and sudden lockdowns, the feeling of being cut off from the world is profound, and so is the feeling of separation and disconnection. Living like this for extended periods of time without our mental health and our relationships being impacted is not realistic. Our basic need is to be together as a human collective; our very survival is determined by social and tactile connection.

Practice Applications
Drawing on the above reflections and case studies, the following applications to practice come to mind:

- It is important to apply a respectful, curious, and creative approach in developing pathways to reach people and use our ‘selves’ as agents of connection and instruments to elicit positive change.
- Stay open to exploring and applying a cultural approach that transcends cultural borders through being responsive and culturally sensitive to the diverse needs of clients.
- Recognise that a cultural language may constitute a safe haven, a place of solace in the COVID storm.
- The education and training of therapists needs to incorporate more cultural awareness, sensitivity, curiosity, and respect.

Conclusion
The pandemic narrative is still unfolding, with countless chapters encompassing twists and turns, and certainly the collective epilogue is still to be written. It has precipitated monumental changes in society at the micro, mezzo, and macro levels, principally through the virus itself, the media, and via measures to contain it. There is a collective pandemic fatigue, pointing to the worst mental health crisis in our lifetime. Core relationships, families, and communities have been frayed through separation and loss of milestones, rituals, and traditions. People are living in a ‘new normal’ of collective panic and social disruption, finding themselves forced into a prolonged survival mode and erratic coping styles, hypervigilant; their SNS switch has been flicked on and is staying on. It is vitally important to learn how to manage and cope with these unexpected changes.

Language may facilitate either a return to an earlier, happier, comforting, familiar time and place, or conversely help clients in finding a new calm, a refuge, a solace in new-found capabilities. At this pivotal time, as family and systemic therapists we again find ourselves in the central role of supporting families and communities as they collectively chart their pathway out of this dark time. We need to be open to innovative approaches, like those from the field of neuroscience, which may help us to deepen our understanding about the multilayered impact of psychological trauma on individuals, systems, and communities in working more effectively with people. We
also need to be prepared to use organic and creative means, such as our own selves, and our culture, as instruments to facilitate change.

**Note**

1 The following case studies have been amalgamated from similar cases and details have been changed to protect client privacy and identity.

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