Dr. Sonia Virani:

Hi, I'm Sonia Virani and I welcome you to Finding our Voice, Fresh Perspectives in Psychiatry, a podcast series hosted by me. This podcast has been developed with the goal to address current issues as they pertain to psychiatry, with a special focus on including the viewpoints and opinions of younger groups, resident fellow members, and early career psychiatrists. Thank you for joining me as we continue our discussions on this segment of the podcast series about structural racism that affects patients and psychiatrists from minority and underrepresented ethnic groups. Today's episode will be focused on Asian Americans, and it is my absolute pleasure to bring to this platform as a guest, my mentor, Dr. Francis Lou, who is Emeritus Kim professor in cultural psychiatry at the University of California in Davis.

In 2020, Dr. Lou received the Lifetime Achievement Award from the Society of Study of Psychiatry and Culture. Welcome, Dr. Lou.

Dr. Francis Lou:

Thank you very much. I very much appreciate the opportunity to speak with all of you today.

Dr. Sonia Virani:

Thanks, Dr. Lou. And we also have with us Dr. Connie Chen, a PGY2 resident at the San Mateo County Behavioral Health and Recovery Services. Welcome Dr. Chen.

Dr. Connie Chen:

Thank you for having me, Dr. Virani. I just want to mention my views don't represent San Mateo County and I'm very glad to be here. Thank you.

Dr. Sonia Virani:

Thanks very much. There has been a dramatic upsurge in violence against Asian Americans over the last year, especially notable since the last month since 84-year-old San Francisco resident, Vicha Ratanapakdee, was pushed to the ground and killed. My colleague in the Addiction Psychiatry Fellowship Program at Yale University is also here with us today. Welcome, Dr. Peter Na. I'm so happy you're here with us.

Dr. Peter Na:

Thank you so much for having me, Sonia. It's a pleasure to be here.

Dr. Sonia Virani:

Peter grew up in Korea and then immigrated to the US very young. I'll let him tell you about his story of immigration to America.

Dr. Peter Na:

Yeah, so I think I'm a unique case. I was born here in the US in Atlanta, Georgia. And then went back to South Korea when I was six years old, and then received all my formal education there and then reimmigrated as an immigrant. So I am a citizen, but I kind of view myself as a more close to a first generation immigrant to the United States.

Dr. Sonia Virani:

I want to tell you all that peter recently published a very interesting piece in the psychiatric news in which he writes, "The Asian Pacific Policy and Planning Council has reported nearly 3,800 incidents of anti-Asian harassment, including verbal slurs, physical assaults being coughed at, spat upon or vandalism since March, 2020. Twice as many Asian women have reported victimization than men and one of eight incidents has involved adults 60 years or older. The most disturbing incident of them all occurred on March 16th with the mass shootings at three massage parlors in Atlanta, resulting in the deaths of eight innocent lives, six of whom were women of Asian descent. This tragic event sparked outcries from various Asian-American and Pacific Islander communities, some of whom reflected on their own immigration history while others responded with fear and outrage for the violent crimes which were primarily against working class Asian women."

I want to turn it over to Peter to walk us through the long history of prejudice against Asian Americans and Pacific Islander. Peter.

Dr. Peter Na:

Thank you, Sonia. So as we all are aware, there has been racist rhetoric used in politics, especially last year, which may be superficially based on the fact that the origin of COVID-19 is from China. But the authors and I think that underneath the recent rise of racial discrimination against AAPIs is based on more deep-rooted xenophobia in our society. So I think it's really important to understand the history of xenophobia against AAPIs in the US to actually decipher the root cause of the recent events that has been magnifying racial tensions.

So from the 1850s, Chinese contract workers were thought to pose economic and moral threats to Americans, which led to the Chinese Exclusion Act in 1882 that actually restricted their immigration. And the lesser known Page Act in 1875 actually prohibited the entry of Chinese women who intended to immigrate for, quote-unquote, lewd and immoral purposes. So we think these early examples of legal parameters actually perpetuated the Asian stereotypes. So as we're pretty much aware that there are hypersexualized views on AAPI women and that has been culturally widespread since the 19th century, and we can see that by the trends of pornography. They have a whole industry on it, sex industry, and also mail order brides. So understanding this historical background I think is really important to decipher the roots of what's been going on recently.

Dr. Sonia Virani:

Thank you very much, Peter, for taking us through that history. You bring up a really interesting and important point. Thanks so much.

And now obviously with COVID-19, the limelight we all know has been cast on Asians. And I feel like this group is just clearly identifiable for reasons of their physical appearance or other things that Peter has just mentioned. East Asians have been singled out, blamed and scapegoated for the pandemic since President Trump and others called COVID-19, the China Virus. Even Jeremy Lynn was recently called Coronavirus on an NBA court and has experienced racist taunts throughout his basketball career. Now, COVID related stress has increased, of course as the pandemic goes into its second year, but racism and racial justice issues and COVID have literally also been called twin pandemics, or even the syndemic, as issues of health, racism and poverty are just interwoven. According to me at least, and according to a bunch of different people who research this topic.

Moreover, Asian Americans are tagged with the model minority myth. Something I want to just briefly mention. This model minority myth presumes that somehow better minorities bootstrap their way into financial success and just don't complain about racism or injustice. So keeping this at the back of your mind, I want us to proceed to conversations with Dr. Lou and Dr. Chen. But while I do also want to say

that it is extremely disheartening to just watch how things have devolved since the outbreak of the virus in Wuhan and how civil and political unrest has been the culmination of a worldwide crisis. Let me now turn it over to Dr. Chen, who will tell us about the experience of a South Asian resident in her program. Dr. Chen, over to you.

Dr. Connie Chen:

Thanks Dr. Virani. I'm so grateful to Dr. Na for sharing that case, for sharing that information about the history of xenophobia in the US. And just to bring it over to how xenophobic racist incidents can happen in the hospital. I have this case that comes from an experience in medical school that while I was rotating on the consult psychiatry service during my psychiatry rotation as a med student, I had a senior resident, his name is Peram. He's a South Asian American man, was in his early thirties at the time, very soft spoken and polite. He wore a turban and on the consult service, he was on call overnight by himself and was asked to evaluate a patient who happened to be a middle-aged white man with bipolar disorder in the ed. And so Peram goes down to the ED to see the patient and introduces himself.

And the patient's first responses is kind of like, "Where are you from?" And Peram says he's from Delaware, which is where he was born and raised, and the patient persists and responds, "Where are you really from and where are your parents from?" And then before long, it escalates to the patient getting out of the gurney and starting to yell and posture at Peram and say things like, "You're just a dirty terrorist. I don't talk to Muslim doctors and they can't be trusted."

And it's making quite a scene. And Peram the resident feels like he can't complete this interview. And so he kind of goes back to the call room by himself on overnight call. And then we hear about the case the next morning during rounds as we're going through all the patients who were new from overnight in a conference room with the attending and the other residents and medical students around the table.

And we hear about Peram's experience and how upsetting it is. And as far as the response, so first of all, the consult attending is the first to speak, and she makes a point to emphasize that the patient's behavior is unacceptable and sets aside time during rounds to debrief. And other residents join in, share about their own experiences and how stressful and terrible it is that Peram had to go through this. And one resident who happens to see a white woman even offered to see the patient instead and complete the evaluation. And when she goes to see the patient, she also explains clearly to him that the earlier behavior and the language that was used was inappropriate.

Dr. Sonia Virani:

Yeah. Thank you Dr. Chen for that narrative. And inwardly, as I briefly chuckled at the very familiar concept of the quintessential turban and classically mistaking everyone that wears it as being Muslim, I know that that's really not something to be chuckled at or taken lightly. But at any rate, I think we recognize that this is extremely rude and disrespectful, but it was also nice and heartening on the other end to see that co-residents spoke up in support of Peram, right? And articulated the problem instead of trying to just diffuse the situation. Now, Dr. Chen, I know that you were just a witness to this incident and news travels fast within residency programs because we are such a tight-knit group when we're training. But how did you feel when your colleagues first told you about this?

Dr. Connie Chen:

Yeah, so during those rounds, as part of that team that was hearing about this the morning after, I felt really encouraged by the team's showed support for the residents. And I think Peram in this case really took a risk to share an experience that was painful and vulnerable. And kind of connecting back to what

Dr. Na shared, I think the Asian experience so often is one of being invalidated or being misunderstood. One moment being a model minority and the next moment being blamed for the "kung flu".

And so often it's hard to speak up and feel that you'll be heard and understood. And I was just really glad that he felt comfortable enough to do that and that the team received it and provided a space for him to feel heard and that even action was taken. It wasn't just brushed over or chalked up to the disinhibited patients that we see in psychiatry or intoxicated patients, which is part of our work. But even so, words that are said can really affect us. And reflecting on this case now, it really connects to me to the concept of racial trauma as well. The idea that the accumulation of years of racial, micro and macroaggressions that people of color experience on a day-to-day basis can become a stressful burden over time. And the team here, and we as team members when we give a show of support, we can help alleviate that burden.

Dr. Sonia Virani:

Yeah, thank you Dr. Chen. I think it is incredibly helpful to see that some residency programs are particularly mindful about this aspect of racial trauma and they stand up solidly in support of somebody that might microaggressions from patients, et cetera, as Peram did. I believe that Dr. Lou at one point had discussed with me about patient provider relationships, especially as it pertained to DSM-5's cultural formulation interview and there's some guidance offered there. So I'd just like to ask Dr. Lou about this party of the DSM cultural formulation interview. Dr. Lou.

Dr. Francis Lou:

Yes, in the DSM-4, there was included an outline for cultural formulation. However, since it appears in appendix I, hardly anybody knew about it. But this was a clinical tool that clinicians could use to bring in the cultural issues, to understand the cultural issues. And fortunately, this tool was revised slightly and included in the DSM-5 in section three entitled Cultural Formulation. And it starts on page 749 of the DSM-5, and it asks the clinician to gather four fields of interrelated information. And then the fifth part of the outline is kind of the call to action. So those four parts are the cultural identity of the individual of the patient. Secondly, the cultural conceptualizations of distress. Third are the cultural stressors and the cultural features of vulnerability and resilience. The fourth part are the cultural features of the relationship between the individual and the clinician. That's what I'm going to come back to in a moment. And then the last part is summarize all of the above information to help you with your differential diagnosis and your treatment planning.

So on this fourth part of the outline, it's really very important really for the clinician to understand their own cultural identity and then to compare and contrast that with the patients. And to really understand that there are cultural elements of the relationship that affects the therapeutic alliance. And it's very important to recognize this when issues come up such as described by Dr. Chen. And I just would like to read it to you here because there were some very important elements that were added in the DSM-5 version. "Identified differences in culture, language, and social status between the individual and the clinician that may cause difficulties in communication and may influence diagnosis and treatment."

Now, this is what's added, "Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter."

So this document acknowledges the importance of understanding the larger social context in which we live that can affect our relationship with our patients. Thank you.

Dr. Sonia Virani:

Thank you so much, Dr. Lou. That is very valuable information. And tying it back into DSM-5's cultural formulation interview is obviously lending us a different perspective because it gives us guidance in something that's available to us already. And it will be helpful to at least keep this at the back of our minds. So, thank you Dr. Lou.

Dr. Chen, do you remember that article you were telling me about that provides useful guidance on this topic, also? The one that was authored by Dr. Williams and Dr. Rohrbaugh at Yale.

Dr. Connie Chen:

Yeah. Yeah, I'd be glad to share about that. So this was a commentary article in the journal Academic Medicine published in August, 2019, authored by J. Corey Williams and Robert Rohrbaugh from the Yale Department of Psychiatry. And it really provides some concrete recommendations and kind of lays out how they recommend trainees, staff, and institutions should respond to incidents of racist verbal abuse directed at providers by patients. And kind of the central point is that whether or not a patient is intoxicated or suffering from mental illness, racialized verbal abuse towards providers can still be really impactful to those providers who are exposed to it. As such, they recommend categorizing incidents of race-based verbal violence with the term verbal assault, verbal assault to reflect the gravity and impact of these events. And in addition, they recommended consistent routine approach to responding to such incidents. Just as when there is an incident of physical assault in psychiatric settings, it's taken very seriously and there's a whole cascade of events in the institution that are activated.

They argue that race based verbal violence should be treated similarly. And so immediately from the unit, they recommend that trainees, faculty and staff, basically anyone around when the incident occurs, should acknowledge the hate speech as a verbal assault or violent incident. And staff should be trained in communication scripts to use in real time to set firm limits with patients against the use of hate speech. And I think it's great that they talk about limit setting, and this is often a technique that we use in psychiatry to be therapeutic. And here they recommend saying something as simple as, "We don't use language like that in our hospital. And in order to provide you the best care because our teams are made up of providers from diverse backgrounds, you cannot use that language."

And then they recommend after the incident that there's a response from the unit to provide a community debriefing, some kind of meeting with everyone on the unit to provide support to those affected and to come up with an action plan. For example, submitting an incident report, providing the option to the provider to have backup coverage for that case or to transfer care if needed. And then on an institutional level, they recommend a post-incident response involving establishing mechanisms to track these incidents and then to develop interventions to support staff and hopefully reduce the frequency of these incidents over time.

Dr. Sonia Virani:

Thank you, Dr. Chen and Dr. Lou. Those are some very useful resources, and while I'm so glad that that kind of stuff is out there, it's also super sad that it's come to the point that we need to develop resources to offer specific guidance on this language cannot be used, hate speech is just not going to be tolerated, et cetera, et cetera.

Anyhow, let's proceed to the next story about Tommy, a Chinese American patient who was managed by Dr. Chen. Would you like to tell us about it, Dr. Chen?

Dr. Connie Chen:

So this is a case from clinic, a patient that I'll call Tommy. So he's a 24-year-old Chinese American man who comes to the clinic for treatment of depression and anxiety. And he's assigned to me for an intake

after he requests an Asian provider. A little more about Tommy, he's the oldest of three, and his parents immigrated from China and own a Chinese restaurant in town. As I get to know him more, I start hearing a lot about his mom. His mother's name is June, and he shares that when he was growing up, June was frequently ill suffering from body aches, fatigue and headaches, and sometimes would be in bed for weeks at a time because of these symptoms. And Tommy and his siblings often helped out in the restaurant when she wasn't feeling well. Another key aspect was that June only spoke Mandarin, and so a big part of his childhood was kind of interpreting for her, including at her primary care appointments starting from a young age. In the clinic, most of the providers that June saw were white consistent with the demographics of the town, and there were no Chinese-speaking doctors at the clinic.

And Tommy, for his part, doesn't remember if an interpreter was ever offered. And then after high school, fast forwarding a bit, Tommy moved a few hours away from home to attend college, but early in his sophomore year, June became increasingly ill and Tommy took a leave of absence from college to help take care of her at home. And so he moves home, but then soon after, June actually has a pretty serious suicide attempt and she's hospitalized psychiatrically. The event is pretty shocking to the whole family. And then during her inpatient psychiatric admission, June is diagnosed with major depressive disorder and started on an SSRI. And she ends up having a really good response to treatment.

Dr. Sonia Virani:

Thank you so much Dr. Chen, for sharing the story of Tommy and his mother June. And while you point out in many different ways, just the gaps in access to services, especially for Asian Americans on multiple levels, not just the availability of providers, but about language barriers, about cultural competencies, et cetera, I still am happy to see that there was a positive outcome for the case, so that was a little encouraging. But I'm curious, whatever happened to Tommy? Did you ever get his take on the whole experience?

Dr. Connie Chen:

Yeah, so Tommy, he returned to college and obviously he was really glad that his mom was doing a bit better and responded to treatment and was alive. But understandably, he was quite shaken by what happened with his mom and really felt a lot of anger that the doctors seemed to have missed making the diagnosis of major depression for 10 years until it was almost too late. And those were the words he used, that it was almost too late.

And he's kind of left wondering whether the diagnosis was missed because of the lack of interpreters trained in mental health or if her doctors maybe couldn't recognize depressive symptoms in a non-white patient. And he also feels a great sense of grief and mourning over all the struggles that he and his family went through as he was growing up, basically spending a lot of his childhood caring for her in part because of inadequate mental health care. And he states that actually he is requesting an Asian provider at the clinic because he felt it would be easier to trust them.

Dr. Sonia Virani:

Yeah, indeed. That's very illuminating, that perspective. Now, I know we've discussed this on previous episode of this seven episode podcast series about how implicit bias is also very much reflected on the patient's side because they almost seem to find it easier to communicate with and trust providers, now that you bring up trust, Dr. Chen, because they share commonalities in their race and ethnicity. What do you think about this?

Dr. Connie Chen:

Yeah, in this case, Tommy expresses a preference for an Asian provider, and I can certainly understand where he's coming from. His mom, June, she'd been followed for 10 years by providers who maybe didn't understand or didn't have the training to appreciate possible cultural aspects of June's symptoms. And the diagnosis was missed until it was almost too late, as he puts it. And this concept of it was almost too late, it really turns out to be born out by the epidemiological research on Asian Americans and mental health issues. And in particular, I want to point out a study in psychiatric services in 2013 by Sentell and colleagues at the University of Hawaii. And I looked at all the inpatient psych hospitalizations in Hawaii from 2006 to 2010, and Hawaii has a very large Asian American and Pacific Islander population, I think over 50%. So they had a sample size of over 300,000 hospitalizations.

And they found that Asians and native Hawaiians were less likely than whites to be hospitalized, but those who were hospitalized, the Asians and native Hawaiians had significantly greater mental illness severity and significantly longer hospital stays than whites. And the authors posit this could be because of stigma or lack of access to mental healthcare or under diagnosis in Asian communities. And I think it's striking that this epidemiological data maps onto June's story really quite well. We have a Chinese American woman whose symptoms went unrecognized year after year who was seen in primary care but not specialty mental health. And when she does finally receive a diagnosis and specialty mental health care, it comes in the form of inpatient hospitalization, so the highest level of care for the most severe symptoms. And her depressive symptoms are very severe. Enough that she has had a suicide attempt.

Dr. Sonia Virani:

Yeah, indeed. Dr. Chen, this is testament to the fact that Asian Americans are known to seek care only when the problem has gotten real serious. Dr. Lou, what do you think about these trust issues, especially because the patient requested for an Asian provider and sometimes there may not be the capacity to match the patient for their request. What do you think?

Dr. Francis Lou:

Yes. Well, I think that it's very important, first of all to empathize with the patient's perspective so that the patient feels respected and understood, and to try as... to make your own assessment as to what extent that cultural identity match is critical. So in the situation where the person has limited English proficiency and the provider can only speak English, there we have a cultural identity difference. Going back to the point I made earlier about understanding the cultural elements of the relationship between the clinician and the patient, language is a very important one for obvious reasons. And this was added in the DSM-5, an explicit mention of language and communication. I think that this is as much as possible, we should try to have a cultural identity match in terms of language. So because we just know how important that is in the assessment and treatment process. Now, if that's not possible because the system doesn't quite have those resources, then we just need to try our best in terms of working with, may perhaps, through another clinician who speaks that language. But ultimately, this brings up systems issues around the need for interpreters. And perhaps we could get into that towards the end of our conversation.

Dr. Sonia Virani:

Yeah, thank you Dr. Lu. I was just thinking about the study I did in residency about the challenges that our patients on the inpatient psychiatric unit, Asian patients face, because I think we had just one provider who was a social worker who spoke Mandarin and Cantonese, and obviously language barriers came up and the need for interpreters came up as the one glaring gap in access to services. Dr. Chen,

what about Asian patients wanting Asian providers and that assumption? What do you think about that judgment and that preference that patients might express?

Dr. Connie Chen:

Yeah, it is a preference that can be expressed. But at the same time, one can assume that every Asian patient wants an Asian provider. Some might actually prefer a provider from a different ethnic group, perhaps due to fear of being judged by someone from their own community. Or, for example, if I live in a small community and I know a lot of other, say, Chinese community members in my town, I might not want a Chinese provider myself due to issues of privacy or stigma. So you never know until you ask.

Dr. Sonia Virani:

Yeah. You bring up a really interesting corollary point of thought with pointing out that sometimes that might not even be the most obvious preference if you look at it from the opposite angle. Dr. Lou, do you remember you were telling me about the cultural and linguistically appropriate standards, the class? Would you like to shed some light on that about professional interpreters since we just talked about it?

Dr. Francis Lou:

Yes. I think this is a very important point, is that when we speak about cultural competence, there is individual clinician cultural competence such as by employing the outline for cultural formulation and the cultural formulation interview as two tools to do that. But there's also another level of cultural competence that listeners should be aware of, and that's the National CLAS Standards, C-L-A-S, it's an acronym for Culturally and Linguistically Appropriate Service Standards. And this was initially put out by the Office of Minority Health in 2001, and it was enhanced and updated in 2013. And these standards are addressed two systems of healthcare and have health organizations and healthcare organizations. And you can access material about this at a website, which is thinkculturalhealth.hhs.gov. Or if you just Google ThinkCulturalHealth, all one word, you'll come to it. There is a beautiful e-learning program for behavioral health professionals about these standards.

There are 15 standards, and four of them specifically are about communication and language assistance. And I'll just summarize them. The first one says, "Offer language assistance to individuals who have limited English proficiency at no cost to them to facilitate timely access to all healthcare and services. Next is to inform all individuals of the availability of these language assisted services. The third one here is ensure the competence of individuals providing language assistance and recognizing that the use of untrained individuals and or minors as interpreters should be avoided. And then lastly is to provide easy to understand print and multimedia materials and signage for languages commonly used by the populations in the service area. So these standards clearly are out there and it would be wonderful for people to utilize these standards and help the organizations that they're working in to achieve them. Thank you.

Dr. Sonia Virani:

Thank you, Dr. Lou. For all my listeners who are not aware, Dr. Lou is just a wealth and a repository of different kinds of resources on so many topics as we talk of cultural psychiatry. So thank you very much again for a very valuable resource that you shared with us. Dr. Chen, about the topic of interpreters, how would you want to tie it back to Tommy and June's case, especially because interpreters bring to light a real translation of what the patient's symptoms actually are. There's also room for misinterpretation if an interpreter obviously isn't you. So what do you think about that?

Dr. Connie Chen:

Yeah, this topic of interpretation definitely also connects back to the case and kind of presenting symptoms for mental disorders and different cultures. In other words, June's symptoms of fatigue and body aches and headaches needed interpretation not only from Mandarin into English words, but also in terms of cultural meaning. And there's evidence suggesting that monolingual Chinese immigrants with depression, which June is, may endorse prominence somatic symptoms as opposed to cognitive symptoms of depression just like June did. And I think referencing back to the DSM-5 cultural formulation, I think there's actually a cultural syndrome in the DSM-5 [inaudible 00:38:17] which maps onto the symptoms that June described. And it's not possible to be an expert about psychiatric symptoms and every different culture, and moreover, cultures are heterogeneous. Not everyone from the same culture presents the same way, but that's why we have all of these wonderful resources that Dr. Lou is sharing about and has dedicated his career to building that we can use and bring into our practice.

Dr. Francis Lou:

Yes, I'd like to chime in here. Dr. Chen mentioned the culture, a cultural concept of distress, [inaudible 00:39:05], which is in the DSM-5 in the appendix. It's called the glossary of cultural concepts of distress, where you'll find nine examples with descriptions of these cultural concepts of distress. I think they illustrate exactly the point here, and I just wanted to also mention that very important in the DSM-5 for some of the disorders, there is a culture related diagnostic issues section and a gender related diagnostic issues section. In the narrative descriptions of those disorders, you can find an index in the back of DSM-5. And as some of you may know, the APA is working on a DSM-5 text revision to update the text of DSM-5, including these culture related and gender related diagnostic issues sections. And this text should be coming out within the next year. And so this will really update information that I would really highly recommend that everybody take a look at.

Dr. Sonia Virani:

Thank you so much, Dr. Lou, for giving us that heads up about what's coming out with the text revision of the DSM-5. Guys, take note of this and maybe try to incorporate a little bit of that into your daily practice as cultural competency becomes more at the forefront of our clinical practice. So with that, we come to the end of our fifth episode of Finding our Voice. My deepest gratitude to our guests on this fifth episode. Dr. Lou and Dr. Chen, we're so thankful for your time, the stories you've discussed and the insights you provided. We really enjoyed learning from you about your various experiences as Asian American providers.

Dr. Connie Chen:

Thank you so much for having us, Dr. Virani.

Dr. Francis Lou:

Thank you very much.

Dr. Sonia Virani:

Thank you. If you take away nothing from this podcast, but the idea that the experiences we share with you are leading you to discovery and individual and collective identity within psychiatry and within society, I will have accomplished a great deal. I'd like to leave you with one final thought, life is offered to us as a means of self-expression, and the highest form of this expression is through acts of kindness. I

hope that we will always remember this in all our interactions with people going forward. Ill see you again soon with more guests and more stories. Until then, take care and be well.

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Speaker 6:

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