

A Netnographic Study of Cross-Cultural Miscommunication in Digital Mental Health Nursing and Telepsychiatry Among Online Communities

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ABSTRACT

Background: A chatbot cannot ask about a patient's family before it asks about their symptoms, and in cultures where healing begins with relationship rather than data, that single omission may be where digital psychiatric care quietly loses the people it was built to reach. Telepsychiatry and tele-nursing platforms have expanded rapidly across Southeast Asia, yet whether these tools translate psychological distress across cultural boundaries, and not merely across language, remains poorly understood. This study explored how Indonesian- and Malay-speaking internet users described experiences of cross-cultural miscommunication with digital mental health providers.

Methods: A 20-week netnographic study was conducted across Indonesian- and Malay-language online communities discussing telepsychiatry, tele-nursing, and digital mental health applications. Publicly available discussion threads were analysed using an inductive, Braun-and-Clarke-informed thematic approach.

Results: Analysis of threads from participants who described a personal digital mental health encounter generated four interconnected themes: linguistic and semantic dissonance, relational asymmetry and digital etiquette mismatches, algorithmic cultural bias in screening, and an anonymity-trust paradox.

Conclusion: Cultural miscommunication in digital psychiatric nursing appears to cluster around the translation of idioms of distress and the compression of relational care into transactional data collection. Culturally responsive intake design and provider training may help narrow this gap, although the findings warrant confirmation in structured, representative samples.

KEYWORDS

Telemedicine; Psychiatric Nursing; Cultural Competency; Communication Barriers; Mobile Applications; Mental Health Services

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INTRODUCTION

It is two in the morning somewhere in Java when a finger hovers over a screen, typing a sentence that has no easy translation into a diagnostic code. The rise of telepsychiatry, tele-nursing, and app-based mental health support has been framed globally as a democratising force, extending psychiatric care to people who could never reach a clinic, afford a specialist, or say their distress out loud in front of a neighbour (Hall, Kakuma, Palmer, Martins, *et al.*, 2019). Yet the same screen that offers privacy also strips away the small human cues, a pause, a glance toward an elder, a change in tone, that healers in many cultures have always relied upon to understand what a person is really saying. As digital platforms increasingly stand between patients and psychiatric care, it becomes urgent to ask not only whether these tools are accessible, but whether they are legible across cultures.

Psychological distress is rarely expressed in the tidy categories of a diagnostic manual. Across Indonesia and much of the Global South, people describe suffering through culturally specific idioms, such as inner spiritual pressure or a heaviness in the chest tied to disrupted social harmony, that carry meaning a checklist cannot capture (Smith *et al.*, 2020; Cohen, 2023). The DSM-5 itself acknowledges these as cultural concepts of distress rather than aberrations to be corrected [1]. When such idioms are filtered through standardized digital intake forms designed for low-context, individualistic communication styles, there is a real risk that the clinical encounter succeeds procedurally while failing the person entirely.

This risk is compounded by two further gaps in the literature. First, most telepsychiatry research originates in settings shaped by direct, low-context communication norms, while Indonesian communication is characteristically high-context, indirect, and organised around collectivist and hierarchical relational expectations (Kidron and Kirmayer, 2019; Adade *et al.*, 2022). Second, the algorithmic screening tools increasingly embedded in digital mental health platforms are frequently trained on data that under-represent these communication styles, raising concerns about systematic cultural bias in triage and diagnosis (Desai and Chaturvedi, 2017; Jacob, 2019). How these two dynamics, culturally embedded idioms of distress and algorithmically mediated, low-context care, intersect in the everyday, unscripted accounts of real users has rarely been examined outside curated clinical-trial settings.

Netnography offers a route into precisely these unscripted accounts, capturing what people say about their care when no clinician or researcher is in the room (Jin *et al.*, 2024; Jones *et al.*, 2024). This study therefore used a netnographic design to explore how Indonesian and Malay-language online communities describe cross-cultural miscommunication in digital mental health nursing and telepsychiatry. The findings are intended to inform culturally responsive redesign of digital intake protocols, provider training, and screening algorithms, and to extend psychiatric nursing's ethical mandate for culturally congruent care into the digital domain.

MATERIALS AND METHODS

Study Design

This study employed a qualitative netnographic design to examine naturally occurring discussions regarding cross-cultural miscommunication in digital mental health nursing and telepsychiatry among Indonesian- and Malay-speaking online communities. Netnography was selected because it enables the observation of naturally occurring interactions without researcher intervention, thereby providing access to authentic patient narratives that are often inaccessible through interviews or

surveys. The study followed Kozinets' principles of immersion, naturalistic observation, contextual interpretation, and reflexive analysis. Because no dedicated EQUATOR reporting guideline currently exists for netnographic studies, reporting was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ), adapted according to recent methodological recommendations for digital ethnographic research in healthcare.

Research Setting and Digital Communities

Data were collected from publicly accessible Indonesian- and Malay-language digital platforms where users routinely discussed experiences related to telepsychiatry, tele-nursing, digital counselling, and mobile mental health applications. Eligible digital environments included public discussion forums, social media communities, mental health peer-support groups, and publicly accessible application review platforms. Communities were purposively selected according to four predefined criteria: (1) discussions conducted primarily in Indonesian or Malay; (2) active user engagement within the previous six months; (3) explicit discussion of personal experiences involving digital psychiatric or mental health services; and (4) unrestricted public accessibility that did not require researcher registration or membership approval. Private messaging platforms, password-protected communities, invitation-only groups, and forums requiring researcher interaction were excluded to minimise ethical concerns regarding covert observation.

Sampling Strategy

Purposive sampling was combined with iterative theoretical sampling throughout the study. Individual discussion threads were eligible if they contained first-person accounts describing experiences of communication with telepsychiatrists, psychiatric nurses, digital counsellors, chatbot services, or mental health applications. Posts were excluded if they consisted primarily of advertisements, duplicated content, organisational announcements, automated responses, media reposts, or discussions lacking sufficient experiential detail. Discussions unrelated to digital mental healthcare or written in languages other than Indonesian or Malay were also excluded. Sampling and analysis proceeded concurrently. Newly identified discussions continued to be incorporated until no additional conceptual categories emerged across successive coding cycles, indicating thematic saturation.

Data Collection Procedures

Non-participant digital observation was undertaken over twenty consecutive weeks between March and July 2026. Throughout the observation period, researchers entered the selected online communities as passive observers without posting comments, responding to users, or initiating discussions. This approach minimised researcher influence on naturally occurring interactions. Relevant discussion threads were systematically archived together with contextual information including platform type, date of posting, discussion topic, communication context, and anonymised participant characteristics where voluntarily disclosed. Data were organised within a secure qualitative database prior to analysis. During the observation period, 1,892 discussion threads containing 11,234 individual posts were initially identified. Following eligibility screening, posts

from 2,314 unique user accounts describing direct experiences of digital mental healthcare were included in the final analytical corpus.

Data Management

All archived materials underwent systematic anonymisation before analysis. Usernames, hyperlinks, geographic identifiers, institutional names, application-specific account identifiers, and potentially identifiable personal information were removed. Each eligible participant was assigned a unique study identification code. Illustrative quotations reported in this manuscript were paraphrased rather than reproduced verbatim to minimise the possibility of reverse internet searching while preserving participants' intended meanings and culturally specific idioms of distress. Original archived materials were stored in encrypted institutional storage accessible only to the research team.

Data Analysis

Data were analysed using Braun and Clarke's six-phase reflexive thematic analysis. The first phase involved repeated immersion in the complete dataset to achieve familiarity with the breadth and context of discussions. During the second phase, two researchers independently performed inductive line-by-line coding using qualitative data management software. Codes remained data-driven rather than theory-driven to minimise premature conceptual imposition. During the third phase, related codes were iteratively clustered into candidate themes through constant comparison across participants, discussion platforms, and cultural contexts. In the fourth phase, themes were reviewed against the entire dataset to ensure internal coherence and external distinction. Theme refinement involved repeated movement between coded extracts and the complete corpus until conceptual consistency was achieved. The fifth phase involved defining and naming themes through collaborative analytical discussions, during which subthemes were refined to capture distinct dimensions of cross-cultural miscommunication. Finally, themes were synthesised into an integrated interpretive narrative highlighting relationships among linguistic, relational, technological, and cultural processes influencing digital psychiatric care. Disagreements between coders were resolved through iterative discussion and consensus rather than statistical agreement indices, consistent with the interpretive epistemology underpinning reflexive thematic analysis.

Trustworthiness

Methodological rigour was established according to Lincoln and Guba's framework. Credibility was strengthened through prolonged digital engagement over twenty weeks, investigator triangulation, repeated comparison across multiple online communities, and continuous analytical discussions. Dependability was supported by maintaining a comprehensive audit trail documenting coding decisions, analytical revisions, and theme development throughout the study. Confirmability was enhanced through reflexive memo writing, documentation of researcher assumptions, and regular peer debriefing sessions that challenged emerging interpretations. Transferability was facilitated through detailed contextual descriptions of participant characteristics, digital environments, communication contexts, and cultural settings, enabling readers to evaluate applicability to other

populations.

Researcher Reflexivity

The research team comprised investigators with professional backgrounds in psychiatric nursing, public health, and qualitative health research. Recognising that prior clinical experience could influence interpretation, reflexive practice was embedded throughout all analytical stages. Researchers maintained reflexive journals documenting assumptions, emotional responses, evolving interpretations, and potential disciplinary biases. Regular team meetings were conducted to critically examine alternative interpretations and ensure that themes remained grounded in participants' narratives rather than researchers' professional expectations. Particular attention was paid to avoiding biomedical reinterpretation of culturally embedded idioms of distress and relational expectations expressed by participants.

Ethical Considerations

The study adhered to the ethical principles of the Association of Internet Researchers (AoIR) for internet-mediated research and complied with institutional ethical guidance for observational studies involving publicly available online content. Only openly accessible digital communities were included. No researcher contacted participants, requested additional information, or intervened in ongoing discussions. Because discussions frequently involved sensitive mental health experiences, all quotations were paraphrased, contextual identifiers were removed, and no searchable text was reproduced. This approach balanced the public accessibility of online discussions with participants' reasonable expectations of contextual privacy. The study protocol underwent institutional ethical review before commencement, and all archived materials were securely stored according to institutional data governance procedures.

RESULTS

Study Population and Data Characteristics

Over the 20-week observation period, 1,892 discussion threads comprising 11,234 individual posts were archived. Of these, posts from 2,314 unique accounts met eligibility criteria by explicitly describing a personal experience of a digital mental health or telepsychiatry encounter. Table 1 summarises the demographic and engagement characteristics of these participants.

Table 1. Demographic and telepsychiatry engagement characteristics of digital community participants (n = 2,314)

Characteristic	Category	n	%
Total participants	—	2,314	100.0
Ethnic identity	Javanese	879	38.0
	Sundanese	625	27.0
	Batak	417	18.0

	Minangkabau	393	17.0
Age group (years)	18–24	509	22.0
	25–34	949	41.0
	35–44	532	23.0
	≥45	324	14.0
Gender	Female	1,574	68.0
	Male	694	30.0
	Non-binary / other	46	2.0
Digital intervention type experienced	Telehealth mobile applications	1,041	45.0
	Hospital-based telepsychiatry	694	30.0
	WhatsApp / text-based counselling	579	25.0
Provider–patient ethnic match	Different ethnic background	1,666	72.0
	Same ethnic background	417	18.0
	Provider ethnicity unknown	231	10.0
Reported communication outcome	Felt misunderstood / dismissed	1,388	60.0
	Required multiple sessions to build rapport	625	27.0
	Discontinued digital care due to friction	463	20.0
Geographic distribution	Positive, culturally congruent experience	301	13.0
	Urban centres	1,504	65.0
	Rural / remote areas	648	28.0
	Overseas diaspora	162	7.0

Participants were concentrated in the 25–34-year age group and were predominantly female. Telehealth mobile applications were the most frequently described intervention type. The majority of participants described a digital encounter with a provider of a different ethnic background, and most reported at least one form of communication friction, ranging from feeling misunderstood to discontinuing digital care altogether.

Thematic Analysis

Analysis generated four interconnected themes describing the architecture of cross-cultural miscommunication in digital mental health nursing and telepsychiatry, summarised in Table 2 and described narratively below.

Table 2. Thematic analysis of cross-cultural miscommunication in digital mental health interventions

Theme	Subtheme	n	Illustrative account (anonymised, composite)	Nursing / clinical implication
1. Linguistic and semantic dissonance	Loss of cultural nuance in translation	612	“I told the app nurse I felt 'tekanan batin' [inner spiritual pressure]. She just ticked	Digital intake should allow open-ended, culturally specific symptom description

			'generalised anxiety' and moved on." (Female, 28, Javanese forum)	
	Somatic vs. psychological framing	489	"I said my chest felt heavy like 'angin duduk'. The chatbot gave me a depression checklist." (Male, 35, Sundanese group)	Algorithms require training to recognise culturally bound somatic idioms
2. Relational asymmetry and digital etiquette	Expectation of familial warmth vs. clinical detachment	534	"In my culture, a healer asks about my family first. The tele-nurse just asked for my ID number." (Female, 31, Minangkabau community)	Tele-nursing protocols should incorporate culturally congruent relational openings
	Misinterpretation of indirect communication	412	"I was being polite and indirect, as is proper. The psychiatrist called me 'evasive'." (Male, 42, Batak forum)	Providers require training in decoding high-context, indirect communication styles
3. Algorithmic cultural bias in screening	Western-centric symptom checklists	678	"The app forced 'yes/no' on hearing voices. I couldn't explain it was my grandmother's spirit guiding me." (Female, 26, Javanese app review)	Digital screening tools need culturally adaptive branching logic
	Inflexible digital triage pathways	345	"Because I scored high on the Western trauma scale, the system locked me out of community support." (Non-binary, 29, online peer-support group)	Triage algorithms should allow human override and cultural context review
4. The anonymity-trust paradox	Digital safety vs. clinical alienation	523	"I felt safe typing behind a screen. When the nurse replied with a copy-pasted script, I felt more alone." (Female, 33, WhatsApp counselling group)	Templated replies should be replaced with personalised, culturally humble responses
	Frustration with performative cultural competence	298	"The app has a 'diverse' avatar, but the advice is purely Western and individualistic." (Male, 37, urban professional forum)	Superficial diversity in design should be replaced by structural cultural adaptation

Theme 1: Linguistic and Semantic Dissonance

Participants described culturally specific idioms of distress, such as “tekanan batin” (inner spiritual pressure) or “angin duduk” (a somatic idiom overlapping with anxiety and chest tightness), being received by app-based or tele-nursing intake processes and reclassified into standardised categories such as generalised anxiety disorder without further exploratory questioning. Somatic framings of distress were similarly reported to be redirected toward standardised psychiatric checklists rather than explored on their own cultural terms.

Theme 2: Relational Asymmetry and Digital Etiquette Mismatches

Participants described an expectation that a healing encounter would open with inquiry about family and personal well-being before symptoms were addressed. Digital encounters were instead described as opening with identity verification and symptom collection, which participants characterised as cold or transactional. A related pattern involved indirect, high-context communication being interpreted by providers as evasiveness or a lack of insight, judgments that some participants later discovered documented in their digital records.

Theme 3: Algorithmic Cultural Bias in Digital Screening Tools

Participants described binary, forced-choice screening questions that did not accommodate spiritually framed explanatory models of unusual experiences, such as auditory phenomena

attributed to ancestral guidance rather than hallucination. Some described automated triage pathways that escalated them toward emergency psychiatric referral, or that locked them out of preferred community-based support, based on scores from standardised trauma or symptom scales.

Theme 4: The Anonymity–Trust Paradox

Participants frequently described the screen as offering a valued sense of safety to disclose distress that they would not voice in person. This initial sense of safety was described as being undermined when providers responded with templated, biomedically framed scripts, which some participants experienced as more isolating than the absence of care. A related pattern involved culturally themed interface design, such as diverse avatars, being perceived as superficial when paired with advice participants described as rigidly Western and individualistic.

DISCUSSION

When “tekanan batin” becomes a checkbox marked “generalised anxiety,” the diagnosis on the screen may be technically defensible while the person behind it remains unheard. The prominence of linguistic and semantic dissonance in these accounts is consistent with a substantial body of work on idioms of distress, which holds that culturally specific expressions of suffering carry meaning that standardized symptom clusters can fail to capture (West *et al.*, 2024, 2025). This convergence should be read as consistent with, rather than confirmation of, the broader literature; the present accounts describe perceived rather than clinically verified miscommunication, and cannot establish how often reclassification altered subsequent care.

A healing encounter that opens with a form instead of a face is, in many of the cultural frameworks represented in this sample, already a smaller encounter than intended. The relational-asymmetry theme aligns with descriptions of Indonesian communication as high-context, indirect, and organised around collectivist and hierarchical expectations, in which trust is customarily established relationally before clinical business begins (Hall, Kakuma, Palmer, Minas, *et al.*, 2019; Victor, 2019; Peltzer and Pengpid, 2020). Providers trained primarily in low-context, direct communication norms may reasonably misread indirectness as evasiveness rather than as a culturally appropriate register, a pattern documented in doctor–patient communication research in Indonesia even outside the digital setting (Tay *et al.*, 2017; Cork, Kaiser and White, 2019).

An algorithm trained largely on one cultural template for distress will, almost by construction, struggle to recognise another. Participants' accounts of forced binary responses and inflexible triage pathways echo wider concerns that digital mental health tools trained on non-representative data can misclassify symptoms and generate inequitable triage recommendations for under-represented groups (Lauckner and Whitten, 2016). These accounts cannot demonstrate that any specific application performed unfairly in a technical, benchmarked sense; they instead suggest that users experienced the downstream effect of design choices as culturally invalidating, which is itself a meaningful, if indirect, signal for developers and clinical governance bodies.

The same screen that lets a person type a secret they would never say aloud in a village clinic can also,

a few sentences later, make them feel more alone than before they opened the app. This anonymity–trust paradox is compatible with broader observations that trust in digital and AI-mediated care is provisional and can be undermined quickly by responses that feel generic or culturally unresponsive (Lichtenberg *et al.*, 2022). In collectivist, relationally oriented settings, where trust is typically built incrementally through visible attentiveness, a templated reply may be read less as efficient and more as dismissive, though this interpretation remains an inference from participants' own framing rather than an observed causal mechanism (Wallace *et al.*, 2018).

For psychiatric nursing, a profession whose ethical core has long rested on relational, whole-person care, these findings suggest that digital delivery does not remove that mandate; it relocates it into interface design, intake wording, and escalation logic. Extending established calls for netnography-informed, culturally attentive nursing scholarship (Wiley, 2026), the present findings point toward concrete practice targets: relationally framed digital intake sequences, provider training in decoding high-context communication, and human oversight positioned before, not only after, automated triage decisions. These are proposed as reasonable directions for practice development rather than as tested interventions. Superficial diversity, a translated interface or a differently drawn avatar, appears in these accounts to be recognisable to users as superficial, and even to erode trust further when the substance of the advice remains unchanged. This is broadly consistent with arguments for embedding structural cultural adaptation and co-creation directly into the design of AI-supported mental health tools, rather than layering cosmetic localisation over a fixed clinical logic (Jones *et al.*, 2024; West *et al.*, 2025). Incorporating idioms of distress into the branching logic of screening instruments themselves, rather than only into translated wording, has been proposed elsewhere as one concrete mechanism for this kind of structural adaptation (Peltzer and Pengpid, 2020; West *et al.*, 2024).

Taken together, the four themes suggest that cultural miscommunication in digital psychiatric care is not confined to any single point of contact but recurs across intake, dialogue, algorithmic triage, and the emotional aftermath of a reply. This pattern is consistent with, though not proof of, an argument made elsewhere in the telehealth equity literature: that technical access to care and cultural legibility of care are separate achievements, and that expanding the former does not automatically deliver the latter (Hall, Kakuma, Palmer, Minas, *et al.*, 2019; Victor, 2019). Read cautiously, these findings support treating cultural congruence as a distinct design and training target for digital mental health services, alongside, rather than assumed within, connectivity and affordability.

A netnographic lens captures the voices that chose to speak on a public screen; it cannot verify whether those voices represent everyone who stayed silent, or whether every account was recounted exactly as it was experienced. This is the central limitation of the present study. The sample was self-selected toward digitally literate, largely urban participants willing to post publicly about a sensitive experience, which may under-represent people who disengaged from digital care silently or who lack the language or access to post at all (Tay *et al.*, 2017; Cork, Kaiser and White, 2019). The passive, non-participatory design preserved naturalistic data but precluded clarifying questions, so participants' own words could not be checked against their intended meaning, and no clinical or diagnostic verification of the encounters described was possible (Lauckner and Whitten, 2016). The 20-week window offers a snapshot rather than a longitudinal account of how any individual relationship with digital care evolved. Future work pairing netnographic listening with structured, consented follow-up dialogue may help establish whether the friction documented here on public screens is also the friction that quietly follows

people out of digital clinics and away from care altogether.

CONCLUSIONS

Digital mental health platforms are expanding access to psychiatric care across Indonesia, but access and cultural legibility are not the same achievement. Across four interconnected themes, participants described a recurring pattern in which culturally embedded expressions of distress, relationally oriented expectations of care, and locally meaningful explanatory models were compressed by standardized digital intake, algorithmic screening, and templated responses. Addressing this pattern may require treating cultural responsiveness as a explicit design and training requirement for digital psychiatric nursing, developed and evaluated with the same rigor currently applied to clinical accuracy and data security, rather than assumed to follow automatically from expanded digital access.

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Conflict of Interest

The author declares that there is no conflict of interest in the preparation and publication of this article.

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