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Healing from War and Trauma: Southeast Asians in the U.S.

A Buddhist Perspective and the Harvard Program in Refugee Trauma

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Abstract: This paper is the written counterpart to a presentation given in Ha Noi, Vietnam, May 15, 2008 during the United Nations Day of Vesak 2008 Convention, on the effects of war and healing. The paper introduces the work of the Harvard Program in Refugee Trauma (HPRT) located in Boston, Massachusetts. It describes the HPRT Global Mission of education and capacity building of health care professionals, international relief workers and policy makers in the area of mental health in nations suffering post-conflict and disaster recovery. In particular the paper discusses the HPRT's unique approach to assisting individuals with severe traumatic histories as seen through the lens of the author's work as a psychopharmacologist with Southeast Asians and a team member of the HPRT in Lynn, Massachusetts, through the Lynn Community Health Center (LCHC). LCHC is a multi-disciplinary outpatient health service clinic located north of Boston, Massachusetts. Many patients who have survived genocide, torture, imprisonment, and war suffer from chronic Post Traumatic Stress Disorder (PTSD) with the sequelae of depression, nightmares, inability to work gainfully, and panic anxiety. Two stories of actual patients (their identifying data protected) are presented to illustrate self-healing and the role of mindfulness, the function of memory in storytelling and recovery, and the value of spirituality, work and altruism in healing.

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THE HARVARD PROGRAM IN REFUGEE TRAUMA

The Harvard Program in Refugee Trauma (HPRT) is located in Cambridge, Lynn, and Lowell Massachusetts, and is part of the Massachusetts General Hospital and Harvard Medical School. The HPRT was founded in 1981, originally as the Indo-Chinese Psychiatry Clinic in Boston by Richard Mollica, MD, a student of the Ven. Thich Nhat Hanh since the 1970s, and Mr. James Lavelle, LICSW.

The HPRT, in collaboration with others, has pioneered the field of mental health care of populations affected by mass violence and natural disasters. Countries the HPRT has been invited to assist include Cambodia, Vietnam, Iraq, Iran, Rwanda, Uganda, Peru, Bosnia, Afghanistan, and Chile (HPRT, Retrieved on April 6, 2008 from <http://www.hpert-cambridge.org/>).

In December 2004, the HPRT and the Istituto Superiore di Sanita (ISS) in Italy created a first time global forum with over 50 Ministers of Health from the world's post-conflict nations along with collaborators from Caritas Rome, Fulbright New Century Scholars Program and the World Bank. The forum, *Project 1 Billion: International Congress of Ministers of Health for Mental Health and Post-Conflict Recovery*, endorsed a science-based, culturally effective and sustainable training project on an international level called the *Mental Health Action Plan* and *Book of Best Practices* for post-conflict recovery.

Project 1 Billion revealed the great need for the education and capacity building of health care professionals, international relief workers and policy makers in the area of mental health in post-conflict and disaster recovery. Toward that end the HPRT and ISS now offer the *Mastery in Global Mental Health Certificate Program*. The program covers a six part framework for Mental Health Recovery that form the core foci

related to society-wide recovery from disaster, war, or genocide (Mollica & McDonald, 2003). The six foci are: 1. Policy/Legislation; 2. Financing; 3. Science-based Mental Health Services, 4. Multi-Disciplinary Education; 5. the Role of International Agencies; and 6. Linkage to Economic Development and Human Rights.

SCIENCE-BASED MENTAL HEALTH SERVICES

The focus of this paper is the third area of Recovery noted above, Science-based Mental Health Services, specific to the Southeast Asian patients. This particular population are treated by the author as part of the HPRT in Lynn, Massachusetts, through the Lynn Community Health Center (LCHC). LCHC is a multi-disciplinary outpatient health service clinic located north of Boston, Massachusetts.

The author is an adult psychiatric mental health (APMHNP) and family nurse practitioner (FNP) and is employed by the LCHC and the HPRT as a member of an inter-disciplinary team (MD, NP, MH worker). The team provides an approach that integrates traditional allopathic western medicine (diagnosing/prescribing) in a setting that respects the patient's spirituality, religion, and culture. The team approach utilizes modalities of acupuncture, mindfulness, and tai chi, chi gong; and employs group work which appreciates the persistence of hardship and dislocation that attends much of the immigrant experience.

The elements of recovery at the patient level include three interpenetrating themes:

1. The Power for Self Healing: The energy of mindfulness and interbeing;
2. Storytelling as Healing: Understanding the power of Memory and the role of Ritual and Altruism;

3. Respect for the importance of Spirituality, Work, and Altruism in healing.

THE POWER OF SELF HEALING

The body has its own force for self-healing. Like the immune system's white-blood cells' ability to contain foreign antigens that cause disease, the healing of emotional wounds occurs in a natural psychobio-spiritual immune system of its own (Mollica, 2006). The mind-body is powerfully fused and immediately sets into action when trauma occurs. This gives rise to remarkable resiliency.

The body's initial response to trauma is commonly known as the "fight or flight" response, mobilizing cortisol, a hormone that increases arousal, attention, memory and learning. Some trauma is so disturbing, however, that the cortisol stress response, located in the feedback loop of the hypothalamus-pituitary-adrenal (HPA) axis, does not shut off. In these people undue levels of cortisol and other normally protective stress hormones stop their protective role and begin to usher in disease: hypertension, heart disease and diabetes, depression and anxiety. Reducing the prolonged stress response becomes critical to avoiding disease and promoting healing. (Ironson, Solomon, Balvin et al., 2002; Mollica, Lopes-Cardoza, Ostofsky et al., 2004).

Mindfulness-type practices, known as Mindfulness-Based Stress Reduction (MBSR), and the Relaxation Response (RR) traditionally taken from Vipassana Buddhist practices, have been widely studied for the past 30 years as methods for reducing stress (Kabat-Zinn, 1990; Benson 1975). The practice of engendering mindfulness has been shown to dramatically alter the stress-response of the body and assist in regulating the emotional centers of the brain and may powerfully contribute to the healing resolution of traumatic memories [i.e., reducing over-production of cortisol;

increasing the thickness of the cortex regulating emotion; and increasing nitric oxide production that enhances oxygen consumption and avoid the hypothalamic-pituitary stress response] (Benson, 1975; Roth & Robbins, 2004; Specia, Carlson, Goddey, Angen, 2000; Lazar, Bush, Gollub et al., 2000; Lazar, Kerr, Wasserman et al., 2005; Dusek, Chang, Zaki et al., 2005; Ironson, Solomon, Balvin et al., 2002).

Assisting in self-healing is the role of the psychopharmacologist. Many patients have prolonged depression marked by disturbed sleep, insomnia, nightmares. Antidepressants and antipsychotics are powerful medicines which work at the genetic level to inhibit or express neurochemicals. They are targeted to support the body's capacity for attention, concentration, interest, pleasure and emotional regulation giving patients a stable base from which to engage their life-world (Lavelle, Torr, Mollica et al., 1996; Mollica, 2006; Reczycki, Luipold, Muscettolla, 2004). Potentiating the medicine are the practices of meditation, practicing mindful eating, walking, and sitting which can be taught in individual sessions.

The capacity for self-healing is often buried so deep within that the survivor is unable to feel it is there. These practices when taught with gentleness and kindness, without judgment, help the survivor tap into their own intrinsic vitality to self-heal (Mollica, 2006; Lavelle, Torr, Mollica et al., 1996).

Story 1. Self Healing: The Energy of Mindfulness and Interbeing

She came into the clinic morose and depressed. Although she had survived the concentration camps under the Khmer Rouge, she journeyed to the U.S. with her son and daughter only to have her son murdered by his brother-in-law. The latter (her son-in-law) was now being considered for parole and the patient could not think of

anything but hatred and revenge. She would not allow him to have the possibility of parole, reasoning that since her son lost his freedom so his murderer should not be allowed freedom either. The need for revenge was not assuaged by this vow. She spoke of bitter taste in her mouth and inability to sleep from the negative thoughts toward her son's murderer. She said that it felt as though all her energy was in her head and she had no rest.

My response was to invite her to sit in a stable posture, breathe abdominally and slowly scan the body from head to her feet, and then to feel the earth under her feet supporting her. The meditation incorporated her own visualized image of her son smiling at her supporting her. We acknowledged the sadness present at the same time there was a felt-sense of his smile and her capacity to smile back. Sadness and support mingled one in the other. She practiced this when she could not sleep. One day she came in and reported that she saw her son smiling, she returned her smile to him and found she was smiling with compassion at her son-in-law, the murderer. She came to see deeply his suffering and she felt her hatred dissipate. She was able to tolerate the parole hearing without revenge and hatred, while maintaining her ground that he was not to be given parole. She did not need medication changes. She had insight into interbeing, the interconnected life-world in which each of us is embedded.

STORY TELLING AS HEALING

Trauma occurs and suddenly the life world of the victim is divided into before and after. The period prior to the traumatic event is usually remembered as stable. When the event(s) is over, the post-traumatic period becomes relatively distorted with the backdrop of the trauma continuously looming into the present. The work of healing is to integrate the traumatic event-

period into the stable past and routine present. To do this the survivor needs to be offered opportunities to share their story in a manner that helps them and the listener (Mollica, 2006).

When survivors of trauma come in and tell their stories they are in the process of creating wholeness from the destruction they have experienced. However, expressing emotions is a necessary part of this struggle. The traumatic story vacillates between two poles: humiliation, sadness, and despair versus fear, anger and need for revenge. Many traumatized persons swing between these poles: feeling shame about the past and sadness for the loss of hope and joy over against being too fearful to go out or too fixated on hatred and preoccupied with revenge to sleep or work (Mollica, 2006).

Telling the story is not enough, though. "The story must be told in a manner that can be readily received by the other person without causing the listener to be overwhelmed and to withdraw" (Mollica, 2006, p.123). Telling a negative affect-laden story with gruesome detail does not assist in the survivor's healing. It is a place many stories start but not where they should remain. To transform a story into a narrative that is healing for the patient and beneficial to the listener requires an empathic listener.

Empathy allows the listener to look and not turn away from the images, motifs, themes and particular symbols of the storyteller. The process of empathic listening is one of 'entering into' the other's world with compassion "the way of awareness in the very midst of suffering and confusion" (Hanh, 2000, p.58). The act is therapeutic for both teller and listener (Mollica, 2006).

The Power of Memory in Story Telling

There are two neurological pathways that store traumatic memories. One is located in the hippocampus in the mid-brain and stores details of events and rehearses

them rationally and symbolically. The other pathway in the amygdale, encodes emotional memory, the protective fear-response center of the brain (Sadock & Sadock, 2003; Mollica, 2006).

The clinical approach to story-telling advocated by the HPRT assists the survivor to share their story using metaphor and reasoning to dominate the story, "sidestepping the stimulation of strong emotions. This approach can lead to the reduction or elimination of emotional memories that have outlived their adaptive value" (Mollica, 2006, p.97).

Some survivors, though, have recurrent emotional memories that fail to resolve. The failure of memories to resolve is often the result of the survivor's need to remember in order to remain close to loved ones who died by violence. Although physically upsetting or disabling, the emotional memories keep their loved ones near them. The cost of maintaining this emotional memory is a cascade of ill-health from the dysregulation of the body's HPA axis. Most only need an educational group to begin to understand this linkage. Once they know that memories can be controlled by techniques that teach compartmentalization and encourage the use of symbol while not overwhelming the listener, they begin to shift their memories into forms that are more accessible (Mollica, 2006).

Spirituality and religion contain the communal forms of ritual. Rituals help to further separate a person's memories into fields of information that can be safely explored and shared, and potentially give birth to new meaning. Rituals take place in a wider context involving others (e.g. Sangha, Temple or Church). Engaging in a ritual potentiates insight into interbeing. It offers the individual more than they might gain alone.

In order to help the storyteller to successfully share their story a Coach is often deployed. This can be an empathic friend, therapist or relative who supports their

story telling and approaches the trauma story as having both emotional and symbolic elements like a work of art. It is with this approach that symbolic content arises. Symbol and metaphor carry more freight than does detail. That is, the core-information needing to be transmitted is more potently expressed and received through the use of symbol and metaphor. Being given permission to try different ways to share the story by narrative, poetry, art, music, and theatre modulates the intense emotions and their expression so they can be contained. Once the trauma victim realizes how important it is to not overwhelm their listeners they can usually find a way to tell their story that contains their emotions (Mollica, 2006).

Another way to have the survivor share their story is to encourage them into the role of teacher. This shifts the emphasis from the individual's needs to an emphasis on teaching and shaping the story in a way that benefits others.

Story 2. The Story teller as Teacher and the Role of Ritual and Compassion

The mother of my patient was blind and dying in Vietnam. The daughter had sent money to have a monk perform a ceremony, but the money was used for other purposes by her sister. When I empathized how difficult that must be, she disclosed that she was very sad and despairing not about her sister but about her inability to influence the snakes. "Snakes?" I asked my interpreter. The patient told me that many years ago her mother was tending the garden, and killed a snake with her hoe and tossed it away carelessly. As a result the snake "community" caused her mother to grow blind. The patient needed the ceremony to be performed to correct the insult that might bring her mother's sight back and could also avoid her from going blind.

Rather than disparage her belief, or see this belief as pathological, I asked her to

teach me about the snakes and what she believed. In her folk-culture, she taught me that between the human community and the more-than-human world, the Snake is revered for its role in mediating illness and health. Killing a snake carelessly could make you subject to a curse that would cause illness. In this boundary there are specific ceremonies performed by a monk or shaman that avoid ill consequences (Lavelle, Torr, Mollica et al., 1996). This type of perception is widely known in other cultures as well (Abrams, 1996).

I considered the patient's story and her medical record that noted she had tested glucose intolerant, a pre-diabetic condition that can be dealt with through diet and exercise. She was diagnosed with major depression with psychotic features that had resolved with medication. Instead of seeing the patient as having a specific delusion that needed to be medicated, or by attempting to convince the patient that her mother's blindness probably had to do with diabetes, I set about helping her explore ways the ceremony could be performed here at a local temple. She thought that a temple monk could do it. This allowed us to also explore ways she could take care of herself, diet and exercise, and by volunteering at the temple (altruism) which would bring her closer to her mother who had once been a temple nun.

RESPECT FOR SPIRITUALITY, WORK, AND ALTRUISM IN HEALING

The social activities that have been demonstrated to have a restorative impact on survivors of trauma are spirituality, work, and altruism (Mollica, 2006; Lavelle, Torr, Mollica et al., 1996).

The HPRT asks each patient to participate in a weekly or monthly individual session of supportive counseling in their language following a plan of care formulated by the team. In addition, all are in-

vited to participate in a monthly large group meeting also in their own language that discusses and works on problems, e.g., housing, money, neighborhood, and family problems. Health promotion and education is offered. Opportunities to influence policy and legislation are taken. These group focused actions are remarkably empowering.

Spirituality is appreciated and patients are encouraged to deepen their practice of the religion of their choice.

Work is the single-most important goal for survivors of trauma (Mollica, 2006). Work is not just making money but anything that enhances material well-being like caring for children and grand-children. In the 1990s, interviews with thousands of refugees showed that resiliency was tied to work regardless of what type. If the activity helped them survive the day to day routine, it had great healing potential.

Altruism is the practice of concern for others without regard to self. It is behavior that enhances self-healing of traumatized persons. A survivor does not have to wait until they are well, whole or free of all illness before they can set out on the path of altruism and practice compassion. Regardless of how disabled one is, there is always a way to share what one has with others who may benefit from it. Altruism's source is compassion for the other. Through taking the risk of giving of one-self something of value to someone else, one heals the other and in so doing heals oneself (Mollica, 2006).

Compassion and altruism are what the ancient Hebrew prophet admonished his traumatized people to practice for their own recovery from war and destruction (~530 BCE) (Westermann, 1969):

"If you pour yourself out for the hungry
and satisfy the desire of the afflicted,
Then shall your light rise in the darkness
and your gloom be as the noonday.
And the Lord will guide you continually,

And satisfy your desire with good things,
 and make your bones strong;
 And you shall be like a watered garden,
 Like a spring of water,
 Whose waters fail not.
 And your ancient ruins shall be rebuilt;
 You shall raise up the foundations of many
 generations;
 You shall be called the repairer of the
 breach,
 the restorer of streets to dwell in."
 (Third-Isaiah 58:10-12)

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