Struggling to Meditate: Contextualising Integrated Treatment of Traumatised Tibetan Refugee Monks

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Abstract

As a result of the recent resurgence of violence in the Tibetan Autonomous Region, the Boston Center for Refugee Health and Human Rights has an increased patient demographic: Tibetan refugee monks. Diagnosed by their *amchis* (traditional healers) as having a *srog-rLung* (life-wind) imbalance and presenting with posttraumatic stress disorder (PTSD), they struggle with their contemplative meditation, which—as a central focus of their daily lives—normally comes with ease. In this article, we consider the pathological implications of the highly relevant Buddhist context for this dual diagnosis. Specifically, we contextualize the classification of 'religious impairment' as well as the significance of ongoing persecution of the devoutly religious for trauma therapy. We then draw upon spiritually oriented Eastern therapies as well as the confluence of specific paradigmatic practices to properly address these intricacies in devising an effective holistic healing approach to the dual PTSD / *srog-rLung* diagnosis.

Keywords: meditation; refugee trauma; PTSD; Buddhist refugees; CSRI; Tibetan monks; complementary therapy

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Prologue[1]

Having finished his morning tea and taken his daily dose of antidepressants, 45-year-old Yonten walks over to a dimly lit room in which he will begin his morning meditations. He begins with his deep breathing exercises, focusing on the balance of winds he strives to achieve. He did not get a good night's sleep again, so concentrating on channelling his energy proves to be a little more difficult than he is accustomed to after decades of meditation experience. Ten minutes into the breathing exercises, Yonten hears yelling in his mind. The image of his monastery burning appears unwanted beneath his eyelids. He recalls this image with more pain than even his final prison beating almost a year ago before he finally fled India, where he had continued his political activity in support of the Tibetan government and His Holiness the Dalai Lama. This memory of his temple burning still haunts him the most, although his flashbacks often take him back to his first imprisonment in China where authorities forced him to watch electric shocks administered to his fellow monks as a warning to other activists. Yonten and his family had been forced to flee to India through the Himalayas after he received threats against his family, and he had to leave them behind permanently upon fleeing to the United States. Although it was beyond his control, this circumstance has caused him significant guilt and sadness, at times rendering him emotionally numb. Consequently, Yonten's contemplative meditation, which was once second nature, has become consistently difficult, especially after nights haunted by frightening nightmares which often put him in a state of hyper-vigilance for the duration of the next day. Although he actively avoids actions and thoughts reminiscent of his trauma, he often feels hopeless in his frustrated efforts at meditative mindfulness despite decades of practice, and finds himself fighting off intrusive feelings of helplessness. He is persistent, and he attempts to ignore the invasive memories and focus on the flows of winds. After a frustrating hour, he walks back to his kitchen and prepares another cup of tea with which he will take his antidepressant medication. He then prepares himself for his trip to the Boston Buddhist centre, where he has integrated himself with a supportive community of Tibetan Buddhists, several of whom are also patients at the Boston Center for Refugee Health and Human Rights (BCRHHR) at the Boston Medical Center.

Religious Refugees

Yonten is one of eight Tibetan monks who have arrived at the BCRHHR as a result of the recent resurgence in the Tibetan independence conflict. As religious refugees, these monks present with psychiatric concerns both *resulting from* and *preventive of* their religious practice. Having fled violent religious persecution at home, they arrive at refugee centres abroad suffering from symptoms of traumatic stress that interfere with, among other things, their meditative practice. Like most refugees who find themselves in a healthcare system which enshrines biomedicine above all alternatives, acquiring access to appropriate care often means being forced to adopt an entirely foreign medical paradigm which may or may not be conducive to their healing. Research in cross-cultural health settings, particularly refugee health services, is making it increasingly clear that successful treatment adequately responds to the patient's own interpretation of illness as well as biomedical categories, allowing them to actively participate in their own healing (Fuertes, 2004; Keller et al., 2006). Kleinman's (1989) claim that 'biomedicine' is simply one branch of medicine that responds to one society's definition of health and disease, and that illness is necessarily contingent on the patient's personal experience and interpretation of well-being (Kleinman, Eisengerg, & Good, 1978), is particularly salient in the arena of trauma-related illness, in which it has been shown that the patient's actual well-

being cannot be divorced from the patient's own understanding of well-being (Kirmayer, 2001). For this reason, the dual diagnosis—as opposed to reliance on biomedical positivism—is indispensable in ensuring appropriate response to alternative medical paradigms, which will inevitably affect the outcome of treatment.

At the BCRHHR, the monks present with almost every symptom of posttraumatic stress disorder (PTSD) along with generalised anxiety, and major depression, and, according to the *amchis* (traditional Tibetan healers) referred to them by the local Buddhist center, a serious imbalance of the *srog-rLung*, or 'life-sustaining wind' ('life-wind'). Although their affiliation with the Buddhist centre is an important first step—in fact, the *rGyud-bZhi* (the main texts, or *Four Treatises*, of the Tibetan medical system) specifically recommends "Enjoying the company of one's close and dear friend" for *srog-rLung* conditions (Tsarong, Drakton, & Chomphel, 1981, p. 102)—a religious context oriented mental health assessment and treatment approach is essential to their healing. This context is relevant both causally and symptomatically, with healing at the core of the Tibetan Buddhist practice of mindfulness meditation (Loizzo, Blackhall, & Rapgay, 2007), which has proved highly applicable for Western clinical settings (Salmon et al., 2004). According to the traditional Tibetan system of medicine, a *srog-rLung* ('life-wind') disturbance has the potential to develop into a serious mental illness which will leave the victim at odds with the balance of the universe as well as their personal health. While the biomedical diagnoses—determined using cross-culturally valid measurement scales developed specifically by for the BCRHHR's use by Dr. Paul Bolton who has extensively researched the validity and development of cross-cultural psychiatric assessment instruments (see, e.g., Bolton, 2001; Bolton & Tang, 2002)—are necessary in determining appropriate treatment options for the Buddhist refugee monks, they can also be detrimental if not harmonised with the highly religious context in which mental illness would develop for these monks.

Boehnlein's (2007) contention that the intrapersonal context of PTSD requires that the patient and clinician strive for a "congruence of their respective models of illness causation and ideas for treatment" (p. 271) reinforces the notion that the PTSD model, as a highly localised model, has been determined to be useful in a refugee setting only if adapted to incorporate relevant ethnocultural differences in the expression of traumatic stress (Friedman & Jaranson, 1994). More specifically, the important role of accounting for religion in cross-cultural psychiatry has been noted in recent years, especially when the patient personally attributes relevance to religion (Tarakeshwar, Stanton, & Pargament, 2003). Research has demonstrated remarkable effectiveness of spiritually oriented healing approaches in treating war-traumatized African immigrants (Janzen, Ngudiankama, & Filippi-Franz, 2005), Cambodian Americans (Douglas & Mam, 2005), and displaced Kosovar Albanians (Goździak, 2002); and has generally called for a focus on the spiritual dimensions of resilience in trauma survivors (Peres, Moreira-Almeida, Nasello, & Koenig, 2007). Yet, there remains a gap in the literature in terms of research specifically concerning devoutly Buddhist trauma survivors whose world view and spiritual beliefs are likely to impact their health outcomes. Guaranteeing an effective integrated treatment plan at centres like the BCRHHR involves both a consideration of how religious context might be accounted for by complementary treatment options as well as how the religiously oriented traditional medical paradigm might be applied to biomedical treatment. The case of these refugee monks thus presents both a unique challenge and urgent opportunity to make further progress in understanding the intricacies and practical implications of the

relationship between Eastern religion and mental health, as their displacement puts their healing at the hands of Western health professionals.

An ongoing history of violence

Although the Tibetan Autonomous Region (TAR) has arguably been in a state of political turmoil since its invasion by the People's Republic of China's People's Liberation Army halfway into the twentieth century, violent conflict quickly escalated at the onset of the Tibetan Independence Movement in 1987 (Tsering, 1999) and most recently intensified in 2008 when 300 monks joined together on March 13th, 2008, in protest of the previous year's upsurge in the imprisonment of political activists ('Fire on the Roof of the World', 2008). Since 1959, which was the year His Holiness the Dalai Lama and the Tibetan Government-in-Exile arrived in Dharamsala, over 110,000 Tibetan refugees have sought asylum in India (United States Committee for Refugees and Immigrants, 2008), and—due to private sponsorship—more frequently in recent years, in Western countries including the United States (home to about 9,000 refugees in 2008) (MacPherson, Bentz, & Ghoso, 2008). Many of these Buddhist monks have been physically tortured and repetitively exposed to psychological trauma (Hooberman, Rosenfeld, Lhewa, Rasmussen, & Keller, 2007), and a majority has developed mental disorders resulting from the traumatic stress of their imprisonment and torture (Mills et al., 2005; Piwowarczyk, Moreno, & Grodin, 2000). What most significantly differentiates the monks' traumatic experience from that of other groups commonly diagnosed with PTSD, though, is that it presents an ongoing threat to their religious practice, whereas groups such as war veterans, for example, are less likely to find difficulty interpreting their trauma as a past experience which no longer presents a continuing threat.

Pathologies of trauma

How the trauma of the Buddhist monks might be understood as the confluence of *srog-rLung* and PTSD involves a deeply historical reading of disease pathologies. In the United States, PTSD was only technically defined—after a number of labelling iterations including the original *shell-shock* description of WWI veterans— in response to the enormous influx of Vietnam veterans exhibiting combat-related stress. Even so, PTSD—defined largely by its symptomatic anxiety and invasive memories—only made its way into the Diagnostic and Statistical Manual (DSM) in 1980 (Summerfield, 2001). The region's historical isolation and relatively recent exposure to violent conflict—already having ways of explaining the impact of trauma from non-conflict aetiologies—as well as outward as opposed to inward flow of traumatised individuals, means that—unlike the West—it has not been presented with the pressures for new disease categories to include in their pathology exposure to traumatic events. Because Tibetan medicine has not thus had adequate opportunity to develop new aetiologies accounting for the unique causes and symptoms of traumatic stress, refugees reporting such symptoms have continued to fit them into the existing traditional medical paradigms. It is not the common PTSD symptoms (such as invasive memories), then, that refugees present as their understanding of illness—or even the proximate causes of traumatic events—but rather underlying psychosocial factors such as political turmoil, social uprooting, and overexertion, which are included in the patient's understanding of traditional disease etiology (Prost, 2006). The imbalance of the central 'life-wind' resulting from traumatic stress has resulted in the traditional Tibetan diagnosis of PTSD symptoms as a *srog-rLung* disorder.

Srog-rLung v. PTSD

The BCRHHR's use of traditional healers to attain a dual diagnosis as opposed to attempting to simply adapt the biomedical PTSD diagnosis avoids the risk that simply "grounding cross-cultural analysis on practices current in contemporary biomedicine may produce findings more artifact than real" (Good, 1994, p. 23). Generally, using traditional diagnoses made by traditional healers in refugee contexts has been shown to be beneficial (Jaffa, 1996; Schreiber, 1995), as has the requisite level of trust in the healing process that can best be established by healers espousing corresponding cultural constructs (Boehnlein, 1987). At the BCRHHR, the dual diagnosis allows for the development of holistic therapy that responds not simply to the biomedical category of PTSD, but also *srog-rLung,* which is closer to how the patients interpret their own condition. *Srog-rLung,* as understood by the Tibetan monks, is defined as an imbalance of the central 'life-wind' responsible for an individual's overall health and, in relative terms, spiritual harmony (Rapgay, 1981). According to the *rGyud-bZhi*, the causes of *srog-rLung,* or 'life-wind' imbalances, include uncontrollable crying, worrying, excessive mental physical or verbal activity, and unhappy mind (Jacobson, 2007); and—currently used to encompass the distress resulting from the Tibetan independence conflict—results in symptoms ranging from high blood pressure to heart palpitations to dysphoria (Janes, 1999b). In this respect, the diagnosis overlaps appreciably with the PTSD diagnosis, although is used by the Tibetan medical paradigm to encompass mental illness more generally.

Underscoring the importance of identifying these differences is that *srog-rLung,* which is partially attributed to overexertion, is actually *most commonly* identified in monks as the product of intellectual overexertion. In fact, it is considered a common condition among monks, especially the high-profile monks which usually find themselves involved in the kind of political and social struggle that eventually drives them into exile (Prost, 2006). Maintaining the same diagnosis of *srog-rLung* as pathologically indistinguishable when manifested as a consequence of violent religious persecution as opposed to the more common characterisations, then, lends itself to the risk of ignoring the symptoms of PTSD that not only differentiate the disorder from more general stress disorders, but, more importantly, necessitate very specific treatment approaches. The lack of a mutually complementary diagnosis, then, means that many refugee monks run the risk of simply being diagnosed with *srog-rLung* as the common result of over-exertion, and subsequently do not receive the specialized treatment that can properly address symptoms of traumatic stress.

Meditation and mental health

While the *srog-rLung* diagnosis aligns generally with the pathology of PTSD with major depression or generalized anxiety comorbidity, the most obvious difference is the inclusion of spiritual imbalance in *srog-rLung* etiology, and the corresponding absence of invasive memories, both of which have considerable implications for treatment. This etiological variation manifests itself most notably as the loss of meditative ease, stemming from a general difficulty with relaxing and overcoming traumatic memories. For Tibetan Buddhists, enlightenment is the highest standard of well-being, towards which mindful contemplation is the primary vehicle (Davidson & Harrington, 2002, p. 84). Tibetan Buddhist tradition holds that the ultimate cure for every kind of suffering is enlightenment, attainable essentially through profound meditation (Dash, 1978). When such enlightenment occurs, the body is said to be freed from all worldly

attachment, including worldly anxieties and fears. Dr. Rapgay (1981), who has written extensively on the topic of *rLung* illness and worked with Harvard clinicians to develop clinically effective meditation therapies, explains, "Mental health is defined as a mind freed from the influence of the afflictive mental factors, and that is the goal of the process of meditation" (p. 31). At the same time, though, traditional healing recommends *against* the use of meditation as a therapy for mental illness, warning against the greater anxiety that might be induced, and recommending that if one does attempt to meditate, that it would best be practiced in exceptionally brief sessions (which have a greater chance of being successful) as opposed to the usual longer sessions (Clifford, 1984). In fact—to complicate matters— *srog-rLung* can actually be *induced* by improper meditation:

> If strain develops in the mind's attempt to concentrate itself on the object of meditation, if rather than being gently guided into one-pointedness the mind is forced into submission, if the mind squeezes and tightens in its attempt at concentration, then the mind is said to "rise up" in its attempt to find the object. As the mind rises up, the *pranic* current on which it is mounted rises with it, producing the symptoms and signs of *sok-rlung* [*srog-rLung*]. This same rise in *sok-rlung* will also occur when obsessive inner thoughts about progress in meditation arise in a mind already concentrated to the degree that external sensory inputs no longer occur. (Rapgay, 1981, pp. 44-45)

Remarkably, this symptom-as-stressor convolution resembles the very same "pathogenic spiral that deepened the patients' chronicity and despair, and exacerbated their dysfunctional behavior" (59) as a result of undiagnosed and misdiagnosed PTSD, which was at the core of the argument for the creation of a new diagnostic category in the DSM-III (Young, 2000).

'Clinically significant religious impairment'

The injurious effect of frustrated meditation, therefore, can be thought of as "Culturally derived and symbolically mediated 'stressful life events' [that] seem to be a common precursor of the 'giving-up/given-up complex,' an emotional frame of mind that facilitates disease" (Hahn & Kleinman, 1983, p. 17). In this respect, the loss of meditative ability is not simply a consequence of traumatic religious persecution, but also a 'clinically significant religious impairment' (CSRI) functioning somewhat like a double-edged sword. While significant discussion has surrounded the topic of how religious impairment ought to be evaluated in a clinical setting, research generally points to the importance of CSRI to the extent that religious experience is important to the patient (Yarhouse, 2003). Its usefulness for the refugee monks—whose world view has a very significant impact on daily activities—goes, therefore, without saying. The validity of CSRI for the refugee monks is reinforced by the regular facility with which Tibetan monks generally practice meditation—as well as the centrality of the practice to their daily lives. The particular ease with meditation which the refugee monks at the BCRHHR would be accustomed to might additionally exacerbate feelings of shame and hopelessness accompanying their psychological trauma, and even more fundamentally so than normal due to the religious nature of the stressors (Acharya Lama Gursam Rinpoche, personal communication, 10 July 2008). This creates a unique paradox in which the difficulty in returning to a healthy, balanced state lies in the tension of meditative practice presenting itself at multiple points along the *srog-rLung* pathology. Frustrated meditation essentially becomes a self-perpetuating symptom. This suggests that the ideal therapy approach would be one that removes the ambiguity of meditation's multiple markers in *srog-rLung* pathology by solidifying its role at one end, enabling the identification of clear symptomatic markers and targets. Making the ability to effectively practice relaxation therapy an identifiable *goal* of alternate therapies (some of which are discussed below), rather than as a therapy itself, is therefore necessary, but also

presents an added challenge in the identification of non-invasive, non-triggering alternative relaxation therapies.

The context of ongoing *religious persecution*

In accounting for frustrated meditation as a CSRI, the designation of meditative ease as an end-point in the healing process is particularly necessary in ensuring that treatment strategies are ethnomedically *as well as* culturally sensitive, which has been presented as best practice for international psychiatry serving refugees (Shah, 2007). If mediating between the role of frustrated meditation as symptom and stressor is aggravated by religious context, it is counterproductive to continue to apply standard relaxation therapies as a means rather than an end. The alleviation of PTSD symptoms is grounded in the establishment of the traumatic experience as a threat strictly of the past, from which one is now safe; exposure therapy, used historically by the Veterans' Association (VA) as a stressor-focused variation of relaxation therapy, is useful in achieving this goal (Rothbaum et al., 1999; Keane, personal communication, 30 July 2008). Yet the application of such a strategy to the Tibetan monks presents a contextually counterproductive challenge. The tension of the ongoing religious persecution means that although the refugee monks can be assured that they personally are safe from police brutality, imprisonment, and torture, the traumatic stressor that has actually been rated among the most common sources of traumatic stress—"witnessing the destruction of religious signs" (Terheggen, Stroebe, & Kleber, 2001, p. 11)—cannot realistically be presented as a thing of the past. As long as the violent conflict in the region continues, the refugee monks know that, on the other side of the world, their fellow Buddhists are struggling to preserve their religious customs, which are irrefutably essential aspects of their lives. As suggested by Bar-On (2000) in his analysis of the Palestinian-Israeli context, the difference between post-peace and pre-peace applications of PTSD is a contextual factor with both diagnostic and therapeutic implications. What is more, the salience of human rights concerns relevant to religious persecution resulting in serious trauma underscores the urgency of exploring contextualized therapy approaches (Moreno, Piwowarczyk, & Grodin, 2001).

Converging paradigms

Promising Buddhist therapies

Because *srog-rLung* involves the embodiment of spiritual imbalance, complementary therapies for Buddhist monks must necessarily correspond to the spiritual paradigm of Tibetan medicine in addition to providing suitable therapy solutions for the symptoms of PTSD. To this end, a number of Eastern therapies can be used as non-invasive substitutes to meditative practice as relaxation therapy without the potential harm of exposure therapy; as Boehlnein (2007) has noted, the emphasis on a more detached or nonjudgmental view of traumatic events in Eastern religious traditions contrasts strongly with Western world views encouraging proactive control of past experiences. Such a view is supported by Friedman and Marsella's (1996) explanation that, because they more closely resemble biological mechanisms, the intrusion and arousal symptoms of PTSD may be more universal than the avoidant/numbing symptoms. While unprecedented (at least in the available literature) for religious refugees like the Tibetan monks, the general use of complementary and alternative medicines was recently found, in a qualitative study, to have no

adverse affect on concomitant use of biomedicine in Cambodian refugees (Berthold et al., 2007), which makes it an approach worth testing (and at the very least, not risky for patients). Aroche & Coello (2004) have explained that constructs such as PTSD "provide useful tools for clinicians to understand and exchange knowledge and ideas that can lead to better outcomes for clients seeking help for their perceived problems…The challenge for the clinician remains to be able to utilize constructs such as PTSD to inform his or her clinical practice, while retaining a flexible approach" (p. 63). A government-funded publication regarding 'clinical' efficacy of Tibetan medicine recently concluded that indigenous therapeutic approaches could be considered to have significant 'complementary' effectiveness (Loizzo et al., 2007). A barrier to more successful research of such therapies is that it is usually conducted with a sample population generally attuned to biomedical paradigm; the relevance of such therapies to the traditional medical practices and beliefs of refugee populations would likely reveal significantly different results than they might with a general sample population more attuned to Western medicine. Kleinman's (1995) widely cited research on Asian medical systems has brought him to the conclusion that, "While the more fluid complementary paradigms of Asian medical systems appear weak in methodological rigor and not conducive to empirical testing, their categories do represent the active ordering of relationships and have produced many positive practical results" (p. 29). While therapies that have been shown to be clinically effective in the treatment of PTSD are few, such research is at least possible due to the existence of trauma as a quantitatively measurable category, which, *srog-rLung,* for example, is not. The existence of cultural-bound syndromes listed in an appendix of the DSM-IV as simply qualitative categories precludes the ability to show clinical efficacy in the treatment of, for example, *srog-rLung.*

Recognizing these barriers to existing evidence-based complementary therapies, the BCRHHR researched its own complementary therapy options. The spiritual aspect of the Tibetan medical paradigm—which was at the core of the monks' experience of illness—guided this research. While they may differ in their specific outcomes, the spiritual paradigms of all these practices along with their observed clinical effectiveness make them suitable alternatives in addressing non-overlapping symptoms of *srog-rLung* and PTSD. One promising option is derived from the ancient Tibetan Bon tradition, a yogic practice involving 'magical movements' which can be used to induce the mind into the relaxed state necessary to purify oneself entirely through motion (Chaoul, 2007a, 2007b). The 'magical movements' of this practice integrate movements of the body and controlled breath with movements of the mind to bring the mind to stability; this offers a fitting alternative to the monks' inability to eliminate invasive thoughts in matching the mind's stability to the body's. Bon yoga has, in fact, been recommended by its practitioners for use when one's normal meditation practice is somehow weakened or difficult, and is particularly applicable to PTSD, as its secondary benefits include stress reduction and the elimination of obtrusive thoughts (Nyima, 2002). Two Bon yoga techniques that incorporate the opening of energy channels are *tsa-rlung* and *trul-khor,* which have been shown to reduce stress and sleep disturbance—primary symptoms of PTSD—through regulated breathing and visual imagery (Cohen, Warnecke, Fouladi, Rodriguez, & Chaoul-Reich, 2004). While such clinical effectiveness has only been demonstrated with cancer patients, its use for Buddhist refugees is promising, as the Bon tradition is identical to the Buddhist tradition in its view of the self, and thus, compatible with the spiritual paradigm of the Tibetan refugee monks (Millard, 2007).

Another valuable derivative of the Bon tradition is singing bowl therapy—a form of music therapy—which is particularly promising in light of the insight provided by a respected meditation teacher that sound has a "direct connection to the heart" (Acharya Lama Gursam

Rinpoche, personal communication, 10 July 2008)—which, in terms of the Tibetan Buddhist spiritual paradigm, aligns with the 'life-wind' imbalance as understood by the monks. By realigning the *chakras*, or energy channels (i.e., the wind channels) to alleviate the disturbances or blocks of life energy flow, singing bowl therapy has been shown to significantly affect the acupuncture meridians that metaphysically correspond to the crown *chakra*, or heart *chakra* (Allen, 2004), which—for comparison—corresponds characteristically to the central 'life-wind.' The full functioning of this *chakra*—and likely balance of the 'life-wind'—is promoted through singing bowl therapy without presenting a threat to meditative practice. The demonstrated effectiveness of the acupuncture approach to PTSD (Hollifield, Sinclair-Lian, Warner, & Hammerschlag, 2007), as well as the VA's precedent of using music therapy in the alleviation of traumatic stress (Kelleher, 2001), deems singing bowl therapy another promising therapy worth further investigation.

Most compellingly, *qigong* and *tai-chi*—Chinese energy-channelling practices used today by Buddhist monks—have recently demonstrated clinical efficacy for treatment of torture survivors at the BCRHHR (Grodin, Piwowarczyk, Fulker, Bazazi, & Saper, 2008). Similarly to the 'magical movements' described above, these practices also use movement, as opposed to physical stability, to focus the mind's attention, and offer a safe alternative to traditional yoga for patients whose trauma history makes certain traditional yoga poses particularly painful. As both *tai-chi* have been previously found to be effective in treating chronic trauma symptoms (Harris, 2003; Sun, Dosch, Gilmore, Pemberton, & Scarseth, 1996), their application on a larger scale to trauma therapy for religious refugees deserves immediate attention.

Traditional concepts, modern therapy

While the BCRHHR's research into more appropriate therapeutic options ensures that the patients receive treatment for their illness in terms of their own illness experience, such therapies are not alternative, but complementary, to the biomedical elements of treatment. Ensuring success of the biomedical interventions, nevertheless, requires integrating traditional medical concepts in a way that is conducive to patient understanding and acceptance. The evident incompatibility of traditional PTSD therapies with the specific religious context of the monks embodies Dr. Tamdin's (personal communication, 13 August 2008) emphasis on the importance of the individualistic approach of Tibetan medicine, which avoids making any generalisations about patient groups, but rather, requires that each symptom be addressed in the context of personal constitution as well as situation. Traditional practice first classifies people into three constitutional subtypes—namely *rLung, Tripa,* or *Badkan*[2]— then situates these types within their environment to make a diagnosis, and only then identifies the appropriate targets for treatment (Rapgay, 2005). Such an approach is particularly important for the *srog-rLung* diagnosis, which is inherently relevant to the initial elemental balance of the patient. Moreover, the application of this highly individualistic approach to the diagnosis of PTSD in religious refugees has potential to more reliably identify contextual details such as the nature of ongoing religious persecution, and thus avoid the kinds of therapeutic approaches (i.e., standard exposure therapy and meditative practice) that might be counterproductive in such a context. Constitution-type classification additionally presents a feasible opportunity for the further integration of traditional and Western medical paradigms. Patient acceptance of foreign treatment options is a common obstacle faced by cross-cultural refugee clinics, particularly when religious beliefs are

associated with the traditional paradigm (Carrillo, Green, & Betancourt, 1999; Kinzie, 1989). The application of a constitution-type classification to the overall diagnosis and treatment plan presentation when substantial foreign elements are involved is a practical way to begin to align disparate medical paradigms; it is especially meaningful if it means the spiritual elements of the traditional paradigm can be incorporated into integrated treatment of deeply religious patients. Particularly in clinical settings involving patients accustomed only to traditional medicine, this traditional paradigm presents an opportunity for heightened patient acceptance of non-traditional therapeutic approaches.

The practical application of spiritually-oriented medical paradigms to achieve sound results for patients within a deeply religious context can be further applied to the biomedical regimen. One challenge that the Harvard Program in Refugee Trauma's Freedom Clinic encountered in integrating a biomedical approach to a holistic treatment of traumatized Cambodian refugees was in enforcing adherence to a strict medication schedule (Kamo, 2005). Yet, one of the greater points of emphasis in the *rGyud-bZhi* are the instructions surrounding the consumption of any of the medicines classified as 'powders,' which provide very specific indications for the time of day, environmental setting, and ritual practices necessary to create the balanced setting in which the medication can actually be effective. For example, the Men-Tsee-Khang, the Tibetan Medical and Astrology Institute of His Holiness the Dalai Lama, provides the following instructions for taking *Rinchen Tso-Tru Dashel-Chenmo*, one of the Tibetan pills given to the monks by their *amchis* for the treatment of *srog-rLung*[3]*:*

> Night prior to intake of pill, it is advisable to take a lukewarm decoction prepared out of about 7 grains of fagara seed in order to open up the bodily channels. During the same evening, crush the pill into a clean unbroken cup without exposing to light and add to it a little amount of hot boiled water. Then, cover the cup with a clean lid and leave it to stand overnight. In the early morning, stir the mixture in the cup with the ring finger and then drink the contents. Before taking the medicine, it would be more beneficial to recite the mantra of the Medicine Buddha … and the mantra of Avalokiteshwara … as many times as possible. This should then be followed by a cup of hot water and go to bed with warm quilt. After about an hour, if one is able to take a syrup prepared from dissolved saffron…avoid eating raw vegetables, fruits, fish, pork, egg… (Men-Tse-Khang, 2008)

The *rGyud-bZhi* warns, in fact, that any deviance from the careful instructions can render the medicine powerless. While this might be an over-exaggeration of the kind of dosing adherence necessary for effectiveness of the prescribed Western medications, a basic application of the ritual-oriented paradigm to encourage adherence to a time-sensitive drug regimen is a perfect example of how biomedical treatment might be made more effective through translational application of Eastern medical paradigms. Whilst the BCRHHR's small patient sample makes proving efficacy of such a strategy difficult, the need for highly contextualized strategies promoting adherence continues to be a need in advancing refugee health services (Depoortere et al., 2004).

Conclusion

Historically, there exists a notable precedent for the use of Tibetan medicine to treat conditions falling outside of indigenous aetiologies. The Nepalese Khunde Hospital serves as an example of a health centre where local leaders, in this case Sherpas, allowed Western medicine to be integrated within a paradigm attributing metaphysical healing to shamanistic practice and physical healing to the complementary Western practice (Heydon, 2007). In 1995, the first large-scale 'integrated' mental health clinic for Tibetan refugees opened in Dharamsala (Mercer, Ager, & Ruwanpura, 2005). Such paradigmatic collaboration is essential in religious contexts,

as demonstrated by the usefulness of applying the ritualistic medication practices of the traditional Tibetan paradigm to the biomedical interventions of Western medicine. And, because the diagnoses of *srog-rLung* and Western stress disorders differ in their symptom aetiology, and the religious context of these differences heightens their importance, an integrated therapy approach accounting for both diagnoses can likely result in the most effective treatment of the largest number of symptoms.

The differences between Tibetan and Western disease pathologies, in the identification of religious stressors points towards the need for evidence-based complementary therapies which address for Tibetan monks in exile and comparable religious refugee populations: first, the compatibility of indigenous and modern disease categories; and second, the role of ongoing religious conflict in affecting the treatment options available for trauma-induced illness. The distinctive tension between meditation as a goal and meditation as therapy resulting in the presence of a CSRI accentuates the need for adaptation of complementary therapies that can address symptoms missing from alternate diagnoses but at the same time correspond with spiritually-oriented traditional healing paradigms (e.g., Bon yoga 'magical movements,' singing bowl therapy, *tai-chi* and *qigong*). Accordingly, identification of specific translatable practices that can help bridge the divide between medical paradigms is essential for integrated therapy approaches to be effective.

As the modern world continues to clash with the remnants of traditional cultures, it is inevitable that conflicts such as the Tibetans' will continue to escalate, producing escalating numbers of refugees surviving ongoing religious persecution. Yet, as Boehnlein (2007) explains, drawing on Anthony Wallace's account of religious and social revitalization, the process of combining cultural elements that appear contradictory can, in itself, promote posttraumatic recovery. And, as Janes (1999a) notes in defence of applications of traditional Tibetan medicine, "If we accept the fact that a general definition of well-being is a significant aspect of medical efficacy and that a level of well-being is in part sustainable through medicine's authority to construct for patients a culturally meaningful clinical reality, then we must also accept that any medical system which works to provide such an experience for patients is effective" (p. 1807). The case of the Tibetan refugee monks arriving at the BCRHHR demonstrates, hence, that the need is urgent for an evidence base contributing to greater understanding of the contextual details affecting the application of Eastern religious paradigms to Western medicine, and vice-versa.

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Notes

1. This composite case study has been created to protect patient privacy, but is based on real patients at the BCRHHR.
2. The three types characteristically correlate to Sheldon's categories (ectomorph, mesomorph, and endomorph) (Zannos, 1997).
3. In spite of a number of language barriers presented by inconsistent transliteration of

Tibetan pharmacopeia, the BCRHHR was able to identify the pills which had been given to the refugee monks by their *amchis* by matching up likely candidates with their correct indications. There were a total of eight different pills that had been given to the monks, namely *Aru-10, Gur-gum 13, A-gar 35* with *Li-khyung Rilbu, bSam-'phel Nor-bu* with *Khyung-lnga, Se-'bru Kun-bde*, and *Zla-shel Chen-mo* (more commonly referred to as one of the eight 'Precious Pills'). *Aru-10* and *Khyung-lna* ceased to be used after consulting with a Tibetan physician (anonymous for security reasons, personal communication, 2 May 2008) who was able to identify the less appropriate ones. Using T.J. Tsarong's *Handbook of Traditional Tibetan Drugs* (Tsarong, 1986) to identify the ingredients of each, the final list of pills was found to be composed almost entirely of herbal substances, although a number of questionable—although, based on basic science literature searches, not discernibly harmful—animal products (such as wild yak's heart and elephant's gallstone) were included as well. The only exception to this was *Zla-shel Chen-mo*, alternatively referred to as *Tso-tru Dashel Chenmo*, which, like other 'precious pills,' sometimes contains nominal amounts of detoxified mercury. Although medicinal uses of mercury are generally considered unsafe, a study examining the effects of mercury content in Tibetan medicines found that the toxicity was not great enough to be considered dangerous (Sallon, Namdul, Dolma, Dorjee, Dolma et al., 2006). The Natural Standard substance reference search and interaction checker was subsequently used to match the nomenclature used in the *Handbook* with the substance's common name and search for any serious side effects the identified ingredients might specify for interaction with antidepressants and ibuprofen (Natural Standard, 2008), which were prescribed by the BCRHHR. No interactions which had any significance greater than the requirement that the combination of the substances only be taken under the supervision of a knowledgeable physician.

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