Stories of Healing from Survivors of Trauma and Torture

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By

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ACKNOWLEDGMENTS

My professional life has led me from medical school in Seattle to Vietnam to Malaysia, back to Seattle for my residency to a fellowship in Hawaii to teaching at a medical school in Malaysia to a faculty position in Hawaii, and finally to my last position at the medical school in Portland Oregon. During those 47 years, I have met many wonderful people along the way. Friends, teachers, colleagues, family members, and often just good decent people. My patients are included in that group.

My life has been shaped by a wonderful family, including my parents whom I wrote about briefly. Growing up, I had many things taught to me by the church and my parents. We argued intensely and respectfully. I respected them for standing up to my irrational arguments and sticking to their beliefs throughout it all. This includes a belief in honesty and respect for other people, which are values all of us should have. Even when I moved away from the church's teachings, most of which I still believe, they encouraged me and maintained a close relationship with me all their lives. I have two brothers, whom I have a deep love for which has only grown stronger as we've grown older. Their support is very much appreciated, enjoyable, and necessary. I have two wonderful sons, who both fill me with pride, not because they are psychiatrists like me, but because they are caring people who bring happiness to the people in their lives. And I have a very supportive and loving wife, who was the main person encouraging me to write this book.

My professional life experiences, some of which are described in this book, make me who I am. I have greatly enjoyed meeting many people of other cultures, and I am eternally grateful to all of them.

Our clinic has recruited and trained many excellent counselors whom we helped grow and work effectively with patients. They are very warm, sincere people, and genuinely have become quite effective and committed advocates for our patients. I would like to mention a few of them who

have worked with us for many years. Vinh, Anh, Kim, Ben, Kanye, Alma, Kamal, Hallma, Abdela, and Kam On are just a few. I apologize to the many others I have worked with over the years who I have not mentioned.

I would like to thank Kim Pham for her help with the case histories in the Vietnamese Refugee chapter and her work managing a very large Vietnamese patient caseload over the years. I very much appreciate the long-time service of Rath Ben to the Cambodian patients and his assistance with the Cambodian patient research. Penny Lee's assistance in providing case histories and historical information about the Mein people was invaluable. I want to thank Kamal Vejo for his excellent insight into clinic work and for providing some of the case histories in the Bosnian Refugee chapter. Several case histories were provided by Abdullah Woticha, who also proved to be an outstanding source of information about the history of Ethiopia. Maryam Amiran M.D. was a great help and provided much of the case material and and historical information for the Afghan Refugee chapter. Finally, David Riley has helped me with computers, writing, punctuation, and clarifying some of my comments. Without him, I could not have done this work, and I greatly appreciate what he has done.

INTRODUCTION

I have had many challenges and remarkable experiences over 50 years of working as an academic psychiatrist. The work is difficult at times, but mostly fulfilling and satisfying. Though I enjoy teaching and research, nothing in my career seems more worthwhile than working with people from non-western cultures. This is especially so when I meet and treat refugees who have been severely traumatized by violence. The stories are difficult to hear, often gut-wrenching, and sometimes bring a tear to my eyes. Keeping an empathetic and therapeutic stance is necessary to help the healing and reduce the suffering. I was not unaffected by these relationships and the cost of this work. I hope to describe my experiences and what I've learned in this book.

The stories of patients presented here as I remember them are all real. The stories included, out of about 2000 refugees I have treated, stand out in my mind and illustrate the issues of refugee patients. I did not have access to patient records, as they belong to the hospital, but it is probably best to report the most impressive ones from memory. Any information that could be used to identify patients has been changed to protect their identities. This included changing names and occasionally changing the country of origin for a few patients. The settings of war and civil violence that occurred in different countries are summarized from my own reading, and the counselors from the countries that provide personal insight into the violence.

The stories come in different ways. Taking a comprehensive psychiatric and medical history provides symptoms and usually physiological changes. However, the information alone doesn't provide insight into the events surrounding most of the symptoms, especially the traumatic events that may have occurred. The revelation of these events rarely occurs in the first interview. They may be hidden from the patient's own consciousness. Denial and avoidance are powerful parts of the traumatic experience. Generally, in a trusting, therapeutic relationship, more information comes forth slowly over months, or in some cases years.

Probably with some patients, not everything is remembered or even told. I believe that a patient doesn't have to reveal everything to get better, but the stories they do tell have to be believed. My patient summaries don't include all the time and trust both I and the patient put into these therapeutic relationships.

One other thing needs to be said, the stories in this book are mostly about the trauma endured and their severe symptoms. The situation is often sad, but not hopeless. Most patients do get much better. After treatment, they can maintain relationships, raise a family, go to school, or gain employment. Their lives aren't perfect, they experience ups and downs, but also happiness and joy which makes all our efforts worthwhile. To those I have treated, I thank them very much for sharing their lives with me, and I hope that I've been worthy of their trust.

CHAPTER 1

VIETNAM 1964–1965

The Vietnam War was said to have started in 1954 when U.S. military activities supported the South Vietnamese against the North Vietnamese communist and their southern sympathizers, together called the Vietcong. The Vietcong used guerrilla military tactics, while the U.S. military slowly increased its military presence. By 1964 there were about 16,000 U.S. military personnel in the country and a reported 200 American deaths. That same year, the president of South Vietnam, Ngo Dinh Diem, was assassinated, likely with the approval of U.S. officials. He had used violence against the Buddhist majority and had lost U.S. support. In August 1964 the North Vietnamese used a torpedo boat to attack U.S. warships in the Gulf of Tonkin. Some U.S. military officials urged caution, but President Lyndon Johnson submitted the Gulf of Tonkin Resolution to Congress. It authorized the president to "take all necessary measures to repel any major attacks against the forces of United States." At the time, there were roughly 23,000 U.S. troops in Vietnam and about 400 had been killed. Following this event there was a steady escalation of U.S. military activity, driven by the fear of the communist expansion, i.e. "the domino theory."

Raised in a historic Protestant Peace Church and opposing the war in Vietnam as a conscientious objector, I was required to perform two years of alternative service. I chose to work with Care/Medico. It seemed a natural place to fulfill my obligation, and I joined the Medico team in Quang Ngai, Vietnam. I arrived in Vietnam in July 1964. Following the Gulf of Tonkin resolution, there was an increase in gorilla activity and sporadic, but unpredictable, military action. There was fear for all American personnel in Vietnam as the military activity on both sides began to increase dramatically.

Quang Ngai, a relatively small town by Asian standards, is on the coast of Vietnam, about 300 miles north of Saigon and 100 miles south of Hue. I flew there on one of the last flights on Air Vietnam and was met at the airport by a Canadian doctor, the director of the team, and two American nurses. The nurses informed me that the airport, although only three miles from the city, was closed at night because of military activity. The nurses also informed me that there was a bounty on my head "just for being an American." I had anticipated this and, in my not reacting to it, I had probably "passed the test." There was a small American army unit in the town and also a Seabee military construction unit. However, my job was to take care of Vietnamese.

Figure 1-1: The Medico team in Quang Ngai, Vietnam 1964. Photo from author's collection.

The hospital was fairly primitive, with about 20 pediatric beds and 50 to 100 adult beds, depending on the need. There was a male head nurse, who was quite competent to run the hospital, but many of the other nurses appeared to be mostly trained on the spot. There was no laboratory and no X-ray equipment, although there was a technician who took a fluoroscopy of each patient's chest and wrote down what he thought he saw.

We had adequate medicines, mostly gifts from drug companies. We had IV solutions but no blood. The medicine was in a locked steel building to prevent theft. Across the street was a military hospital with several Vietnamese doctors trained in surgery. There were four Vietnamese interpreters assigned to our team, and each had been given an American name. The one I worked with was named "Jack." It is a little embarrassing that I never learned the actual Vietnamese names of any of our interpreters—their names were lost during work with the Americans. Our interpreters were extremely helpful, thorough, and quite dedicated to their jobs. We also had a cook and a housekeeper.

Figure 1-2: Dr. Kinzie (left) treating Vietnamese patients in Quang Ngai, Vietnam 1965. Photo from author's collection.

The patients were some of the sickest people I had ever seen—with a substantial number of infectious diseases. Fortunately, most of our antibiotics worked at that time. Resistance did not become a concern until years later. We saw patients with pneumonia and skin infections, some quite serious. The ward for tuberculosis patients was named after the founder of the organization, Tom Dooley. I was never quite sure all the

patients in the small unit had TB, but since they were taken care of and avoiding a war no one tried to move them out.

After almost 60 years, some patients still stand out in my mind:

> Several children came to the hospital with diarrhea and severe dehydration. Our nurses tried oral hydration but simply couldn't keep up with the loss of fluids, especially at night when they were understaffed. We lost four kids in the first couple of weeks. This was the most depressed I felt about my medical responsibilities, and I desperately wanted to quit, but of course, there was nowhere to go. Finally, I tried doing IVs on several children by doing a small 'cut down' incision in the leg to find a vein and start IVs, usually with an antibiotic. The staff could adjust the IVs throughout the day and night. I was greatly relieved when the next five children with diarrhea all lived.

> A young very pregnant woman arrived at the hospital with massive edema. She had severe hypertension and had experienced seizures while in the hospital. We started rapid diuresis and she seemed to improve. Later, I received an urgent call to come see her. When I arrived, she was squatting over a bedpan containing a newborn baby with the umbilical cord still attached. The baby was alive, and I delivered the placenta and tended to the mother. With continued blood pressure medicine, she improved, and her blood pressure went down. She and the baby looked quite normal within a few days.

> A middle-aged man came to the hospital with total body rigidity. He had stepped on a bamboo spike. His wound had become infected and at this point, he had developed tetanus. He was unable to swallow, and I felt the situation was quite hopeless. We cleaned the wound and started IV medicine and fluids. We started a muscle relaxant (valium) and gradually he became more mobile, and his

rigidity markedly decreased. Eventually, he was able to eat on his own and was walking almost normally. This was a good outcome for a case that American doctors probably never saw.

A male patient was brought to the hospital in a sling attached to a pole carried by two of his friends. He was unresponsive and quite delirious. A few days before he had been bitten by a dog. He clearly had all the symptoms of rabies, although I had never seen a case before. I was asked to help him, but sadly no treatment could save him. All we could do was make his life more comfortable. The man's friends said thank you, but he needed to die in his village. They turned around and carried him back to his home in the sling.

A young woman arrived who appeared to be suffering from severe anemia –at least by physical examination. She had heavy bleeding and most likely would receive a blood transfusion at any American hospital. I asked her husband if she needed blood, would he be willing to help? Although, even if he agreed, I had no idea how we would be able to crossmatch the blood with our primitive equipment. He said that he could not give blood because he was a member of the village defense force, and he needed all his blood for strength. I was struck by his total lack of concern for his wife and told him so. Instead of a transfusion, we started her on a course of iron tablets and vitamins, and she seemed to improve in a couple of weeks.

We held a clinic for a Vietnamese Army unit and at the end of the day the unit’s captain asked me to examine a prisoner. He was a young person, probably no more than 17, only wearing shorts. He had a bullet wound in his arm, bandaged in a makeshift sling. I looked at him and we exchanged friendly gazes. I started to take him to my vehicle for a ride to our hospital, thinking he would be

treated in a more appropriate manner. I was stopped, and a long discussion between our leader and the unit captain ensued. Finally, I was told we could not take him because he knew where a machine gun was hidden, and unless he told them where it was, he would have to stay there. I was very frustrated that nothing more could be done. Later, I was told that the prisoner had been beheaded. I never knew if that was true or if it was simply a rumor. My utter frustration with not being able to help a young boy, albeit an enemy soldier, and the fact that he was killed, led to ongoing frustration and outrage at the war.

During the monsoon season, our hospital was flooded with three or four inches of water on the lower floors. The pediatric unit was completely flooded. This prompted most of our patients to leave the hospital, and it was not clear where they had gone. One young, approximately ten-year-old boy, who had remained, was found unresponsive with no obvious cause. He could not go home because of the flood, so we took him to our house and set up a bed for him in the living room. His mother stayed with him, and I kept the IV going with an antibiotic. When night came, I checked on him every two hours. His condition was unchanged but did not appear to be fatal. By 5 AM, however, he had died. I hugged the mother and said I was very sorry in English, and I think she understood. At 7 AM I went to the boy's room. His body was gone, and the mother was in the kitchen preparing a meal for me. I was overtaken with grief and consideration. I tried to stop her, but she kept on preparing the meal, wanting to show her appreciation for my efforts in some way. It was very touching, but also terribly sad.

We were flown by Army helicopter to a remote village to give a clinic. There were several extremely ill patients, usually with infections, and we were able to help them. After a while, we started seeing only healthy young men. I had the feeling we were doing

pre-induction physicals. Nevertheless, we all tried to give them something for their alleged ailments which included headaches, diarrhea, backaches, etc. –anything we could possibly treat. As we were leaving, I saw the young men exchanging pills, trading a blue one for a red one, etc., until everyone had a least one of each. I could have handed out M&Ms for three hours and it would not have made any difference.

One morning we saw a large group of patients from a small village that had come under a barrage of artillery fire the night before. They told a story of sitting around in the evening when they were suddenly bombarded. I remembered hearing a large gun going off in the middle of the night, and wondering what they were shooting at. Later, I asked a Vietnamese soldier why they were shooting at this particular village. He said that a nearby bridge was blown up, and they believed that people there must know something about it, so they aimed their heavy artillery at the village.

One evening a group of Vietnamese soldiers came to our clinic and said they had been under enemy fire and had lost several soldiers. The officer in charge seemed confused with pressured speech, very anxious, and overwhelmed by the whole experience. At present, I would make a diagnosis of PTSD, but that condition would not be described for another 15 years. They wanted to sleep on the floor in the hospital for safety, and that is where they spent the night.

I was once called to treat a young Vietnamese man whom I was told had been shot. He was lying on an operating table in the surgical room. He had a bullet wound in his neck and could only speak when I plugged the hole in his trachea. He said that he was not experiencing any pain and did not feel like he was in distress. After thinking about this for a minute, I realized that the bullet had

probably gone through his spinal cord as well as his trachea. He was likely now a quadriplegic and would be unable to move or feel anything below the bullet wound. His breathing was labored as he was using only the muscles in his upper neck area. I asked my interpreter to step outside with me while I considered what we should do. Unfortunately, we didn't have the ability to treat someone with this type of wound and there was no place we could send him. There was simply nothing we could do. I went back into the room to talk to the patient, but he had died while we were gone. He didn't have the strength to carry on with his impaired breathing. I never learned any more about him or how this happened.

A U.S. military helicopter carrying an injured American soldier landed near our hospital. The injured soldier had taken a bullet to his belt buckle. The buckle prevented the bullet from penetrating his body directly, but it had shattered on impact sending debris into his abdomen. I told the commanding officer that there was nothing we could do. We had no surgical equipment, and especially no blood. It was critically important that they take him as fast as possible to the nearest army hospital. He was alive when they arrived at the army hospital, but later died in surgery—another casualty of this damned war.

The ongoing war was always around us and becoming closer every day. People were shot within 100 yards on each side of our house. One was apparently trying to escape, and the other was an enemy Viet Cong trying to enter the city. His head was placed on a stake outside the town. That was the ultimate disrespect of an enemy Vietnamese.

There were some Americans around the city, although the numbers were not large. They represented both the courage and cruelty of soldiers perhaps everywhere. A couple of noncommissioned officers took a jeep to a nearby village and brought back a couple of patients to the hospital. They had come under gunfire during the trip, and I was impressed with their courage. However, they also told me that they take no Vietcong

prisoners. They told me a story about taking a couple of Vietcong prisoners up in a helicopter. They said they thought one of the prisoners seemed to have less information than the other, so they threw him out of the helicopter. Then they reported that the other captive suddenly became very cooperative and started providing information. After that, they threw him out too. As with anything in war, one never knows the complete truth. There was macho braggadocio among soldiers which goes along with widespread disrespect for the Vietnamese. Nevertheless, these stories are often told without embarrassment or guilt.

I spoke to an American military advisor to the Vietnamese and told him that I understood that the unit he was with had captured some Vietcong prisoners. I also had heard that the Vietnamese Army had lined them up and shot them. He said he hated seeing that and he turned away, so he did not have to. The advisor to the Vietnamese did not think to advise them about international law on the treatment of POWs. It probably wouldn't have mattered at this point in the war because vengeance was overcoming all sense of morality and legal precedent.

I was shocked by the antipathy and derogatory comments made by some Americans towards the people they were trying to help, the Vietnamese. "Gooks" and other vulgar terms were constantly applied to the communist, and sometimes to the South Vietnamese as well. To many Americans, the Vietnamese seemed lazy, corrupt, and deceitful. There was little consideration of how a long Civil War affected people or culture and destroyed the basic functions of a society. I met many Vietnamese for whom I developed a sincere affection.

I developed a strong attachment to Asian people of all types early in my life. My mother, brother, and I moved to Seattle when my father was with the Public Health Service. I started the third grade with another student who was also new to the class. We were egged on by some of the other kids to get into a fight, which we did. We were promptly sent to the principal's office, where we were told to be nice to each other. I had moved from Indiana and Kenji, my opponent in the fight, had moved from Idaho. We became good friends, and it was not until years later that I understood that his family had lived in an internment camp for Japanese

Americans during World War II. One day my mother, brother and I walked to a store where we had shopped regularly in the past. My mother stopped before we went in, looked around, and appeared upset about something. The store's new owner had placed a sign over the door that said, "No Japs." I asked my mother what that meant and she said, "Your friend Kenji is a Japanese American." "Do you mean Kenji can't go in here?" I asked. My mother said, "Yes and we can't either!" Even at this early age, I learned something about life that I didn't understand. I also learned something about my mother which I later grew to appreciate even more. Kenji and his family became friends with my family, spending much time together. Before my family moved from Seattle, Kenji's mother took him, my brother, and me to some of the most expensive restaurants in town. This was a new experience for us. My brother Steve and I both ordered hamburgers.

In Vietnam, we were vaguely aware that the danger was encroaching on us, but it never occurred to us to ask to be transferred. As we kept working with patients, we forgot about the main events of the war. One day, two Vietnamese officers came to talk to me, commenting casually that we have very different careers. Mine to save lives and theirs to take lives. Then they came to the point of the conversation. One officer asked if I would adopt one of his daughters and take her to America. I said that I could not as I was unmarried and had many obligations. But behind the question was their awareness that the war was going badly and that they would probably be killed. He wanted at least one of his children safe so that there would be someone to remember him. I was aware that the war for them, and probably many Vietnamese, would end in failure and the deaths of many.

A bridge across the river near our town was partially blown up resulting in very limited traffic. While waiting for traffic to pass, I saw a bundle of clothes covered with mud. I looked closer and saw that it was a body. I said to myself "Just another dead Vietnamese." I suddenly caught myself and realized that I was saying a human life was worth no more than a passing comment. I began to question what happened, and why I had lost my sense of value for human life and the respect that it deserved. The guilt overwhelmed me, and I realized that I too had become a victim of the war. I had become insensitive to death and felt guilty about it. It was time to

leave, but that decision couldn't be made by me alone. The decision was made by the MEDICO office in New York. I would be reassigned to another location. It was difficult to leave and yet necessary. There was guilt about a job not finished and relief about the horrors of war left behind.

I had the feeling as I was saying goodbye to our Vietnamese friends, that I would probably not see any Vietnamese again. Little did I know that Vietnamese refugees would become a major part of my professional life.

CHAPTER 2

GOMBAK 1965–1966

Gombak is a hospital for the aborigines of Peninsula Malaya. The peninsula includes parts of Malaysia, Southern Thailand, and the southernmost tip of Myanmar. In the Malay language, aborigines are called Orang Asli. The hospital is located near the Malaysian capital city of Kuala Lumpur, but it is in the middle of a jungle. It had 200 beds, but many more patients were admitted. Whole families were permitted to gather even if only one was the actual patient. The Orang Asli is a diverse heterogeneous group of tribes living in the primarily jungle areas of Malaya. When I was there, I was told the population was 30,000, but Wikipedia shows the population as 198,000. The population is generally divided into three main groups:

- Negritos, the oldest ethnic group in Malaya.
- Senoi, which includes the two largest tribes, the Temiar and the Semai.
- Proto-Malays, which were colloquially defined as Malays who never became Muslim.

There were several native languages, but almost all spoke some form of Malay, which they used to communicate with us, and with each other. Providing medical care for these diverse groups scattered throughout the jungle was a difficult task. It was solved by the genius of a British doctor, Malcolm Bolton. Dr. Bolton met with many of the tribal medicine men and gave them Western medicines to make them more effective. These included medicine for diarrhea, headache, or other minor pains, and some salves for skin infections. With their resistance attenuated, he was able to then bring some bright young people from the tribe to the main hospital at Gombak and train them further as medical assistants. These assistants were rotated between the hospital and their own villages, spending three

months at each one. The villages had radio contact with the main hospital for emergencies or even questions about medical issues.

When I was at Gombak, there were about 200 beds in the hospital divided amongst various little houses, separated by a small distance to prevent cross infections. The primary illnesses were malaria, tuberculosis, and various kinds of accidents and injuries resulting in infections or some cases broken bones. During the year I was there, I did medical rounds in the southern part of the peninsula, while Dr. Bolton took the northern part. We spent two weeks out in the jungle and then two weeks at the hospital. Once when Dr. Bolton went back to England, I managed the hospital alone for six weeks. In addition to Dr. Bolton and myself, there were three nurses, two Americans, one Canadian, and two Malay aides who had worked with Dr Bolton for a long time. The rest of the staff were trained aborigines as mentioned before.

I traveled in the jungle with my aide, a Malay, who was very supportive and knowledgeable about the local cultures. When we arrived at a jungle village, we heard laughter which turned to dead silence as soon as we were spotted. We asked if anyone was sick, and the answer was always “No.” We sat down and joined the men in a circle. No one said much, but then someone rolled up a cigarette and passed it around and we all took a puff and waited. Eventually, an old man, probably the chief, said that his wife had been sick and asked if we could take a look at her. I did and determined that she had a serious case of pneumonia. I explained to them about the need for medicine and instructions on how to take it. I provided some supportive comments and told them that she would get better. When I left the chief’s hut, there was a long line outside of villagers waiting to see me. Indeed, many people were very ill and needed treatment. It takes time and patience to be trusted by some cautious tribes.

On other occasions, we arrived by helicopter and talked to the village leaders. Most of the parents wanted their children to be vaccinated so that was not an issue. On one occasion, when we arrived a woman came running up, holding her about six-year-old child. His shins were all misshapen and he had many lesions on his body. It was a case of yaws, and the mother knew as well as I that a shot of penicillin would cure it.

The cases of leprosy were more subtle and were not something I had really been trained to diagnose. I asked Dr. Bolton how to diagnose it and he said, "Just ask the patient - they know when they have it." This turned out to be correct.

The doctor before my time had been interested in birth control for the tribes. She taught the women to start birth control pills on a full moon and continue until they were out of medicine and start again the next full moon. Unfortunately, on a rainy or cloudy night when the moon was not visible, the birth control pills were not started, and a lot of pregnancies resulted. I thought a better way would be to use an IUD. The first one I placed came out with the baby nine months later. Afterward, I asked the mother if she wanted to try again but she said, "No." However, they were generally acceptable and other than this one case, effective. Many women asked for them.

Deliveries were usually straightforward, but occasionally it could be very difficult. I had one occasion with a breach birth when the cervix wrapped around the midsection of the baby, and it was difficult to proceed. Luckily, my parents were visiting, and I decided that even though it was 3 AM it was time to “call dad.” He was also a doctor and had a long-time obstetrics and gynecology practice back home. Dad was able to use some simple maneuvers to get the baby out easily and safely. He had done it many times and saved many babies in the small town where we lived. I reminded him that he wouldn’t get paid for this delivery, and he said it wasn’t the first time.

I was to hold a clinic in an unfamiliar village deep in the jungle village. I had read an anthropological report about the village’s beliefs including an elaborate idea of life after death, in which a man would be reunited with his wives and children and whole family. It was an impressive concept. After I made the rounds of the village, I sat down and spoke with a middle-aged man. I said that I understood he had a belief in life after death and described what I read. He looked puzzled and thought about it for a minute, and then remembered that an uncle had talked about it, but no one believed him. The man said when you die, they put you in a hole in the ground and that’s the end of it. He was not a believer in life after death. I

don't know if the anthropologist or my new friend was more accurate. I do suspect that the majority of his tribe were skeptical about the elaborate after-death concept.

Psychiatric Disorders

There have been romantic articles written about idealistic primitive societies in which there are no mental illnesses. The corollary of this is that the stresses of civilized, modern life create conditions that give rise to mental disorders. The aborigines are not totally isolated, primitive societies. However, much of their lives remain fairly isolated from even the main Malay society. The following cases describe some disorders encountered:

> One aide started to act strangely, grabbed a stethoscope, and began examining patients. He generally was laughed at but tolerated. He had increased energy and intrusive behavior with some elevated mood. I talked to him briefly about his hypomanic behavior but in a few days, he was gone. There was no explanation, but I suspect he was transferred back to the village as happens with some of the aides who fail.

> A woman was admitted with agitation, poor sleep, and loud behavior. She described a river spirit that had invaded her body and controlled her. I asked a man from the same village if it was true that they believed in a river spirit. He said yes, but not the way she does. Clearly, her inappropriate disruptive speech and behavior was and was not normal for that culture.

> We were traveling in a Land Rover to a town in central Malaya and stopped at a village for a medical visit. We were met by an unusual and disruptive site: A woman was kept in isolation in a stick cage, screaming, yelling, and threatening. Everyone was keeping away from her. I spoke to the husband and told him we had medicine that

would help if she would just take it. He wanted to try and climb into her cage and was met with a screaming wife scratching and hitting. After a while, she swallowed the medicine (8 mg perphenazine). Eventually, she quieted down and was able to come with us in the Land Rover back to the hospital. I sat with her as we drove back and she said that she wasn't completely crazy, in a way providing some confirmation. I said that was true and that she would get better with medicine and did while in the hospital. We continued the antipsychotic (perphenazine), and she greatly improved and returned to her village and hopefully continued with the medicine. I thought about this as cruelty, placing her in a cage, but I really didn't know what else could have been done.

Mental Illness Among the Aborigines

After I finished my psychiatric residency and a fellowship in transcultural psychiatry in Hawaii, I returned to Malaysia as a visiting psychiatrist in the Department of Psychological Medicine at the new medical school. Since I was known to have experience with Aborigines, I was referred most of the mentally ill patients from the various Aboriginal tribes. I and Dr. Bolton collected information from 20 mentally ill Aborigines and reported on this. Of the 20, 19 were diagnosed with psychosis. Clearly, we didn't have a DSM diagnosis at the time, but the behavior was very bizarre and upsetting to the community. Most had symptoms of hallucinations and bizarre behavior that I think met even the strict DSM criteria for psychosis. 16 of the 20 were diagnosed with schizophrenia. They all responded to anti-psychotic medicine, which was very helpful. Long-acting IM antipsychotic medicine was particularly useful since it could be given by the aides treating the patient in the jungle. These cases indicate that psychosis can occur in non-western, isolated aborigines and not only in developed countries.

CHAPTER 3

NORTHWEST NATIVE PEOPLE

I began my psychiatric training in 1966 at the University of Washington Medical School. It was a time of many changes in psychiatric theory and practice. The theoretical model used by the faculty was mostly psychoanalytic. Indeed, required reading on psychiatry for the medical students were Freud's books and lectures in psychoanalysis. Many of the senior faculty taught psychoanalytic theory, but younger faculty included topics such as community psychiatry, social psychiatry, biological psychiatry, medicine, and techniques involved in diagnosis. As a resident, my job was to integrate this varied material, try to be an effective psychiatrist, and treat patients. It was a difficult job, and I was not always successful. Psychiatry residency was challenging, to say the least. We didn't have the long hours of surgery residents, but we had the complex task of integrating models of the mind and developing self-awareness. Eventually, I became more comfortable and confident as I had good support from certain faculty and other residents.

I remember having a unique experience while interviewing a patient behind a one-way mirror. The interview was going well as the other residents and faculty watched concealed behind the mirror. Thinking about being watched, I'm getting nervous, and my leg starts shaking, which came as a surprise since I'm normally calm. Eventually, my body became cold, and my teeth started chattering. I made it through the interview, but I wasn't just experiencing a case of nerves –I had contracted malaria. I treated patients with malaria when I was in Asia. I had been taking a suppressant medicine, which I stopped about six weeks before. After becoming ill, I stayed in the hospital for two days so my blood could be drawn, and slides could be made for teaching students. I was the first identified case of malaria at the university hospital, and after being treated I was sent home. A few months later I had a recurrence, but they just gave me medicine and I was no longer anything special.

During my senior residency in 1969, I teamed up with a fellow resident and good friend, Dr. James Shore. We proposed an epidemiological study of a Native American Village. At that time Native Americans were referred to as American Indians. After a lot of negotiation and planning, we were given the green light to begin the study.

The village we studied was near a waterway. Its main economic activity consisted of fishing and forestry products which employed many members of the village. The Public Health Service provided the village with a physician and nursing support. Jim and I conducted semi-structured interviews with 100 subjects drawn from the village. Thirty-two percent, we determined, had moderate to severe psychiatric impairment. As practicing psychiatrists, we repeated our study in the same village 19 years later. This was after some new psychotic criteria were developed and described in DSM III. We interviewed 100 subjects including 31 villagers who were part of the original study done 19 years earlier.

Between the first and second studies, the village economy had changed significantly. Fishing and forestry still dominated, but the number of villagers employed by these industries and their income had diminished considerably. In 1988 only 28% of men and 22% of women had full-time employment. One-third of the population had some college or vocational training. In the 1969 study, 52% of men and 13% of women had an alcohol disorder. Fourteen percent of women and four percent of men had some form of affective disorder, usually depression. There were no schizophrenics identified in 1969, but two percent were diagnosed in 1988. There were no cases of PTSD found in 1969 as this was not a diagnostic category at that time. However, six cases of PTSD were found in 1988. These cases stemmed from military service, assault, and domestic violence.

In the 1969 study, 15% of villagers had peptic issues, while in 1988 that number was down to six percent. The decrease was undoubtedly due to preventive medicine. The alcoholic prevalence of 52% among men in 1969 was very high, although it had dropped to 37% in the second study. Women's alcoholism rate was 13% in the first study and had gone down to seven percent in the second study. The decrease in alcohol disorders may

have been related to increased public awareness through a campaign that related the effects of alcohol on individuals and the community. Of the elders I interviewed, several mentioned that religion had helped them to stop drinking. Others reported giving up alcohol simply because it had become too difficult to keep drinking and do other things.

My work with the Indian population caused me to reflect on the effects of and reaction to acculturation by the general population. Some of the effects were clear –alcoholism and high unemployment. Though, for many tribal members life on the reservation has become easier. There were ongoing efforts to revive lost cultural heritage with an impressive museum, an authorized limited whale hunt, which was a traditional village activity, and an annual regional salmon feast.

We were told a story that occurred in the 1940s during the early days of World War II. An Indian youth was walking alone on the beach. The Coast Guard spotted him and accused him of being a Japanese invader. He tried to convince them that he was an American, but they didn't believe him. He took the Coast Guardsmen back to his house, and his mother confirmed that he was indeed an American Indian, and not Japanese.

A tragic episode in the village's history occurred when the children were taken from their homes and sent to an Indian boarding school hundreds of miles away. The goal was to "civilize" the Indians by eliminating their traditional ways of life and replacing them with mainstream American culture. One method of achieving this goal was to forbid the children from using their native languages. Now many native languages are only spoken by a dwindling number of elders. I heard about some university anthropologists who wanted to interview these elders and record them. The idea was to try to keep these languages alive, at least as recordings. The elders allegedly said, "You made me stop speaking my language when I was young and now you want me to speak it?" Although probably exaggerated, the elders apparently said, "No way.

CHAPTER 4

VIETNAMESE REFUGEES

The end of the Vietnam War, and the Resultant Exodus of Refugees

In January 1968, during the Tet holiday, the North Vietnamese and Viet Cong surprised the South Vietnamese with major military attacks on numerous cities. The North Vietnamese may have suffered 60% casualties in a desperate attempt to win in South Vietnam, but the result was America's understanding of the vulnerability of an increasingly unpopular war. There were several graphic examples of the brutality of the war, including the Mai Lai Massacre in which 500 civilians were killed by American forces. The picture of the brutal execution of a Vietcong prisoner by the South Vietnamese general Nguyen Ngoako Loan was particularly shocking. Perhaps the most disturbing of all was a photograph of a young Vietnamese girl, screaming, and running naked after a napalm bomb inflicted burns over her body. Despite increased US and Vietnam military actions, the futility of the war became apparent. A peace agreement was signed in 1973 but fighting continued until North Vietnamese troops entered Saigon on April 30, 1975. The war ended with an appalling loss of life. American soldiers accounted for 58,281 deaths. The North Vietnamese and the Viet Cong are estimated to have lost 1,062,000 and the South Vietnamese lost an estimated 741,000.

Vietnamese tied to the US, or the South Vietnamese government knew the dangers of a communist takeover. It could involve reeducation camps, torture, and even execution. Those with influence, money, or connections, were able to leave the country in an organized way. Others weren't so lucky. An exodus of "boat people" left the Vietnamese coast heading for safety in Thailand, Malaysia, or the Philippines. It was a dangerous trip. They traveled in poorly maintained boats, often running out of food and