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CARING FOR REFUGEES AND OTHER HIGHLY TRAUMATIZED  
PERSONS AND COMMUNITIES

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# THE NEW H<sup>5</sup> MODEL

TRAUMA AND RECOVERY:  
A SUMMARY

HARVARD PROGRAM IN REFUGEE TRAUMA  
MASSACHUSETTS GENERAL HOSPITAL  
HARVARD MEDICAL SCHOOL



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IN REFUGEE TRAUMA



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## I. NEW H<sup>5</sup> MODEL

Recognizing the urgent need to address the humanitarian care of those affected by human violence and aggression, the H<sup>5</sup> Model focuses specifically on the millions of refugees living in camps worldwide, but it is our hope that it can also be used to serve civilian and mainstream populations suffering from trauma. The H<sup>5</sup> Model addresses the mental and physical health issues related to trauma suffered by refugees, the relationship between mental and physical health problems prevalent among refugee populations, the potential for trauma to persist in refugee camps, and the need for a new, more comprehensive model of refugee care. This new model explores 5 overlapping dimensions essential to trauma recovery by highlighting findings from studies of refugee populations. It presents recommendations for implementing culture and evidence-based policies and actions for traumatized refugee populations around the world. The H<sup>5</sup> Model has received widespread acclaim since it is one of the first models to address from a theoretical perspective the major source of risk and vulnerability affecting highly traumatized persons and communities. Because of its comprehensive and holistic approach to recovery, it is receiving attention from mainstream media and mental health practitioners engaged in creating a culture of trauma-informed care policies and psychosocial and cultural programs. The complete model is presented in a chapter entitled *The New H<sup>5</sup> Model of Refugee Trauma and Recovery in Violence and Mental Health*, currently in press from Springer Publishing Company by Professor Richard F. Mollica and his co-authors Dr. Robert Brooks, Professor Solvig Ekblad and Dr. Laura McDonald.

A summary of the five overlapping dimensions and the core of the model, the *Trauma Story*, is presented below. This new model for the recovery of traumatized refugee communities worldwide is based upon five dimensions essential to recovery. These five dimensions are anchored in the centrality of the trauma story. All dimensions of the H<sup>5</sup> Model are culturally sound and evidence-based. (See Figure 1)

Figure 1: The Five Overlapping Dimensions and Core Elements of the H<sup>5</sup> Model



## THE TRAUMA STORY:

**Trauma stories** are stories told by survivor patients of distressing and painful *personal* and *social events*. Sharing these stories serves a dual function not only of healing the survivor but also of teaching and guiding the listener – and, by extension, society – in healing and survival. The *trauma story* has four elements. The primary element of the story is the **Factual Accounting of Events**, or what actually happened to the storyteller, i.e. the brutal facts. These facts are usually graphic and detailed embellished presentations of the individual's traumatic life experiences. When such facts are collected from even a few persons, they can provide historical documentation of the concrete behavior of perpetrators of crimes against humanity, revealing the intentional, well-orchestrated methods of perpetrators.

In addition to recounting the facts, each trauma story reveals the survivor's sociocultural history in miniature, depicting the traditions, customs and values in which their story is embedded. The storyteller cannot avoid revealing the **Cultural Meaning of Trauma**. Although men and women in every society perceive violence as deeply injurious and socially *degrading*, responses differ by culture.

The trauma story also provides a view into the survivor's spiritual life: his or her capacity to achieve an **Enlightened View of the World** divorced from ugly and distressful emotions. Often the survivor reaches deep insights when reflecting upon his or her situation, for example, coming to reject social beliefs or attitudes that say he or she is "bad" for having been involved in a tragic event. These insights can prove very liberating. Trauma stories provide unique insights into the narrator's cultural framework. In every tragic event, this is an opportunity to uncover deep revelation and gain insights. Some call this "posttraumatic" growth.

The fourth and final element of the trauma story is the **Listener-Storyteller Relationship**. Storytellers are vulnerable to physical and emotional pain when they retell their stories; therefore, a listener's patience and sensitivity are crucial. The trauma story does not in fact completely exist unless it is told to someone else; the listener must choose to become part of the story. Under ideal conditions, the storyteller is the teacher and the listener is the student. The obligation of the listener is to apply the lessons of survival and healing to their personal and professional lives. By understanding that they are part of a historical process, all involved in the sharing of trauma histories becoming personally stronger and more resilient.

The repetition of the story makes the storyteller more comfortable. In effect, having a listener is part of the therapeutic process. In turn, the listener becomes more knowledgeable, not just of the pain of the trauma survivor, but also of what the storyteller has accomplished. In particular, the trauma story, in each of its four elements and as a whole, offers an incredible amount of new information on survival and healing, of allowing the survivor to have the motivation and strength to fight for recovery once tragedy is shared with another. Survivors must be allowed to tell their stories in their own way, just as listeners must remain enthusiastic and sensitive, so that the trauma story will flow without any outside influence. The trauma story can be told in groups with other people who have faced similar events.

Carefully attending to the four elements of the trauma story lets the storyteller share their deeply private life experiences, in order that we all might heal from and survive human tragedies. Attention to these elements gives everyone a way to tell and interpret their own

stories, not only those of others. Appreciation of the trauma story's scope and depth allows it to have a significant personal and social role in recovery from violence's humiliating and disturbing goals.

### H.1. HUMAN RIGHTS

Human rights violations are embedded in the definition of refugee. Safety and security is a foundation of refugee care. All human beings faced with the experience of violence want to tell someone else they trust their *trauma story*. At some point in the refugee camp process, individuals must have an opportunity to officially tell camp officials their violent history and reveal to authorities all of their experienced human rights violations, past and present. While it is not expected that the refugee in the acute crisis will be able, or should be able to do this, ultimately as safety and security are established the individual's traumatic life story must be recorded and acknowledged. Some sense of justice must be discussed with the refugee and their community and related human rights violations.

All violence violates a human being's human rights. Usually we reserve the term human rights violations to describe actions of extreme violence perpetrated in international and foreign settings. But concern for human rights is equally valid in the American setting. Violence treats all citizens alike whether they are children being sexually abused by a parent or an elderly man being exploited physically and emotionally within a nursing home. This important aspect of healing is often overlooked in therapy. The denial of proper and culturally effective health and mental health care causes tremendous human suffering and can even lead to death. Stigma toward the mentally ill and social prejudice and abuse of people different from the mainstream is a lack of respect for the human dignity of all living beings. All violated people expect and crave justice. The refugee community cannot wait years (while it is common) to have their desire for justice addressed by the international community.

### H.2. HUMILIATION

Humiliation is closely associated with feelings of shame, embarrassment, disgrace, and depreciation that are common reactions to violent actions. These feelings are often hidden by other intense emotions. Perpetrators intentionally drive victims to a place where all the values and features of *normal* existence are destroyed. The goal of violent acts, regardless of intensity, is the same – to create a state of emotional humiliation. Every characteristic of the abused person becomes bad or wrong; perpetrators try to introduce into the minds of their victims their fundamental worthlessness.

Perpetrators of violence use humiliating acts (e.g. rape) to create the state of humiliation. Humiliation is a very complex human emotion because it is primarily linked to how people believe the world is viewing them – that others may view the survivor as worthless or deserving of pain. Humiliation leads to a total loss of self-respect and can have major impacts on a refugee's personal and social behavior, being associated with learned helplessness, leading to a lack of self-efficacy. Often, the state of humiliation is re-created in the camp environment when individuals are not allowed to work, grow food, or make money.

The healing and recovery process must consciously strive to overcome in the mind distortions that produce feelings of helplessness and worthlessness. The healing response must be clear that violence is wrong, no matter the rationale. For healing to move forward, it is important to identify the feeling of humiliation and its associated emotions. Every

traumatized person needs to find that solid ground of original sanity – unblemished by the lies of aggressors – where their personal power still exists and upon which the healing process can grow.

### H.3. HEALING (SELF-CARE)

Self-healing is one of the human organism's natural responses to psychological illness and injury. Like the body's response to physical damage, the healing of the emotional wounds inflicted on mind and spirit by severe violence is a natural process. After violence occurs, a self-healing process is immediately activated, transforming, through physical and mental responses, the damage that has occurred to the psychological and social self. For example, sharing a *trauma story* can lead to the reduction or elimination of emotional memories that have outlived their adaptive value. The trauma story is only one self-healing pathway that has not traditionally been fully acknowledged. Dreams are now slowly being appreciated as a major self-healing response in traumatized persons.

Self-healing occurs at the psychological level when the mind is able to construct new meaning out of violence. At that point, behaviors are implemented that help the traumatized person cope with their emotions of humiliation, anger, and despair. These behaviors can either restore the old life-world of the survivor or, more commonly, create a new one. At the core of the psychological dimension of self-healing is the will to survive and recover. The individual makes a decision to do whatever needs to be done, not to “cave in” to violent acts.

Self-healing involves a social dimension as well as a psychological one. Positive social behaviors such as *altruism*, *work*, and *spirituality* enhance neurobiological processes that promote health and reduce the negative consequences of stress. These behaviors and others, such as the use of humor, social support, and physical exercise, help the individual recover psychologically. One of the first steps of a traumatized person's recovery, whether child or adult, is to break his or her social isolation by acknowledging that the forces of self-healing are at work and will ultimately lead to a good outcome, including the return to normal life. In this regard, helpers are essential because they can use their empathic skills to reinforce this therapeutic optimism in survivors.

### H.4. HEALTH PROMOTION

There is emerging evidence that refugees, persons in post conflict countries and those impacted by conflict have increased levels of long term chronic illnesses attributable to their traumatic experiences and high levels of distress. Research demonstrates that persons who experience trauma are more likely to die younger of all causes, develop chronic illnesses (e.g. ischemic heart disease, diabetes) and severe social disabilities. Trauma survivors have poorer behavioral health, smoke more, use alcohol and drugs more, exercise less and have poorer eating habits resulting in obesity and the metabolic syndrome. All are risk factors for the development of chronic disease. In other words, trauma generates chronic disease through direct effects and indirect effects through mental illness (PTSD & Depression) and impaired lifestyle. This connection between trauma and poor physical health demands a new emphasis on health promotion.

### H.5. HABITAT

The word *habitat* is used in place of “housing” to connote the total surroundings and/or living environment occupied by refugees, which does not necessarily qualify as a

house. The word *habitat* is derived from the Latin *habitare* and in the ancient world meant the natural environment of a person or the place where an organism dwelled. And there was a belief that a reciprocal and positive relationship existed between the physical and natural environment and those living organisms who lived and prospered within that environment. The dilapidated tents that over 1/2 million Haitians have live in more than 3 years after the earthquake of January 12, 2010 are not just broken down tents but a social environment plagued by poverty, social chaos, and gender-based violence. Traumatized persons and communities need to enter after a humanitarian emergency into a *healing environment* that can begin to initiate the healing process. Unfortunately, the latter concept is still poorly understood by the international humanitarian aide community.

Habitat is a new area of refugee mental health research. Initial studies of refugee living conditions point to a significant relationship between health problems, mental illness, crowding, lack of privacy and chronic violence. The H<sup>5</sup> understands the overall quality of housing and its relationship to trauma recovery as an important and relevant issue, and suggests that new design and building materials can make modern, healthy and safe housing a cost effective option.

## THE H<sup>5</sup> MODEL APPLIED TO REFUGEE CARE

Recommendations based upon the H<sup>5</sup> Model are:

- 1.) All past and ongoing human rights violations and social justice issues must be openly addressed with the refugee community, immediately documented, closely monitored, and brought to the attention of refugee camp authorities, who can respond to and remedy these violations to the degree they are able.
- 2.) Refugee camp policies and programs should be designed to actively enhance self-healing, independence, and self-sufficiency. The humanitarian response must not further degrade refugees or tolerate any form of gender and child based violence. Similarly, UN staff and NGOs should never humiliate, degrade or exploit the vulnerability of the refugees they serve. A UN Code of Respect by the UNHCR must be written, enforced, and widely disseminated.
- 3.) All refugees should receive an initial needs assessment to determine their self-healing status and then be supported in their recovery by psychosocial programs built on the strengths illuminated by the aforementioned assessment, with psychiatric services readily available for the seriously mentally ill.
- 4.) International aide should implement a universal health promotion program for all refugees that includes diet, exercise, stress reduction, and sleep promotion, among other health promotion techniques and programs.
- 5.) In order to ensure that the camp meets refugees' cultural and personal needs, refugees should participate in the design, construction and management of their homes and their new living environment. Homes should be safe and well-constructed and adequate lightning (e.g. solar powered) should be made available to all woman and children. New building materials that are ecologically sound and inexpensive need to

replace current use of tents with urban design replacing a haphazard and chaotic camp environment.

## II. THE H<sup>5</sup> MODEL APPLIED TO TRAUMA INFORMED CARE

The H<sup>5</sup> Model is extremely relevant and useful to mainstream health and mental health programs. It is consistent with the values and culture of the trauma-informed care movement (TIC). TIC sets a clear priority that all levels of the health care and social welfare system, introduce the values and practices of TIC for client/patient, staff and administrators. While the H<sup>5</sup> Model was developed for refugee populations, it certainly can be applied to those communities that have been traumatized by crime, poverty, catastrophic situations such as 9/11, the Boston Marathon bombings or Hurricanes Sandy and Katrina.

The H<sup>5</sup> Model helps us have a better appreciation of the underlying forces necessary for the recovery of those members of the general population who have survived or are coping with domestic violence, childhood sexual abuse, gender-based violence, and the stresses and strains of crime, poverty, family dysfunctionality and social stigma.

### THE TRAUMA STORY:

The *trauma story* again is the centerpiece of the medical and emotional care of all patients who have experienced or are experiencing violence. The four dimensions of the trauma story described above remains a good approach to understanding the life experience of traumatized patients living in our mainstream communities. These four elements detailed in the previous section are

1. *THE BRUTAL FACTS*
2. *CULTURAL MEANING OF TRAUMA*
3. *REVELATION "LOOKING BEHIND THE CURTAIN"*
4. *THE STORYTELLER-LISTENER RELATIONSHIP*

It must be remembered that all human beings experience tragedies in their lives. Because of this there is an immediate solidarity between trauma survivor and therapist. Extensive research has revealed the therapeutic power of *deep listening*, i.e. patients love being listened to and heard. There are many clinically effective approaches to listening to the trauma story, from a simple acknowledgment of the patient's traumatic narrative, through the use of diaries, and the systematic reliving of the trauma events through exposure therapy. Due to the potential to trigger upset in the patient, proper administration of story-telling techniques necessary – i.e. they should only be used once trust has been established; most patients maximize their recovery from having an ongoing conversation with the therapist. The moral of the story is that deep listening heals.

Therapists using a holistic approach are used to considering the *bio-psycho-social and spiritual* domains of the patient's suffering. The H<sup>5</sup> Model overlaps with the latter by offering a broader cultural, wellness and sociological approach that integrates into one model all aspects of the trauma survivor's health problems and underlying resiliency. Each of the H<sup>5</sup> elements is real and forms a platform for understanding the survivor's medical and psychiatric diagnoses such as PTSD and depression. The H<sup>5</sup> elements encompass survivor's personal narrative that helps us to determine the illness and resiliency of each and every survivor within the general population. The H<sup>5</sup> Model can be easily adapted to a trauma-informed care approach.



## H.1. HUMAN RIGHTS VIOLATIONS:

All acts of violence are human rights violations. TIC therapists should take a careful look at the *UN Declaration of Human Rights*. This document codified after World War II by the United Nations is one of our world's greatest achievements. It is sad that few American doctors and/or their patients have read the UN Declaration of Human Rights. Acts of domestic violence, for example, are human rights violations. A recent front page article in the *Boston Globe* (August 10, 2014) highlighted the hundreds of ways people, mainly women and children, are abused. This is not to say that men and the elderly are not frequent victims of domestic violence. This important article collected from the Boston Police files reveals that whatever is at hand becomes a weapon:

*The ways to hurt are infinite when you live with an abuser, everything is a weapon. In their hands innocent objects like ice-cube trays and checker boards and apples and pillows become ways to inflict suffering to demand submission.*

Over the past 3 decades using culturally validated instruments such as the *Harvard Trauma Questionnaire* (HTQ) we have been able to document the brutal facts associated with the refugee experience worldwide and for resettled refugees in the U.S. Now, we need to get this energy into the TIC approach for our local mainstream communities. The psychological experts on the *Holocaust* have called this “bearing witness.” The horrible facts witnessed in the *Boston Globe* article for example need to be brought out in the doctor's office and made public as well. Unfortunately, in our medical and psychological settings, extensive research reveals that they rarely emerge, or are even acknowledged by medical professionals.

## H.2. HUMILIATION

Humiliation is the major instrument of violence used by perpetrators to create the state of humiliation in all violated persons. Unfortunately, that key emotional state is linked to self-destructive behaviors, self-deprecation and learned helplessness. Humiliation is hidden behind the more prominent symptoms of somatic complaints, depression and posttraumatic stress disorder. The state of humiliation needs to be identified and transformed – and can be transformed – as part of the recovery process. This phenomenon also explains why traumatized persons are very sensitive and emotionally distressed by the perceived empathic failure of insensitivity within the health and social service system.

HPRT's clinical experience after 3 decades of caring for torture survivors and survivors of mass violence (N=10,000) reveals the following:

First, *“healing is a shared empathic partnership between 2 people working together in a community to create a new world-view.”* This aphorism acknowledges that the humiliated state of the survivor needs to be transformed and that it can only be done in a “shared” empathic partnership. The survivor and the therapists are *partners* and they each have empathy for the other. While the patient needs the empathic response of the healer, the healer needs the empathic response of the survivor. Otherwise, how can either of them bear to listen to such unbearable pain and suffering? And while humiliation destroys all that the survivor believed in was good, the survivor and therapist can create a new, and maybe better, worldview and reality. HPRT in it's clinic has witnessed the latter over thousands of times. It is not a rare experience.

The second acknowledged truth is that *“healing can only occur when the patient believes they can become whole again.”* Some survivors feel so damaged, they believe they can never recover. This is called in the therapeutic scientific literature *self-efficacy*. In our clinic, we always take

this up immediately, otherwise if a patient has no belief in their own “self-efficacy,” the therapy will fail.

### H.3. HEALING (SELF-CARE)

The remarkable realization that all persons affected by violence have a powerful physical, mental, and social self-healing response is critical to facilitating the patient’s healing recovery. In essence, the therapists have to recognize this self-healing response and build upon it. Patient survivors are not passive recipients of medication or talk therapy. They are doing a lot to help themselves, over and beyond the brief and important time they spend with the health professional and/or therapist. In fact, in the HPRT clinic we tell every patient that they are our *teachers* and we are their *students*. It is incredible the joy this statement brings to the most *humiliated* person to be seen as a *teacher* of the doctor.

The self-healing activities revealed to the therapist are sometimes unbelievable but are always profound. Since we have learned through our scientific studies the important self-healing power of (1) work/school (2) altruism (3) spirituality, we check out each of these areas in the life of the survivor. If some area is lacking or underdeveloped we try to find out why – correct and remove the barriers – and work out a prescription to encourage the self-healing activity. Many of our older Cambodian women, for example, have little time for themselves. They are given a prescription to take home to their families and say something like: “*the doctor has ordered me to go to the temple on the weekends.*” And usually after seeing the doctor’s note, the families agree to this.

### H.4. HEALTH PROMOTION

The famous Adverse Child Events (ACE) study has done more than any other study in America to demonstrate to mainstream American communities the impact of child abuse and past traumatic life experiences on the health and well-being of community members. Many other studies have demonstrated in Canada and America the terrible long-term impact of past and current violence on all organ systems, but especially stress-related illnesses such as diabetes, hypertension, heart disease and the metabolic syndrome. Not surprisingly depression, PTSD, drug and alcohol abuse and suicide are also associated with traumatic life events.

HPRT has spent over a decade developing a culturally valid health promotion curriculum for Cambodian torture survivors as well as a special diabetes group. All persons who have experienced violence should be in a health promotion activity that includes diet, exercise, meditation, stress reduction and practical life style changes directed at caring for insomnia and symptoms of PTSD (e.g. flashbacks). The data from our refugee studies and from other mainstream population based studies reveal that health promotion alone can have a dramatic impact on reducing depressive symptoms.

### H.5. HABITAT

Many survivors not only live in psychologically oppressive environments but also in terrible housing situations. For many abused patients it is not uncommon to find them and their family living in terrible and filthy conditions; fire traps, over-crowding and many other adverse living situations negatively affect patients. Perpetrators of domestic violence often force their victims to stay in one room or a closet. In one situation at HPRT, an elderly Cambodian woman was forced to sleep on a couch in the middle of her landlord’s living room. In another situation, a small baby was brought to a crowded house of a boyfriend

with a lot of partying and drinking going on. The teenage mother and baby slept on the floor and the baby swallowed a small object, choking to death. Our patient's daughter was devastated by this situation. Yet, it is rare for health professionals and therapists to ask the survivor about their living environment. Hopefully the H<sup>5</sup> Model will help to change this very neglected area in therapy.

### III. THE H<sup>5</sup> MODEL SCALE:

A culturally valid scale with known psychometric properties is in its earliest stages of development. However, all therapists can rate the survivor's responses on the following scale as an overview of elements of the H<sup>5</sup> Model:

First try to define what *you* mean by each of the responses since the scale is still being developed. Then take a look and see how the survivor is doing. This should be very informative, especially those answers where the survivor is scoring a 3 or a 4. This simple assessment may be able to help you guide your treatment approach.

<b>H<sup>5</sup> Model Scale</b>	1 (none)	2 (minor)	3 (moderate)	4 (severe)
<b>H.1.</b> Human Rights Violation				
<b>H.2.</b> State of Humiliation				
	1 (very good)	2 (adequate)	3 (poor)	4 (totally inadequate)
<b>H.3.</b> Healing Activities (self) - Altruism - Work - Spirituality				
<b>H.4.</b> Health Promotion				
<b>H.5.</b> Habitat / Housing				

## RECOMMENDATIONS FOR TRAUMA INFORMED CARE BASED UPON THE H<sup>5</sup> MODEL:

Recommendations based upon the H<sup>5</sup> Model are:

1. Once trust is established try to conduct a *trauma story* interview reviewing the 4 elements of the *trauma story*. A diary that can be used called the *Trauma Story Assessment and Therapy* (TBAT) is available at <http://www.lulu.com/shop/richard-f-mollica/trauma-story-assessment-and-therapy-journal-for-field-and-clinic/paperback/product-20342010.html>.
2. Once trust is established try to understand the nature and scope of the survivor's experienced human rights violation(s). This will help you understand the abuse and recommend the appropriate medical, psychological and social support.
3. Evaluate the survivor's self-healing response. This interview is also available in the TSAT diary <http://www.lulu.com/shop/richard-f-mollica/trauma-story-assessment-and-therapy-journal-for-field-and-clinic/paperback/product-20342010.html>.
4. All survivors need to be in a health promotion program.
5. Extensively explore the living environment of the survivor. Make this a priority.

## IV. CONCLUSION

In conclusion, it is hoped that the H<sup>5</sup> Model will provide you with new insights and techniques for assisting the traumatized person in *all* environments. Patients/clients and therapists should add their experience and insights to this working document especially as the model is adapted to different cultures and ethnic groups. We look forward to your input and feedback.

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