

Buddhist Approach to Healing and Wellness: A Vietnamese American Case Study for United Nations Millennium Development Goals

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ABSTRACT

While the topic and issue of mental health is not one of the focuses of the United Nations Millennium Development Goals (MDGs) established at the Millennium Summit in New York in September 2000, it is embedded in all eight MDGs that seek to “...eradicate extreme poverty and hunger; to achieve universal primary education; to promote gender equality and empower women; to reduce child mortality; to improve maternal health; to combat HIV/AIDS, malaria and other diseases; to ensure environmental sustainability; and to develop a global partnership for development” (United Nations Economic and Social Council). All eight MDGs focus on bettering the human condition, especially among the displaced and underserved who live in extreme poverty and face multiple threats that limit their potential to life and happiness. The eight MDGs focus on macro variables for improving living conditions globally, while establishing new strong global partnerships to secure peace and human well-being. One variable that the eight MDGs does not directly address, but must consider is the mental health and well-being of people worldwide, especially those who face poverty, hunger, and need education and healthcare. Among the

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refugee community, mental health and well-being is critically important, as living conditions and coping behaviors are directly correlated to good mental health and well-being.

INTRODUCTION

While the topic and issue of mental health is not one of the focuses of the United Nations Millennium Development Goals (MDGs) established at the Millennium Summit in New York in September 2000, it is embedded in all eight MDGs that seek to "...eradicate extreme poverty and hunger; to achieve universal primary education; to promote gender equality and empower women; to reduce child mortality; to improve maternal health; to combat HIV/AIDS, malaria and other diseases; to ensure environmental sustainability; and to develop a global partnership for development" (United Nations Economic and Social Council). All eight MDGs focus on bettering the human condition, especially among the displaced and underserved who live in extreme poverty and face multiple threats that limits their potential to life and happiness. The eight MDGs focus on macro variables for improving living conditions globally, while establishing new strong global partnerships to secure peace and human well-being. One variable that the eight MDGs does not directly address, but must consider is the mental health and well-being of people worldwide, especially those who face poverty, hunger, and need education, and healthcare. Among the refugee community, mental health and well-being is critically important, as living conditions and coping behaviors are directly correlated to good mental health and well-being. Unresolved war traumas and the complex processes of assimilation into a new host society contribute to the mental health and well-being of Vietnamese refugees in the United States. There is an abundance of scholarship from psychology, clinical counseling, and medicine that have focused on cultural and linguistic variables that prevent Vietnamese refugees from seeking mental health services (Brower, 1980; Gold, 1992; Lee, 1996; Wong, 2002; Nguyen & Anderson, 2005; Dow, 2011). Moreover, this body of scholarship was geared towards mental health professionals to assist them with Vietnamese clients. Current scholarship makes it clear that the Vietnamese refugee population underutilizes mental health services and ignores the intersection of religion and mental health.

This article argues that Vietnamese Buddhist approaches to mental health therapies are necessary to treat the Vietnamese refugee population in America. First, we discuss the relationship between Buddhism and mental health. Second, we explore the literature on Vietnamese Americans and mental health. Third, we make recommendations for culturally informed and religiously ecumenical therapeutic approaches for Vietnamese refugees, and by extension, Vietnamese Americans with mental health issues. These recommendations can be embedded into the current MGDs to highlight the importance of mental health and well-being in achieving all eight MDGs by 2015 (United Nations Economic and Social Council).

BUDDHISM AND MENTAL HEALTH: ASSESSING THE FIELD

Writing about Vietnamese Americans and mental health came about because of the everyday stresses that I have witnessed firsthand, such as financial and family problems that stemmed from the sudden need to flee Vietnam for America. The difficulties dealing with illnesses within the family, language barriers, not having enough money for bills and food, and expectations to support one's family in America and remaining kin in Vietnam are all issues that I have seen create tensions and stresses, which together impact mental health and wellness among first generation Vietnamese refugee Americans. First generation Vietnamese refugee Americans practice chanting Buddhist verses, or listening to Buddhist mantras, or reading literature from Buddhist temples, and/or presenting incense to one's ancestral altar provide solace and peace-of-mind amidst great mental anguish and suffering. Growing up, I witnessed all these Buddhist practices, which seemed normal to me, so I did not question it, and did not equate it as ways of coping with mental and emotional hardships. Seeking professional help such as counseling is discouraged among the first generation Vietnamese refugee communities, because it is viewed as negative. Talking about one's problems occurs within the family, but even that sometimes is difficult. The experience of being a Vietnamese refugee and coming to America abruptly due to the Vietnam War is not something that I experienced myself, but growing up as a second generation Vietnamese American, it does directly affect me. Researching ways that may be more appropriate for Vietnamese Americans to heal

from mental and emotional illnesses and disorders drives this thesis in the direction of discussing mental health and Buddhism.

The notions and dialogues around Vietnam and Vietnamese people mainly revolve around the discussion of the Vietnam War and the struggles Vietnamese refugees endured leaving Vietnam suddenly and by force. Early scholarships in psychology, medicine, and clinical counseling on mental health served as a comprehensive guide for mental health professionals to be able to serve the Vietnamese refugee population. These literatures often embodied an overall discussion of varied topics such as Vietnamese cultural-lifestyle, language, and values as they relate to mental health. They are informative and attempt to build a holistic view in order to understand and address Vietnamese mental health issues (Brower, 1980; Gold, 1992). Some mental health problems that plague the Vietnamese refugees population are depression, anxiety disorder, and post-traumatic stress disorder, (PTSD) all of which are usually associated with combat, imprisonment, and brutal pirate attacks (Purnell, 2008, p. 65). Trusting authorities is one of the main issues that mental health professionals need to be aware of, because it would be difficult to provide counseling services to Vietnamese refugees when they would not open up about their issue (Brower, 1980; Gold, 1992; Purnell, 2008). Cultural differences such as values, language, religious beliefs, and immigration circumstances were examined and explained thoroughly as well. A sensitive and understanding approach were encouraged to build better rapport with Vietnamese refugees (Brower, 1980; Gold, 1992; Purnell, 2008). For example, Brower (1980) encouraged counselors to look for signs of stress and emotional problems that may be related to the war and the refugee experience. Counselors need to do this because Vietnamese refugees lack familiarity with mental health and may be unwilling to reach out for help (Brower, 180, p. 650). The resettlement system is important to understand as well because they have to go through a series of agencies; process such as paperwork for government assistance, and all these may create adjustment problems therefore affecting their mental health (Gold, 1992, p. 292).

A vital point that was also addressed was how Vietnamese refugees are unfamiliar with mental health in that they do not see a connection

between the process of going through therapy and how that may solve their problems (Gold, 1992, p. 292). The word “counselor” does not have an equivalent in the Vietnamese language, which adds to the problem (Gold, 1992, p. 292). Among Asian-Americans, the term “mental health” may have different meanings. For example, “depression” would be considered a type of mental illness in the United States, but not in countries like China and Vietnam, which adds to the complications of providing mental health services to Asian Americans (Hampton, Yeung, & Nguyen, 2007, p.17). The term “psychiatrist” in Vietnamese does not have the same definition as in America, the literal translation would be “nerve physician” (Purnell, 2008, p. 65). The variation in definition for mental health points to the assumptions that mental health is the same for others, when it may actually not be the case.

Dow (2011) focused on immigrant’s perceptions and barriers to receiving mental health services. Though Vietnamese Americans were not the central focus of the study, there were findings that related to them. Dow (2011) says that immigrants are unclear on the purpose of counseling and prefer direct and quick solutions to their problems. Mental health services often operate on western principles, which may be at odds with values and beliefs of immigrants from the east (Dow, 2011, p. 179). Dow (2011) also emphasized the lack of attention given to immigrants, saying, “Due to little attention given to the psychological needs of minorities in counseling centers and the common utilization of mainstream counseling styles, such as the primacy of the individual over group and a focus on competition and achievement, minorities may feel that most counseling services simply do not apply to them and therefore do not initiate services” (p.179).

Even with attempts to create culturally and linguistically appropriate services, Asian Americans, specifically Vietnamese Americans, show low rates of seeking and completing treatment for mental health disorders (Leong & Lau, 2001). The underutilization of mental health services and low success in mental health treatment for Vietnamese Americans has been commonly linked to the refugee experience (Yoo et al., 2013).

One of the main religions that is practiced by Vietnamese refugees

is Buddhism, which also incorporates elements of Confucianism, Taoism, and Catholicism (Purnell, 2008; Lee, 2011). There is a strong belief that spirits and deities control and affect Vietnamese lives, and spirits of dead relatives continue to live on in the home (Purnell, 2008; Lee, 2011). Early scholarship has shown that Vietnamese people go to Buddhist monks for help with mental health problems that were believed to be caused by evil spirits and can be resolved by religious means (Brower, 1980, p.650). There have been incidents that have been reported such as when a Vietnamese woman believed she was taken over by a ghost and brought to the Community Mental Health Agency (Gold, 1992, p.290). The staff there was unable to help her and so she asked to be taken to a Buddhist temple where she was exorcised and prayed over. Later she recovered and was fine (Gold, 1992, p.290). According to Gold, there is reluctance, or an inability to separate between psychological, physiological, and supernatural causes of illness for many Southeast Asians (Gold, 1992, p. 292).

Studies on Vietnamese persons and mental health (Brower, 1980; Gold, 1992; Nguyen & Anderson, 2005; Dow, 2011) have explored the interaction between mental health and religion among Vietnamese Americans, but none has focused specifically on Buddhism and its connection to mental health therapy. There have been other studies examining the interplay between religion and mental health for other Asian Americans such as the importance of Taoism and its impact on mental health for Chinese Americans (Yip, 2004). Yip (2004) described how Taoism is appropriate in handling mental health in the Chinese communities by comparing and contrasting Taoism understanding of mental health and the modern western approach to mental health. There have been other works such as the effects that religious involvement have on Chinese Americans (Huang, Appel, Ai, & Lin, 2012) and about Lao Buddhism and how religious workers and rituals play a vital part in preventing mental illnesses and ameliorate mental health problems in Laos because there are no mental health professionals there such as psychologists and psychiatrists (Westermeyer, 1973). According to Dow (2011), religious beliefs and activities such as prayer have had positive effects on people's lives and well-being. There have been studies with Indochinese and Malaysian people that used

religious counselors, traditional healers, and family members as their support with their family members who have a mental illness (Dow, 2011). Religious commitment is seen as a form of coping with mental disorders and life stresses for many individuals and families in the United States (Dow, 2011, p. 177). This is something that is lacking in scholarship on the Vietnamese Diaspora and should be examined closely because it could provide help to the Vietnamese Americans who are not receiving mental health services.

VIETNAMESE AMERICAN CASE STUDY: BUDDHISM AND MENTAL HEALTH

This section is an analysis and discussion of studies that have examined the issues surrounding Vietnamese Americans and mental health. Research on this matter has branched into many fields such as medicine, counseling, psychology, religion, and social work.

A prevalent theme in the field of medicine and counseling is examining mental health barriers. Frederick T. L. Leong and Anna S. L. Lau's (2001) critical review of literature regarding Asian American mental health discussed the barriers that Asian Americans encounter when accessing mental health services. According to Leong and Lau (2001), mental health barriers had two focuses: barriers to initiate mental health services and barriers to stay in treatment. Cognitive barriers such as perception of what mental illness is and physical barriers such as not being able to access services due to monetary means were huge factors in why there may be resistance and reluctance to seek mental health services (Leong & Lau, 2001, p.203). An important finding in Leong and Lau's work was how the data for the Vietnamese population varied. "Findings of utilization rates among Southeast Asians have been mixed with one study finding lower utilization and more premature termination among Vietnamese and another study finding higher rates of use for Southeast Asian groups" (Leong & Lau, 2001, p.202). Southeast Asians also show less improvement in treatment than other Asian groups (Leong & Lau, 2001, p.202). This shows how the data for the Vietnamese population are inconclusive and demonstrates how difficult it is to prove the utilization

of mental health services for Vietnamese Americans.

The reason for low utilization rates among Vietnamese could be how they view and understand mental health. Nan Zhang Hampton, Teresa Yeung, and Courtney Hoa Nguyen, (2007) in a qualitative study, interviewed 40 Chinese and Vietnamese participants on their perception on mental illness and rehabilitation. The findings showed that participants connected physical health and mental health together (Hampton, Yeung, & Nguyen, 2007, p.17). The content analysis of the study revealed two themes: physical and mental/psychological viewpoints (Hampton et al., 2007, p. 17). Physical perspectives included being pain free and the ability to go to school and work while the mental/ psychological health included having good memory, thinking clearly, and being happy (Hampton et al., 2007, p. 17). A participant stated that “depression could be related to chronic illnesses such as cancer” which showed the link between physical and mental health (Hampton et al., 2007, p. 17). All participants reported that they would seek help through a doctor for physical and mental illness, but rarely was there any mention of consulting other mental health professionals. Mental illness was cured through medication (Hampton et al., 2007, p. 17). The inability to differentiate between mind and body, which Gold (1992) also discussed about Vietnamese refugees, was prominent and this study supported that notion.

Hoa B. Appel, Bu Huang, Amy L. Ai, and Chyongchiou Jeng Jin (2011) discussed this issue of not accessing mental health services, but focused on Asian American women, including Vietnamese women. This study focused on physical, behavioral, and mental health issues in Asian American women. It used a nationally representative sample of 1,097 women from the National Latino Asian American Study (NLAAS) where annual rates of accessing mental health services were examined (Appel et al., 2011, p.1703). They discussed the underutilization of mental health services and found out immigration status was a key factor (Appel et al., 2011, p.1704). According to Appel et al. (2011), the fear of how confidentiality may not be maintained discourages the accessing of mental health services. This is another significant issue that affects the rates of seeking mental health services.

Vietnamese immigrants” and refugee women”s mental health was examined in a study done by Chris Brown, Codi L. Schale, and Johanna E. Nilsson (2010), on the length of stay, income, and English proficiency to see if there were differences with mental and physical distress. The participants were 83 Vietnamese women whose length of residency in the United States ranged from 2 to 30 years (Brown, Schale, & Nilsson, 2010, p.66). Participants rated items using a 4-point Likert-type scale with 1 indicating less symptoms distress and 4 indicating a high symptom distress (Brown, et al., 2010, p.68). According to Brown et al. (2010), women who had poorer English language proficiency also had a greater amount of physical discomfort. They also had a lower income compared to women with better English language proficiency (Brown et al., 2010, p.70). English proficiency does increase chances of obtaining a better paying job which could affect Vietnamese immigrants and refugees” quality of life and well-being because they would not have to worry about money (Brown et al., 2010, p.73). Brown et al. (2010) also discussed how professional counseling should be sought for Vietnamese immigrants and refugees women to deal with the general and somatic distress experienced by coming to America.

In psychology, the analysis revolved more around the Vietnamese Americans” mindset, especially around their beliefs. Paul Bao Lam (2003) discussed the relationship of Vietnamese refugees in the United States with spirituality, religion, coping strategies, and life satisfaction. A survey and four questionnaires were given to 232 participants who were recruited through churches, temples, and community organizations (Lam, 2003, p.96). Results showed that spirituality and religion were important to Vietnamese refugees who participated in the study because it provides coping mechanisms to deal with daily life stressors (Lam, 2003). Life satisfaction was related to high income, good health, problem-solving skills, and less stress in people”s lives (Lam, 2003). According to Lam (2003), “Psychologists and mental health professionals should use the Vietnamese religious community and leaders as a supportive system” (p.170). Establishing a good relationship among mental health professionals and spiritual and religious leaders, would be a step towards finding a solution that would work for Vietnamese people (Lam, 2003, p.184).

Quang Charles X. Nguyen and Louis P. Anderson's qualitative study on Vietnamese Americans attitudes towards seeking mental health services was conducted with 148 participants who agreed to answered questionnaires using a scale to show the connection between stigmas and accessing services (Nguyen & Anderson, 2005). Outside help is sought for mental health problems when the family cannot help the individual. Going to a religious figure such as a priest and Buddhist monk are more acceptable (Nguyen & Anderson, 2005, p.215). However, there is still fear of bringing shame to the family and being ridiculed by the community because it is a sign of weakness (Nguyen & Anderson, 2005, p.215). Their findings showed that there were no connections to the influence of stigmas interfering with accessing services, which is inconsistent with prior reports about how the stigma of mental illness deters Vietnamese from seeking mental health services (Nguyen & Anderson, 2005, p. 226).

Jerry Vu (2012) discussed how Vietnamese American adolescents are encountering barriers to mental health services which he shows through interviewing two psychologists and a psychiatrist, and presentation questionnaires and evaluations to mental health professionals. The results of the interviews showed that trauma from the Vietnam War has been transmitted to the younger generation and affects their mental health (Vu, 2012, p.63). Problems such as post-traumatic stress disorder, anxiety, and depression sometimes manifest into domestic violence that harms the family (Vu, 2012, p.63). The resettlement in America is difficult for the younger generation as well and the issues take on the forms of behavioral and substance problems: skipping school, getting into fights, drinking, smoking, and disobeying authorities (Vu, 2012, p.71).

Vu (2012), defines the term acculturation and enculturation by writing, "... for some Vietnamese Americans, *enculturation* refers to the process of socializing into and maintaining the norms of Vietnamese heritage and culture, whereas the term *acculturation* explains the process of adapting to United States cultural norms." (p.35). This is significant in that it starts to direct the dialogue away from refugees to a discussion on the younger Vietnamese generations who have become more Americanized. According to Vu (2012), acculturation and enculturation definitely affects people's perspectives and acceptance of mental health services and should

be examined when discussing the rates of utilization among Vietnamese Americans.

The field of social work addressed issues that were not discussed in other literature such as clinicians' perspective on spirituality. According to Uyen Nguyen (2011), spirituality is a controversial issue in clinical practice. The need to integrate spirituality in clinical practice has been recognized, but even with this recognition there is still resistance and limited research on this topic (Nguyen, 2011, p. 5). This study focused on Vietnamese clinicians' perspectives on ethics and ethical standards when addressing their Vietnamese client's spiritual needs (Nguyen, 2011, p.39). This is the area where my research will expand on. I will interview mental health professionals as well, but will focus on what the best practices are and if mental health professionals have created a model that has worked for them to deal with conflicting ideologies of mental health such as religious beliefs. This qualitative study used focused groups. The study had 14 participants from Orange County and 1 participant from Los Angeles, California. There were 11 females and 4 males clinicians in the focus groups (Nguyen, 2011, p.33). In this study, three focus groups answered questions regarding: culturally-based spiritual practices among Vietnamese clients, ethical dilemmas around spiritual practices, and recommendations on how to address ethical dilemmas based on clinicians past experience (Nguyen, 2011, p.39). The results showed that there were issues that created internal conflicts for Vietnamese clinicians. For example, there were difficulties in knowing when to call Child Protective Services because at times families turn to traditional practices and not scientific studies. There was a case where a family tried to beat the evil spirits out of the child, and the participant understood where the family was coming from, but as a mandated reporter the mental health professional needed to report these types of incidents (Nguyen, 2011, p.55). The results also showed that Vietnamese clinicians encountered many cases of conflicts between ethical dilemmas and spiritual needs even though the clinicians were Vietnamese. For example, there were many cases of how Vietnamese clients believe that their mental illness were the cause of bad things that they did when they were younger or in their past life such as robbery (Nguyen, 2011, p.49). Another example is that many clients

used prayer as a way to heal from mental disorder (Nguyen, 2011, p.51). These examples demonstrate the conflicts and difficulties for clinicians to help clients because they do not have the appropriate tools and training to address these issues. According to Nguyen (2011), the study was a way to bring up the topic of spirituality, western mental health services, and explored the complexity of the topic. The study was to provide clinicians with a better understanding of Vietnamese clients and to better address the subject of spirituality in a clinical setting (Nguyen, 2011).

HieuNhu Nguyen's (2008) study used self-administrated questionnaires to examine Vietnamese American mental health professionals' self-construal, how one views and relates to others (p.5), and multicultural competency, how they maintain practice that is sensitive when working with others from different cultures (p. 18). The sample consisted of 43 Vietnamese American mental health professionals from various locations in Orange County, California (Nguyen, 2008, p.45). There were 32 females and 11 males (Nguyen, 2008, p.50). The results were that Vietnamese Americans in the sample identified with independent self-construal, viewing themselves as self-reliant (Nguyen, 2008, p.13), rather than interdependent self-construal, viewing themselves in a group oriented framework (Nguyen, 2008, p.14), which prior research have suggested. Participants may also be more acculturated and hold more Western views and values which may have led to this result (Nguyen, 2008, p.69). Report of higher level of multicultural knowledge and the number of years in the field correlated with better multicultural skills to interact with people from different cultures as well (Nguyen, 2008, p.70).

Georgia Yu's (2013) study administrated online surveys to gain a better understanding of Asian American mental health professionals' religious and spiritual beliefs, affiliations, and involvements through a psychology perspective instead of social work. The goal of the study was to see if their religion and spirituality impacted their own professional practices (Yu, 2013, p.28). A total of 46 surveys were analyzed (Yu, 2013, p.29). A large number consisting of 18 participants identified as Chinese/ Taiwanese and second was 12 participants who identified as Indian/ South Asian. There was only one participant who identified as Vietnamese (Yu, 2013, p.29). The results had many interesting findings such as how 13 out of 46 did

not think their graduate education and clinical training in dealing with religious and spiritual issues in psychotherapy was adequate (Yu, 2013, p.50), 17 out of 46 participants were influenced by their own religious and spiritual beliefs to pursue a career in psychology and in the mental health profession, and 32 out of 46 shared that their work is meaningful to them (Yu, 2013, p. 52).

Not much has been studied about Vietnamese well-being, but an earlier study discussed social and economic factors that were important in Vietnamese people's lives. A research study of 145 Vietnamese refugees living in two geographical areas in Texas and Oklahoma answered questionnaires, which were both in English and Vietnamese, about their well-being such as socioeconomic, anxiety levels, and marital status (Tran & Wright, 1986). According to Tran and Wright (1986), a Vietnamese refugee was happy and content with their life when the person had a strong social support system, was not afraid to interact with Americans, had a high income, and who was married. English proficiency was also very important because this helped with Vietnamese refugees' confidence in their everyday interactions and increased their chance of landing a better paying job (Tran & Wright, 1986). This is still prominent in the Vietnamese communities in that there are still language barriers and economic hardships that may affect people's satisfaction with life, which can affect their mental health status.

The literature on Vietnamese Americans and mental health has definitely built a cohesive understanding of Vietnamese life here in American and the mental health problems that exist from the refugee experience. Major fields such as medicine, counseling, psychology, sociology, and social work discuss common themes such as Vietnamese refugees, mental health barriers, and religion, but they share the same common solution as well – counseling. Many scholars have looked at difference aspects of spirituality and religion, but it is either mentioned in passing or revolves around the clinical setting and practice. The strength for all these studies were the many aspects that were covered on counseling for Vietnamese, but the weakness is also the emphasis on counseling. There should be more alternatives to counseling, especially since prior work has showed that the Vietnamese refugee experience and war trauma has been linked to mental

health issues. This means that other approaches should be considered because one solution may not work for everyone. My goal is to examine the interplay between religion, specifically Buddhism, and mental health therapy through interviews with mental health professionals. This way we can understand more about the mental health professionals' struggles and see what methods they have implemented themselves to address the conflicting ideologies encountered with their Vietnamese clients.

William A Vega and Rubén G. Rumbaut (1991) discussed the definition of "mental health" – pointing out how the original intention was to reflect psychological well-being and satisfactory state of being. According to Vega and Rumbaut (1991), the term "mental health" has gradually progressed, "Nonetheless, despite this optimistic facade, researchers and services providers, from that time until the present have been narrowly focused on mental disorders" (p. 355). This is prominent in most literature on Vietnamese Americans and mental health. For this study, mental health is defined as "... psychological well-being and resilience; in essence, a satisfactory if not optimal state of being" (Vega & Rumbaut, 1991, p.355). The operationalized variables of mental health will encompass aspects such as physical and spiritual. The physical manifestation of psychological problems such as fatigue and body aches will be examined. Vega & Rumbaut (1991) discuss how some ethnic groups "somatize" psychological problems. "... somatization occurs when "individuals experience serious personal and social problems but interpret them and articulate them, and indeed come to experience and respond to them, through the medium of the body"" (Vega & Rumbaut, 1991, p.358). Another important aspect is spirituality. According to Lam (2003) spiritual and religious support provides coping strategies, promote healing, and prevent problems.

RECOMMENDATIONS FOR MENTAL HEALTH AND THE EIGHT MDGS

According to the UNHCR: The UN Refugee Agency's report produced in 2002, "Measuring the Well-being of People of Concern,"

The United Nations Millennium Development Goals (MDGs) are

directly applicable to refugees, internally displaced, returnees, stateless persons and others of concern to UNHCR. Indeed, the basic rights of these people often fall short of those of local populations. Some UNHCR indicators are identical to those used for promoting the MDGs, whereas others are more indirectly related. There is also a close link between the UNHCR indicators and those of the Sphere Project” (UNHCR: The UN Refugee Agency-emphasis added).

The “Standards and Indicators Report (SIR)” notes,

The overriding priority in ensuring protection to refugees is respect for the principle of non-re-foulement and treatment in accordance with basic human rights and refugee law standards. The rights of refugees to physical security and the enjoyment of other fundamental human rights, lie at the core of UNHCR’s international protection mandate, which is summarized in the Preamble to the 1951 Convention: “to assure refugees the widest possible exercise of... fundamental rights and freedoms” which are normally secured to for the individual by his or her government (2002).

We argue that key to achieving MDGs and SIR goals is providing resources that not only meet the physical and somatic needs of displaced people, but also resources to repair their spiritual, emotional, and mental health and well-being.

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