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Nutritional Psychology and Somatic Approaches for Optimal Health

A Clinical Conversation with Leslie Korn, PhD, MPH, and Robert Rountree, MD

Leslie Korn, PhD, MPH, is a Harvard Medical School-trained specialist in integrative medicine providing telemedicine for mental health nutrition and nutritional psychology to help patients recover from trauma, reduce psychiatric medications and achieve optimal health. She provides case consultation to physical and mental health professionals about complex cases with options for integrative and nutritional methods and offers courses in nutrition and integrative medicine for post-traumatic stress disorder and complex trauma, mental health, diabetes, cognitive decline and Alzheimer's.

Robert Rountree: Tell me about your professional journey. I understand that it began for you in the jungles in Mexico, correct? What led you there? And how did you end up going from rural Mexico to studying at Harvard University?

Leslie Korn: Yes. Like I like to say, the jungle of Harvard. The jungle of Mexico prepared me for the jungle of Harvard. You may hear in my accent a little bit of the Bostonian that remains. I grew up outside of Boston in a very affluent community, and I couldn't wait to get out. I grew up in a close-knit Ashkenazi Jewish family, fairly secular, but there was a strong theme of *tikkun olam*, giving back. And while I was surrounded by all that, I was in the progressive '60s, I really was champing at the bit to leave. I left home at 16 and lived in the city for a while and—obviously this was during the time of the Vietnam War—had a growing political and social justice consciousness at that time. I was also involved in the feminist movement, which at the time in Boston was very focused on *Our Bodies, Ourselves* and on women's self-care. I also had dreams of being a writer. I had a very early vision as a young child of living in the jungle and doing health care. And yet while I'd had, in many ways, a charmed childhood, I also had a fair amount of trauma that I was not aware of for many years. And so, I was really searching, and I think many of us were searching, during that time, and I think it's the time to search, at that age, but I was really looking for some meaning and purpose. And I was lucky: I attended one year at Washington University, in St Louis, and I was very influenced by a Chinese philosopher with whom I studied, and who I trained with doing auricular acupuncture. That influenced me a great deal. I learned Taoist meditation, and yoga, and was thrust onto this path, then, where this was very satisfying to me, and I was off on my adventure. Hightailed it by bus to Mexico. ◀AU0

Dr. Rountree: That must have been a very long bus ride!

Dr. Korn: It was a long bus ride. And for many years, all I could afford was the bus ride. And I was really in search of an adventure. In retrospect, feeling quite divinely guided, but at the time, just not knowing a thing. What do we know at the age of 20? Not much—except the intense dissatisfaction with the life that I was leading. So I dropped out of my second year of college in search of being a writer and in search of meaning and purpose. What else are we doing at that age? I landed in a little village south of Puerta Vallarta, Mexico. No running water, no cars, no electricity. Pigs and cows galore. I was in heaven. It was a small indigenous fishing village, and I felt right at home.

Dr. Rountree: Did you speak Spanish?

Dr. Korn: I didn't know Spanish. I knew nothing. I knew absolutely nothing. I had my little tattered copy of *Our Bodies, Ourselves*.[1] It was the first newspaper print edition. I was embraced in this community, and really felt quite at home—that I had found where I belonged. I stayed for 10 years the first time and I did not leave, until I returned 10 years later and worked there another 8 years. I got sick with absolutely everything there was to get sick with, every mosquito, virus, bacteria, strange, even undiagnosable disease, and that just furthered my quest for understanding the mind and the body. There was no doctor, no nurses—there were village healers, *curanderos*, herbalists, and this became my education.

Dr. Rountree: I remember a popular book from back then, *Donde No Hay Doctor, by* David Werner.[2]

Dr. Korn: That's right. Yes, I loved that book. It was my bible when I opened my health clinic. It was a brilliant book, and The Barefoot Doctor's Handbook, which was used to train Chinese acupuncturists. I think you and I are the same generation, Robert. And so those were very influential. I had hated school. I say this to everyone who looks at all my credentials now. But I barely graduated high school. I hated school. I was so bored by it all. I was a very kinesthetic learner, creative learner, and I had the opportunity to start a little school, a little one-room schoolhouse, and there I was able to do the kind of school and be the kind of teacher that I had always wanted. We would dance and write poetry and bake to learn arithmetic. I did that for the first few years. I made $20 a week and just lived that life in a hammock and in a little thatched roof and just was happy as a clam, and during that time obviously became friends with the women in the village and the children. It was during this time, also, that I had these very powerful spiritual experiences. I was exploring out-of-body experiences, and altered states, and I had dreams, lucid dreams, that really had me focusing in this area of altered states and the capacity for healing myself. And certainly, as we see now, as I write about in my books, in my work, many of us who have experienced trauma and dissociation do have these, what we think of as paranormal or extranormal skills that we don't always understand where they come from, but we often explore them, and then channel them in very positive ways. AU0►

Dr. Rountree: Did you have any guidance when you were having those experiences—were there local shamans or mystics with whom you could consult, or were you just on your own and coming up with the best interpretations that you could muster?

Dr. Korn: It was more books. I had books, or I would somehow get a hold of books, really what we think of as the perennial wisdom. I remember the work of Robert Monroe.[3] Jane Roberts.[4] Yogananda.[5] These were all early influences, along with Sylvia Ashton-Warner, a New Zealand educator and novelist. *Summerhill* influences all of this around children and creativity and teaching.[6] So there were these kind of merging ideas about creative education, but also kind of exploring consciousness. The work of Gurdjieff, what we think of as the esoteric books. The *I Ching*, which is what I had studied, Chinese philosophy and Taoism at Washington University with Dr. Ho. I was also introduced to various entheogens and psychoactive plants by local healers as well.

Dr. Rountree: Did you learn about all those progressive ideas while you were still in Mexico? How did you get access to that information?

Dr. Korn: You know, people came through, or I had to travel every six months by bus to the border and change my visa and come back, so I wasn't isolated in that regard. Or people would visit and bring me things. But it was experiential. And at that time, I had a profound experience of meeting, really, my teacher in bodywork. That's where I began. I began in polarity therapy and craniosacral therapy. The stage had been set with my acupuncture instructor, my acupressure instructor, and so I was just beginning to practice with my friends in the village when I met someone who trained me, basically, in polarity therapy and in craniosacral therapy. So that became my work, and I opened a little free health center. And by this time I was already working with the women in the village. I was using my *Our Bodies, Ourselves* to support women around birth control, because women were having, still, 9 and 10 and 12 children. Vasectomies were never mentioned on the tips of anyone's tongues at that point in time. And so evolved, really, a women's health center, but really a health center for everybody. I ended up treating men who had diving accidents, who had decompression syndrome, as we called it. We didn't have a chamber nearby, but we would treat people while we were waiting for the boat to get ready to whisk someone off to the city, to then fly them to the chamber, so you can imagine. It was quite an ordeal. I write a story about this in my book, Rhythms of Recovery, Trauma, Nature and the Body.[7] ◄AU0

So I had the opportunity to treat all kinds of people, and I think this influenced my fearlessness and what I encourage in my students is a fearlessness of practice. Someone falls out of a boat or falls out of a hammock and dislocates their sacrum or the coccyx or falls onto a cactus spine or is a domestic violence survivor or just has plain old neck pain—everybody came to me. And did I know what I was doing? Most of the time I didn't, not at first. But what I did know is they'd lay on my table, and I cradled their head, I touched their bodies, and out came their stories as their pain was released. Out came the stories of the trauma, whether it was acute or latent, sometimes accessing memories. This is the practice I had for the first 10 years. And during that time, as I understood my practice, over the years, I began to teach. I invited people to study, to learn rural medicine, to learn rural health, to understand indigenous society, to eat the herbs and the fruits and understand all of that while they learned how to touch to heal. That supported the health clinic, it supported the pro bono work that I did. That was throughout most of the '80s and then again in late 90s. ◄AU0

Dr. Rountree: Did you have to get government approval or some kind of license for what you were doing, or did they just leave you alone?

Dr. Korn: Mostly I was left alone. We were a very rural indigenous village, which was under its own rule. In the later years, when I formalized the clinic, I got government approval, yes. But for many years, it was just very ad hoc, and just really a function of being part of the community. I really felt strongly about giving back to the community and contributing to the community, being quite grateful for living in this community. You could not own anything because it's indigenous land, so I was a guest. I really entered what I considered Bhakti yoga, that of service and giving back. At a certain point, I hit the wall

intellectually, meaning I had learned everything I felt that I could, and it was time to go back to Boston, as I've joked with you already, the jungle of Harvard. But before I did that, actually, I entered into a Master's degree program. I went back to visit Boston, and this was really kind of a burgeoning time. This was the mid-'80s. This was the beginning. You know, you remember, stress wasn't even on anyone's tongue at that time.

Dr. Rountree: The idea that chronic stress could contribute to health disorders was way out of the box back then. Post-traumatic stress disorder (PTSD) was a problem that could happen to war vets, but otherwise the relationship between stress and illness was not commonly talked about.

Dr. Korn: Yes, exactly. Herbert Benson was pioneering his work on the benefits of meditation and regulating the autonomic nervous system to alleviate chronic health conditions at Beth Israel. But it was quite novel, the kinds of things I was thinking about and considering and wanting to integrate. I was allowed to enter into a Master's degree that I self-designed, so I skipped the last two years as an undergraduate and did a Master's degree in Cross Cultural Health Psychology at Lesley University, Cambridge, Massachusetts, and then went back to Mexico for a few years, and then I returned back, and that's when I did my MPH at Harvard and was fascinated by the intersection of traditional medicine and what we think of as biomedical research. One of the interesting things that I observed in Mexico that always really stayed with me was the men would slaughter a cow every Sunday, and one of the men would climb up a papaya tree and cut down green papaya and slice the skin and it oozed out this white papain, the proteolytic enzyme, and they put it on the freshly slaughtered beef. And I was very interested in this. Wow! What is this that he's doing? And why is that working? And of course, it tenderized the meat. So, I held this within me. And then, of course, we used proteolytic enzymes for the treatment of intestinal helminths, for example, and I had to use it several times personally and with patients. I watched people in the village apply papain to abscessed teeth, or skin infections. So, when I was at Harvard, I thought: Well, let's do some research on this and maybe bridge this traditional knowledge with what biomedicine says about papain and proteolytic enzymes. I think that was a primary influence that's continued with me, this intersection of indigenous knowledge, empirical science, and indigenous sciences, with biomedicine and how they influence each other. That's remained with me really my whole career, wanting to educate people around the origins of many of the methods we use, or the changes in those methods and why they may or may not work, for example, the extraction of these so-called active substances, and how the extraction and concentration of them works in some regards, but sometimes taking it out of the whole plant, even the whole ritual, brings with it some potential unforeseen consequences, like, for example, taking sugar out of sugar cane, or concentrating cocaine out of the coca leaf.

So I spent a couple of years at Harvard studying tropical health and really getting a good education. Being the only midwife and traditional medicine person in a class of 100, I got a great education about public health, which is a passion of mine. And then from there, I went over to the medical school, to the department of psychiatry, because, as I mentioned, working with people, and touching their bodies led to all of their stories of trauma, and I thought: How do I talk with them about this? How do I even begin to understand what's happening when I'm touching a spastic trapezius, or even a spastic anal sphincter? You know, these parts of the body that are screaming their story. How do I help someone? And so that took me to the study of psychology, psychodynamics, psychotherapy, and post-trauma therapy, at the medical school. And, again, really a trial by fire. I discovered my passion for the history of medicine, the history of psychiatry and studied psychodynamic therapies, certainly psychoanalytic theory and behavioral medicine as I attempted to make the links between these conventional methods and what I was observing in my clinical practice with complexly ill people. I trained and then practiced as a psychotherapist and body psychotherapist for decades. This is another principle that has guided me. I think it is very important for those of us who want to communicate methods that we call traditional, indigenous, complementary, integrative—whatever this approach is—that we have to learn the various languages of the disciplines to communicate with others and find the ways in which we are describing similar phenomena, just perhaps from a different lens. In essence to be truly integrative we need to understand multiple disciplines from the inside out, and not just "add in" different methods.

Dr. Rountree: I'm intensely curious about whether your professors at Harvard had an appreciation for the somatic approach to trauma—in other words, mind-body work, or the idea of body armoring that Ida Rolf or followers of Wilhem Reich were exploring? Was any of that discussed?

Dr. Korn: It was an interesting time. This was in the mid-'80s, and I was doing a clinical fellowship. So I was in community health and training, basically, in a fellowship in psychology and religion, and the intersection between the two. Well, people thought I was heretical, the idea that you touch the body. The department was still full of analysts. And listen, let's remember, Sigmund Freud began by touching the body and then turned to hypnotherapy and only then the talking cure. We were also talking about energy fields and touch, and this goes way back. Mesmer, the German physician who was one of the forerunners of modern hypnotherapy, explored energy fields and trance states. Pierre Janet and his colleagues were intensely concerned with understanding the mind-body problem, especially as presented by women who we now know were victims of trauma, of what was then called hysteria, then hysterical conversion somatization and what we now refer to as the dissociative disorders. We finally understand that everything is psycho-somatic, but we are still trying to catch up in our treatment methods, which by and large remain separated

into the treatment of the mind and the body. And of course, this was a time of ferment, as you recall. Mindfulness was whispered about. Vipassana was becoming integrated into psychology and understood by many of the people who had a foot in both worlds, as I did and as you did, but it was still not at all integrated into formal care.

Benson was doing his work, but it was still fringe work, it was still seen by some people that he had gone off the rails. But it was the incipient stage, for sure. It was just burgeoning. It was not really being integrated, except in private practice. So, I had a private practice while I was doing this work. And this was also the time, not only of the awareness of PTSD, as you point out, and the war, but this was really Dr. Judith Herman's work in breaking open yet again the silence around incest, with the publication of her book *Father-Daughter Incest*, and she was directing the Victims of Violence program at Cambridge Hospital at the time, where I was. I was more in the behavioral medicine side. I studied with Dr. Daniel Brown, whose brilliant work on hypnotherapy and trance states was exploring the psychophysiology of exceptional states of function. I was influenced by Dr. Elmer Green's work on psychophysics. But I was also immersed in psychodynamic theories, which informed my understanding of memory, telling our stories and making meaning of the traumas of our lives. I also had developed a feminist critique of why we are so afraid of touch, in psychology, because there's so much abuse of touch, but that we're also so afraid of the body and that we elevate the mind.

Dr. Rountree: So the body functions as a protective shield?

Dr. Korn: Yes, but that we think verbal presentation is a more elevated form of distress, of discussing distress. And, you know, that old concept of somatization in psychology, where we say that people somatize—which I think is certainly an outmoded concept, now, because we know mind and body are one and the same.

Dr. Rountree: Yes! We're all psychosomatic creatures!

Dr. Korn: Exactly. We know everything is psychosomatic.

Dr. Rountree: If we're not being psychosomatic, something is deeply wrong.

Dr. Korn: Right! And let's listen to the body. And listening to the body, the language of the body is touch. And even preverbal trauma is, even though we don't have language before the age of two or so. So, I became very interested in trying to define, in what were really conventional psychological or even physiological, biological terms—which continued over my career—what is happening when we touch the body, and it speaks to us? It tells the story of its distress. What is this memory that's stored in the body, and how do we release it? How do we decondition the memory? How do we resolve it? And can it be? What are the limits of resolution, and how do we help and heal? And engage energetically with the unseen forces, as well? So this became my practice for many, many years.

Dr. Rountree: It sounds like you have really an intense intellectual curiosity about what is going on under the surface. It wasn't just about identifying the presenting problem and fixing it. You really wanted to know the entire process. How did the person come to inhabit their current state?

Dr. Korn: Yes. That led me, a number of years later, to the opportunity to do a research study that was funded by the NIH, because I had observed, with thousands of hours of work with people on the table, what happened. The stories they told. The contacting the viscera, and the imagery. I remember one young woman I worked with. When we were doing a guided visualization and I was palpating her intestines, and she experienced pain around the ileocecal valve, she said, "I've got barking dogs at the gate! They won't let me go." Powerful imagery. And so clinically, I was participating in very rich healing sessions with clients. But in the back of my mind, I wanted also to research: How do we validate, how do we talk about what we're seeing clinically? Because there were so many challenges to that, as we know, in acupuncture, in bodywork—this is often what it's about, it's one person that we are treating not whole populations, and that obviously is a problem with nutrition research and herbal medicine research. This is the challenge of studying large populations vs. the individual. So years later, I had the opportunity to go to the NIH when I was working as research director at the Center for World Indigenous Studies (CWIS; www.cwis.org), which is a Native organization based in Washington state. In 1996 I had brought the Center for Traditional Medicine, which I had started in rural Mexico, into CWIS as a program and began developing a portfolio of research that continues today. So we worked with tribal communities in the Pacific Northwest to understand what was important to them to do what's called community-determined research. I'm not going in there and saying, "Let's study this," but going in there and saying, "What's useful to you? What do *you* want to learn about your community's health? How can we support what you do and want to be doing?" This collaboration included every detail of the conduct of a clinical research project, the methods, the assessments, community engagement and delivery of results. And then we worked with researchers at University of Washington. We put together community, tribal, and academic researchers, and then went to the NIH and said, "OK, let's research stress and pain and quality of life using a polarity therapy protocol with family dementia caregivers." These are going to be mostly elders, women, middle-aged women who are grandmothers, mothers, still working, and often chronically ill with histories of trauma with multiple sequelae. We asked: How do we measure this? How do we measure what we're doing? And just trying to bridge the intellectual conundrum of what we do as healers and helpers and integrative practitioners with the needs for controlled research and the needs for evidence and the needs to move policy in the direction of the government paying for services. And in this case, we wanted to change Indian Health Service policy and support tribal needs to enhance their

traditional medicine programs with caregivers in mind. We wanted to support tribal governments in supporting caregivers. So we carried out a randomized controlled trial looking at psychological, biological, physiological, and spiritual measures of a protocol, and once again, we were faced with developing a standardized protocol when, in fact, clinically we don't standardize anything.

Dr. Rountree: Every person is different and for that reason needs a personalized intervention!

Dr. Korn: I know! So there again, it's the intellectual conundrum. But I developed a protocol where I said to myself, "Well, if we put together some ways of touch that for almost everyone would bring about parasympathetic dominance, help deep relaxation, engage theta states of consciousness, enhance that felt sense of integration, what would it be?" And so that was what we did in a homage to randomized clinical trials.

Dr. Rountree: I have to applaud you for going down the path of clinical research, especially when the tools we have for validation are so limited. Having received craniosacral therapy quite a few times, my direct experience of it is what really changed my attitude. Initially I approached it from an objective perspective and wondered, "What do the studies show about its effectiveness?" However, the studies I could find seemed pretty murky and it was tempting to conclude that it isn't very scientific or evidence-based. But once I experienced it, I knew that something powerful was going on, and it wasn't just the enjoyment of having someone hold my head in their arms. There's much more to it than that.

Dr. Korn: So true. You've really hit the nub of this issue here with that statement. I'll tell you a funny story. My brother's at NIH in neuroscience, and we're quite opposite in that regard. We would have heated discussions and he would question all the scientific literature, and, as we were just talking about, it's very hard for one method to quantify or even qualify—in this case, that craniosacral works. So, I said, "Just get on the table, and let's not talk about it anymore." After the session he sat up and said: "Oh now I get it!" But the analogy that I also use is love. Tell me about reading about love. Read the science of love. Read the literature. It means nothing! You must experience it. And I think so many of our methods are like this as well.

Dr. Rountree: This is kind of a hard question to articulate, but I'm curious about how you would compare the conventional approach to treating trauma, compared to what could be called integrative or somatically oriented approaches. I'm wondering about how best to address the deeper "psychosomatic" impacts that occur whether someone has had a very serious auto accident, or suffered from emotional abuse, or experienced more subtle forms of trauma that didn't cause any kind of overt physical injury. I'm sure you're familiar with Peter Levine's work,[8] that focuses on what happens on a very deep level of the psyche when a person is traumatized, and what needs to be done to help resolve that.

Dr. Korn: I would say the place that I draw the line, where I reject the conventional approach, is in the extensive use of pharmaceutical drugs. My work has been very informed by what we think of as conventional psychological understanding of trauma. I've been very influenced by that. I integrate that, as a psychotherapist and as a post-trauma therapist, with my understanding of somatics and the body. I've developed a model that I call the Brainbow Blueprint. It evolved in a funny way, because it reflects all the colors of the rainbow, and it evolved as an initial way to convey to my clients about eating all the colors of the rainbow for their brain health, but over time it's evolved into an integrative approach that begins with biochemical individuality, that everyone is an individual. It has import for diet. You know, there are Inuit people and there are people in sub-Saharan Africa, and they are not going to need the same foods. So the idea that everyone is an individual. And then it moves into an integrative assessment. If you're a mental health provider, you also need to understand the body and assess the body. If you are in physical health, you need to understand the psychology. I move through 17 different areas that include understanding the role of nature, diet, digestion, nutrients, herbal medicine, hydrotherapy, detoxification, breath and breathing meditation, exercise in all its variety of applications, spirituality, altered states of consciousness, in particular entheogens and their role. And then adherence. We can have all the best ideas and programs and interventions, but we must understand what will help someone overcome the learned helplessness that's often part of trauma and chronic depression, and really tailor that and work with them, coach them, support them, walk the path with them. So over time, back to your question, I developed a way to integrate all these methods, and then to work with each person where they are, meaning someone may say, "Don't talk to me about diet, but I'm willing to do an exercise to decrease my anxiety." Someone may say, "Don't talk to me about exercise or meditation or that froufrou stuff," and I might refer them, then, to neurofeedback as another gateway into self-regulation. So, I think essentially I don't disagree with what we think of as conventional approaches, but over time, I think there's a limitation, and so that's why my passion is training people in the missing pieces of their practice, to amplify their options—whether they're going to do it or whether they're going to refer for it, so they understand the opportunities for this integration. And culture is a huge piece of this, too—the idea of how we can use our cultural identities, our heritages, to think of our ancestral wisdom as it informs our genetics, as it informs the kinds of foods or herbs or rituals that will help create and reconstitute a connection to something that's bigger than ourselves, that transpersonal self, that cosmic connection, whatever we might call it.

Dr. Rountree: What you are describing is so much more comprehensive than simply focusing on desensitization.

Take, for example, the person who has had a car accident in a particular location. A typical strategy would be to work on allowing them to get closer and closer to the location until it doesn't elicit the trauma response, and if they need medication to accomplish that, the drug would be readily included in the plan. I'm not criticizing that strategy at all, but it is just one piece of the puzzle. Trauma elicits a much more pervasive problem in the psyche, and you've got to address that on multiple levels.

Dr. Korn: Absolutely. Desensitization is a concept that I use. I've applied this concept—not the methods, necessarily, because I came to understand bodywork as a desensitization or even a deconditioning method. A client was referred to me by her psychologist. She had—and this is something we see quite commonly, and I'm sure you see it in your practice, as well—a kind of addiction to surgery, what I call this sense that I can cut it out of me, that they can go in and take it out. And we see this with a lot of elective surgeries and a lot of cosmetic surgery. In this case, it was liposuction. It was repetitive, serial liposuction. She was referred to me, and she was very unhappy, this lovely woman, very unhappy with her thighs, and lots of liposuction to try to suck out the fat, but what she was trying to suck out was the memory of being incested by her father. So our work together was to decondition that memory. I asked her if I could touch those areas over the scar tissue where those surgeries had been. And as I touched, out came the memories. Now, she had been talking about the memories, there was verbal discussion in therapy, and that had been useful, but she had been yet unable to make the connection between the physical force of the memory, where that memory lived, and her efforts to "suck it out," as I say, and we were able, over time, to experience what I considered this dissociated memory. I've been influenced by the work of the trance states, of the hypnotherapeutic reframe, and reframe access, this dissociated memory, to bring it back and integrate it with the memory, the experience, the feeling state, and reclaim it, and decondition it. So in that sense, I've learned a lot from the conventional approaches, but the nub for me is the drugging of the feelings and the sensations, and so much of my practice is responding to people who are having side effects or are stuck developmentally because of the use of the psychotropics. Now, they're going to be called for in some cases—I would suggest in acute stages of managing suffering—but I think in the long term, I'm not convinced of their utility for many people. AU0 ►

Dr. Rountree: In some ways, they're kind of putting off the inevitable, which is this needing to reintegrate the psyche, otherwise the consequence of splitting off all those dissociated internal parts is a generalized numbness of the self. When do they get the opportunity to reintegrate?

Dr. Korn: Yes, indeed. Absolutely.

Dr. Rountree: Is this what you call the "rhythms of recovery"?

Dr. Korn: Yes! It's this idea that we are rhythmic human beings. We pulsate within ourselves, our autonomic nervous system, our peristalsis, our digestion, everything is a rhythm. And as rhythms get disrupted, particularly in trauma, and in trauma at a very early age, the disruption of the hypothalamus, pituitary, adrenal, and thyroid axis disrupts endocrine function, disrupts the immune system, and then the individual is left with trying to self-regulate, and that self-regulation need turns to alcohol, drugs, prescribed pharmaceuticals, extreme exposures and activities, the attempts to come back into rhythmic balance. Until we provide options that are healthy options to understand and address what that need is. What are these rhythms we're trying to re-establish? So that really forms the basis of this work. It is most effective when we explore all these methods—bodywork, nutrition, herbs, psychotherapy and more. ◄ AU0

Dr. Rountree: Is there a way to apply these principles on a larger community level? I bring this up because the community I live in has recently been through some major collective traumas. We had a mass shooting at a grocery store last year, and then not long ago we had a huge fire in which over a thousand people lost their homes. So when I read the news, every day I notice a lot of dialogues about the trauma our community has experienced. And we're not unique in that regard. This is a worldwide phenomenon, where all kinds of bad things are happening: floods, tornadoes, earthquakes, refugee crises, you name it. How do you apply some of these techniques on a larger level? If you're not necessarily able to work with an individual, is there a way to apply this information?

Dr. Korn: Well, I'll share with you some of the ways that I've done it. My entry into community trauma was entry into indigenous communities' trauma. I've worked in community trauma in both Mexico and in the Pacific Northwest. One of the projects that we did, and I'd love to share the book with you that came out of this project, was to look at community trauma in rural Mexico. And there's kind of a sub-aspect of that, which I call "nutrition trauma." This is the introduction of foods that are biologically inappropriate for a particular community. Now, we could say that white sugar and white flour are that for everybody, but, in indigenous communities, it disrupts the traditional foodstuffs that nourish brain, mind, and body. Along with that is the disruption called "development," and perhaps the myth of progress in development in certain communities, and then of course the migration trauma, and the disruption of the fabric of families in communities because of migration stresses, let alone all of the other elements of, you know, the addictions and violence. So, all of that together. So what we did, again, is this principle of "let the community define for itself"—the community defines what it needs, and then we, as part of that community and as helpers in that community, help people achieve that, and the process of naming it begins the process of healing. What we did is we worked with the community, and the teenagers said, "We want to learn

about all the herbs that our *abuelas*, that our mothers know about, our grandmothers know about. We don't want to lose that knowledge." So, we evolved this whole community project that involved everyone: the mothers and the grandmothers taught their grandchildren about the herbs that they thought were important. They sat around in sewing circles and wrote dialogues for a little book that became part of a community-wide book. The children in the schools got art supplies to draw pictures of the herbs. The young men were the toughest to capture, as you might imagine, the adolescent boys. So we said, "Hey, you want to improve your soccer game, you come to this class, and we'll teach you some herbs that will make you a better soccer player." And on and on it went, involving the elders. So the whole community became involved in producing different projects that they defined, that they wanted to safeguard the community knowledge: "This is what we do, and this is how we validate what we do." Because so many times, particularly in indigenous communities, you've got the outsiders coming in, especially around health care, and saying, "Hey what you do or what you know is not valuable, and what we do is," and so this inner validation—and I think it has both reality and metaphor—of one's experience and one's inner wisdom and how that's reinforced by community ritual, which is essentially a psychobiological energetic co-healing ritual of coming together. And we applied a similar approach, but culturally different, in the Pacific Northwest, with tribal communities, with the concept I call—it's a highfalutin idea—culinary pedagogy. And all that means is that everyone loves to get together, gather foods, gather herbs, cook together, eat together, talk together about their lives and experiences, and so we did these three-day workshops about this, about trauma, about the trauma of chronic illness, like diabetes, as well. Included movement and touch and foods and herbs and drinks. So that's been some of my approach to community healing. And I think we can take principles of that and then apply them in a culture-specific context. AU0 ►

Dr. Rountree: You just touched on an amazing concept, which is the idea that there are traumatic *experiences* and then there are traumatic *conditions* like metabolic syndrome and type 2 diabetes. You are saying that the experiences and the conditions have more in common than have been appreciated. I know that you've written books on type 2 diabetes as well as trauma recovery, so I think it is interesting that you've kind of woven those two threads together.

Dr. Korn: Well, what I discovered when I started thinking: Why is it minorities are so vulnerable to type 2 diabetes? And it goes back to the nervous system. It all begins with stress. Yes, sedentism. Yes, poor quality food, let's say food insecurity. But ultimately stress is what disrupts the whole capacity of the body to digest and utilize and uptake glucose. And then from there often depression goes along with that. I always say where there's depression there's a history of stress. Depression doesn't come out of nowhere; you will always find stress underneath that. So for me it's stress, depression, and then it may be metabolic syndrome and then pre-diabetes and then full-blown diabetes. So the stress of being a minority in the United States, or the stress of being indigenous in Mexico is a contributing factor, I think, to the vulnerability. And I think this is where our work in social justice and the fabulous work of the group I belong to, Integrative Medicine for the Underserved, comes in—that we can't separate our commitment to social justice from our commitment to individual and public health. ◄ AU0

Dr. Rountree: Absolutely! Is that commitment something you believe our mainstream colleagues in public health are starting to get? Or do we have work to do?

Dr. Korn: I think both are true. I think our colleagues in public health have always been among the most progressive in understanding the importance of social justice. I think we're certainly facing a time right now where public health is under a great threat. And I'm frankly not particularly optimistic about the direction in the macro scale. The CDC, rightly so, is asking for the ACE, the Adverse Childhood Events questionnaire, to be integrated into everyone's primary practice. And there are many practices doing that. It's fantastic, because it's understanding how trauma underlies most all chronic poor health—I won't say everything, but think about autoimmune illness, the addictions, the eating disorders, chronic pain. You can't look anywhere without looking at the history of the adverse events. Now, what we're seeing is some pushback among some people in primary care, and I think it's a function of the system in which people work, because let's face it, we all go into this work because we want to help or heal, and the system is often quite oppressive against that desire. You know, the 15-minute appointment! How is that possible? It's untenable. I think what we're hearing from some primary health providers is, "Well, don't ask *me* to open up this Pandora's box of trauma in my patients. I'm not equipped to handle that. I don't have time to handle that." ◄ AU0

Dr. Rountree: Primary care doctors don't have time to talk to people—they are too busy filling out electronic medical records.

Dr. Korn: Exactly. Time to talk. I think there's understanding, but I think we've got this huge umbrella or dome over practice that we're struggling against with large swaths of the population.

Dr. Rountree: I have a few patients in common with UCHealth, The University of Colorado Health system, and I've noticed that the referral summaries I receive have an entire "Social Determinants of Health" section. I think that's encouraging because it means they're paying attention to these issues. So it seems like a start.

Dr. Korn: Absolutely. And there are oases. I think especially with our younger generation of practitioners, there's a growing awareness. There's a wonderful resource in the

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Diagnostic and Statistical Manual of Mental Disorders (DSM-5). I think it's the best part of the DSM-5, and it's called the "Cultural Formulation Interview." And that is a great complement to the social determinants questionnaire, because it gives the provider a way to ask questions around belief systems: Why do you believe this is happening to you? In your cultural tradition, how would you treat this? It really expands our capacity to speak to diverse populations in their languages and recognize that there are many languages of distress and many languages of healing.

Dr. Rountree: There is so much going on for you professionally, I wonder if you could give us an overview of all the things that you're involved in right now. What would you say is your main focus? Where are you going with your work and what do you see yourself doing in the future?

Dr. Korn: I've got a couple of areas of focus. I continue to have a private practice. I have a supervision practice, where I train clinicians in integrative mental health. I've got three main courses that people can attend, and then if they want to integrate these approaches and do it under live supervision, that's a passion of mine, really giving people the tools to integrate these methods. So I've got a clinical practice. I teach. It's all live telehealth these days. Though I still work in rural communities in Mexico. I raise funds, and right now we're working on a documentary about a particular nut and its nutritional and health value. And we're also doing a medical massage project for diabetes, that was funded by the Massage Therapy Foundation, in very rural areas among poor people to bring medical massage, and training massage therapists here in Mexico to do that. So that is always an ongoing passion. And I'm updating my *Rhythms of Recovery* book; a second edition will come out, I'm hoping, by the end of 2022. I'm also working on a new workbook called *The Brainbow Blueprint*, which really gives clinicians lots of tools to apply this work. So that's what I'm doing: teaching, writing, and continuing to work with people, and really trying to help people find alternatives to medications.

Dr. Rountree: What gives you the energy to get up in the morning and start working on all these different endeavors? What would you say is your primary source of motivation? Is it intrinsic? Are you one of these people that just wakes up every day and can't wait to dive into the next project? Or is there something that particularly inspires you on an ongoing basis?

Dr. Korn: Well, I would say yes, it must be intrinsic. I just feel passionate about it, but I'm going to be half-facetious and half-serious with you now. One of the things that I teach my students is: Coffee is a drug, it's not a beverage. So use it wisely.

Dr. Rountree: I completely agree!

Dr. Korn: I'm my own laboratory. And as I spoke earlier, I come out of a history of trauma. Things have not always been rosy. I believe we must be exploring these methods that we are wanting to share with our clients. So I don't have a full answer for you about where it comes from. I just know that it is.

Dr. Rountree: Seligman[9] would say you're a natural optimist. You've managed to incorporate the principles of optimism into your whole life.

Dr. Korn: I think that's interesting. My husband would suggest otherwise! I think ultimately I'm both. I think I sit squarely in the middle. I shared with you the elements that I'm very pessimistic about in our world today, but I think there's always been and always will be this underground in which we work, this way in which we have to look at ourselves and do the best we can to support the people who cross our paths, and with whom we cross, to support and make things better for them and for the world, even in spite of the other types of images that we're exposed to daily or, as you point out, the traumas that have occurred in your community of late.

Dr. Rountree: If someone wanted to follow your work, what's the best way to reach you?

Dr. Korn: My website is drlesliekorn.com, and you can contact me there directly and reach me directly. I think that's the best place to find me and learn about what I've written or what I'm teaching, or just to connect.

Dr. Rountree: Great. It sounds like you've got book projects and training projects and lots of other irons in the fire.

Dr. Korn: Absolutely. As I said, you and I are probably the same generation, and so we have been working to get to this place. Right? We have been working for 40+ years to now see the fruits of our work, to see this, reach this embrace that our methods are finding. And so when people say to me how hard this work is, I say, "Uh uh. No. When you have mindfulness being taught in maximum security prisons, when you see yoga being taught to three-year-olds, when you see alternatives in herbal medicine at NYU or psilocybin at Johns Hopkins, we know that our time has come."

Dr. Rountree: It's been a long trajectory, but things are really starting to gel now.

Dr. Korn: It has, it has. It's been thanks to your work.

Dr. Rountree: Thank you so much. It's been a great pleasure talking to you, and I certainly hope that we interact again soon.

Dr. Korn: Yes, I would look forward to that. ■

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