



Healing the Heart Through the Creative Arts, Education & Advocacy

Hope, Healing & Help for Trauma, Abuse & Mental Health

“Out of suffering have emerged the strongest souls; the most massive characters are seared with scars”. Kahlil Gibran

The Surviving Spirit Newsletter May 2019

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“One thing: you have to walk, and create the way by your walking; you will not find a ready-made path. It is not so cheap, to reach to the ultimate realization of truth. You will have to create the path by walking yourself; the path is not ready-made, lying there and waiting for you. It is just like the sky: the birds fly, but they don't leave any footprints. You cannot follow them; there are no footprints left behind.” Osho

- 1] May is Mental Health Awareness Month, as an advocate who has tried to raise awareness on trauma,

abuse and mental health concerns, so many times I have felt dismayed, beaten down and marginalized by a 'system' designed to break the hardest of souls. But, I have never lost hope or sight of the countless courageous folks and organizations trying to change the paradigm and create a shift in society's mindset that there is '*something wrong with you*', that you're different, less than human, etc.

No, the simple truth, folks have struggled through incredible challenges, traumas and abuse and have put one foot in front of the other, every darn day. So a shout out to all of who have been my side when I have trampled the well worn path in my efforts to find peace, joy and love. And please feel free to share with those who have stood by your side as a simple gesture of, *Thank you*.

Thank you folks, Michael Skinner. [By My Side Live at the River Ledge](#) You Tube 3:38 minutes

“We all build internal sea walls to keep at bay the sadnesses of life and the often overwhelming forces within our minds. In whatever way we do this through - love, work, family, faith, friends, denial, alcohol, drugs, or medication - we build these walls, stone by stone, over a lifetime. One of the most difficult problems is to construct these barriers of such a height and strength that one has a true harbor, a sanctuary away from crippling turmoil and pain, but yet low enough, and permeable enough, to let in fresh seawater that will fend off the inevitable inclination toward brackishness.” Kay Redfield Jamison

2] [We Need New Ways of Treating Depression](#) - [Vox](#) - Pocket - By Johann Hari, author of Lost Connections

Experts are now looking to the social and environmental causes of the disorder affecting millions.

As the 21st century was beginning, a South African psychiatrist named Derek Summerfield happened to be in Cambodia conducting some research on the psychological effects of unexploded land mines - at a time when chemical antidepressants were first being marketed in the country.

The local doctors didn't know much about these drugs, so they asked Summerfield to explain them. When he finished, they explained that they didn't need these new chemicals - because they already had antidepressants. Puzzled, Summerfield asked them to explain, expecting that they were going to tell him about some local herbal remedy. Instead, they told him about something quite different.

The doctors told Summerfield a story about a farmer they had treated. He worked in the water-logged rice fields, and one day he stepped on a land mine and his leg was blasted off. He was fitted with an artificial limb, and in time he went back to work. But it's very painful to work when your artificial limb is underwater, and returning to the scene of his trauma must have made him highly anxious. The farmer became deeply depressed.

So the doctors and his neighbors sat with this man and talked through his life and his troubles. They realized that even with his new artificial limb, his old job — working in the paddies — was just too difficult, that he was constantly stressed and in physical pain, and that these things combined to make him want to just stop living. His interlocutors had an idea.

They suggested that he work as a dairy farmer, a job that would place less painful stress on his false leg and produce fewer disturbing memories. They believed he was perfectly capable of making the switch.

So they bought him a cow. In the months and years that followed, his life changed. His depression, once profound, lifted. The Cambodian doctors told Summerfield: “You see, doctor, the cow was an analgesic, and antidepressant.”

In time, I came to believe that this little scene in Southeast Asia, which at first sounds just idiosyncratic, deeply “foreign,” in fact represents in a distilled form a shift in perspective that many of us need to make if we are going to make progress in tackling the epidemic of depression, anxiety, and despair spreading like a thick tar across our culture.

It’s not just about brain chemistry

For more than 30 years, we have collectively told one primary story about depression and anxiety. When I was a teenager and I went to my doctor and explained I felt distress was pouring out of me uncontrollably, like a foul smell, he told me a story.

The doctor said that depression is caused by the spontaneous lack of a chemical in the brain called serotonin, and I simply needed to take some drugs to get my serotonin levels up to a normal level. A few days before I wrote this piece, a young friend of one of my nephews, who was not much older than I was when I was first diagnosed, went to his doctor and asked for help with his depression. His doctor told him he had a problem with dopamine in his brain. In 20 years, all that has shifted is the name of the chemical.

I believed and preached versions of this story for more than a decade. But when I began to research the causes of depression and anxiety for my new book, [*Lost Connections*](#), I was startled to find leading scientific organizations saying this approach was based on a misreading of the science. There are real biological factors that contribute to depression, but they are very far from being the whole story. The World Health Organization, the leading medical body in the world, explained in 2011: “*Mental health is produced socially: The presence or absence of mental health is above all a social indicator and therefore requires social, as well as individual, solutions.*” The United Nations’ special rapporteur on the right to health, Dr. Dainius Pūras - one of the leading experts in the world on mental health - explained last April that “the dominant biomedical narrative of depression” is based on “biased and selective use of research outcomes.”

“Regrettably, recent decades have been marked with excessive medicalization of mental health and the overuse of biomedical interventions, including in the treatment of depression and suicide prevention,” he said. While there is a role for medications, he added, we need to stop using them “to address issues which are closely related to social problems.”

I was initially bemused by statements like this: They were contrary to everything I had been told. So I spent three years interviewing the leading scientists in the world on these questions, to try to understand what is really going on in places where despair in our culture is worst, from Cleveland to Sao Paulo, and where the incidence of despair is lowest, including Amish communities. I traveled 40,000 miles and drilled into the deepest causes of our collective depression.

I learned there is broad agreement among scientists that there are three kinds of causes of depression and anxiety, and all three play out, to differing degrees, in all depressed and anxious people. The causes

are: biological (like your genes), psychological (how you think about yourself), and social (the wider ways in which we live together). Very few people dispute this. But when it comes to communicating with the public, and offering help, psychological solutions have been increasingly neglected, and environmental solutions have been almost totally ignored.

The hotly contested studies of chemical antidepressants

Instead, we focus on the biology. We offer, and are offered, drugs as the first, and often last, recourse. This approach is only having modest results. When I took chemical antidepressants, after a brief burst of relief, I remained depressed, and I thought there was something wrong with me. I learned in my research that many researchers have examined the data on antidepressants and come to very different conclusions about their effectiveness. But it's hard not to conclude, looking at the evidence as a whole, that they are at best a partial solution.

Depression is often measured by something called the Hamilton Depression Rating Scale, a 17-item test administered by clinicians, where a score of zero means you show no symptoms of the disorder and a score of 52 would indicate an absolutely debilitating episode.

[The studies that most strongly support chemical antidepressants](#) found that some 37 percent of people taking them experience a significant shift in their Hamilton scores amounting to a full remission in their symptoms. When therapy and other interventions were added in addition to or in place of these drugs - in treatment-resistant cases - remission rates went higher.

Yet other scholars, looking at the exact same data set, noticed that over the long term, fewer than 10 percent of the patients in the study - who were, incidentally, receiving more support than the average depressed American would receive from their doctor - experienced complete remission that lasted as long as a year. When I read this, I noticed to my surprise that it fit very closely with my own experience: I had a big initial boost, but eventually the depression came back. I thought I was weird for sinking back into depression despite taking these drugs, but it turns out I was quite normal.

Steve Ilardi, a professor of psychology at the University of Kansas, summarizes the research on chemical antidepressants this way, via email: "Only about 50 percent of depressed individuals experience an initial positive response to antidepressants (and only about 30 percent achieve full remission). Of all of those depressed individuals who take an antidepressant, only a small subset - estimated between 5 and 20 percent - will experience complete and enduring remission." In other words: The drugs give some relief, and therefore have real value, but for a big majority, they aren't enough.

Irving Kirsch, a professor of psychology who now teaches at Harvard Medical School, was initially a supporter of chemical antidepressants – but then he began to analyze this data, **especially the data the drug companies had tried to keep hidden from the public**. His research concluded that chemical antidepressants give you a boost, above the placebo effect, of 1.8 points on average on the Hamilton scale. This is less than a third of the boost that you get, by some estimates, from improving your sleep patterns.

(Kirsch points out that [a study recently released in *The Lancet*](#), to much media coverage, confirmed

what we already knew and everyone already agreed on: that chemical antidepressants have more effect than a placebo. The more important questions are: by how much, for how long?)

And even people less skeptical than Kirsch point to this inconvenient fact: Although antidepressant prescriptions have increased 500 percent since the 1980s, there has been no discernible decrease in society-wide depression rates. There's clearly something very significant missing from the picture we have been offered.

After studying all this, I felt startled, and it took me time to fully absorb it. Kirsch regards the 1.8-point gain he finds as clinically meaningless and not justifying the benefits of these drugs. I found his studies persuasive, but I disagree a little with this takeaway. There are people I know for whom this small but real benefit outweighs the side effects, and for them, my advice is to carry on taking the drugs.

But it is clear, once you explore this science, that drugs are far from being enough. We have to be able to have a nuanced and honest discussion that acknowledges an indisputable fact: that for huge numbers of people, antidepressants only provide either no relief or a small and temporary amount, and we need to radically expand the menu of options to help those people.

Our focus on biology has led us to think of depression and anxiety as malfunctions in the individual's brain or genes - a pathology that must be removed. But the scientists who study the social and psychological causes of these problems tend to see them differently. Far from being a malfunction, they see depression as partly or even largely a function, a necessary signal that our needs are not being met. Everyone knows that human beings have innate physical needs - for food, water, shelter, clean air. There is equally clear evidence that human beings have innate psychological needs: to belong, to have meaning and purpose in our lives, to feel we are valued, to feel we have a secure future. Our culture is getting less good at meeting those underlying needs for a large number of people - and this is one of the key drivers of the current epidemic of despair.

I interviewed in great depth scientists who have conclusively demonstrated that many factors in our lives can cause depression (not just unhappiness: full depression). Loneliness, being forced to work in a job you find meaningless, facing a future of financial insecurity - these are all circumstances where an underlying psychological need is not being met.

The strange case of the “grief exception” — and its profound implications

The difficulty that some parts of psychiatry have had in responding to these insights can be seen in a debate that has been playing out since the 1970s. In that decade, the American Psychiatric Association decided, for the first time, to standardize how depression (specifically, “major depressive disorder”) was diagnosed across the United States. By committee, they settled on a list of nine symptoms - persistent low mood, for instance, and loss of interest or pleasure - and told doctors across the country that if patients showed more than five of these symptoms for more than a couple of weeks, they should be diagnosed as mentally ill.

But as these instructions were acted on across the country, some doctors reported a slightly awkward problem. Using these guidelines, every person who has lost a loved one - every grieving person - should be classed as mentally ill. The symptoms of depression and the symptoms of grief were

identical.

Embarrassed, the psychiatric authorities came up with an awkward solution. They created something called “the grief exception.” They told doctors to keep using the checklist *unless somebody the patient loved had recently died, in which case it didn’t count*. But this led to a debate that they didn’t know how to respond to. Doctors were supposed to tell their patients that depression was a brain disease to be identified on a checklist - but now there was, uniquely, one life situation where that explanation didn’t hold.

Why, some doctors began to ask, should grief be the only situation in which deep despair is not a sign of a mental disorder that should be treated with drugs? What if you have lost your job? Your house? Your community? Once you entertain the idea that depression might be a reasonable response to some life circumstances - as Joanne Cacciatore, an associate professor in the school of social work at Arizona State University, told me - our theories about depression require “an entire system overhaul.”

Rather than do this, the psychiatric authorities simply got rid of the grief exception.

Now grieving people can be diagnosed as mentally ill at once. Cacciatore’s research has found that about a third percent of parents who lose a child are drugged with antidepressants or sedatives in the first 48 hours after the death.

Once you understand that psychological and social context is crucial to understanding depression, it suggests we should be responding to this crisis differently from how we now do. To those doctors in Cambodia, the concept of an “antidepressant” didn’t entail changing your brain chemistry, an idea alien to their culture. *It was about the community empowering the depressed person to change his life.* All over the world, I interviewed a growing group of scientists and doctors who are trying to integrate these insights into their work. For them, anything that reduces depression should be regarded as an antidepressant.

To know what to fight, we need to think harder about causes of mental malaise. I was able to identify nine causes of depression and anxiety for which there is scientific evidence. Seven are forms of disconnection: from other people, from meaningful work, from meaningful values, from the natural world, from a safe and secure childhood, from status, and from a future that makes sense to you. Two are biological: your genes, and real brain changes.

(It is too crude to describe these as a “chemical imbalance,” the typical shorthand today; Marc Lewis, a neuroscientist at the University of Toronto, told me it makes more sense to think of them as “synaptic pruning” - your brain sheds synapses you don’t use, and if you are pushed into a pained response for too long, your brain can shed synapses, making it harder to navigate away from dark thoughts.)

These scientists were asking: What would antidepressants that dealt with these causes, rather than only their symptoms, look like?

“Social prescribing”: a new kind of treatment

In a poor part of East London in the 1990s, Dr. Sam Everington was experiencing something uncomfortable. Patients were coming to him with depression and anxiety. “When we went to medical school,” he told me, “everything was biomedical, so what you described as depression was [due to] neurotransmitters.” The solution, then, was drugs. But that didn’t seem to match the reality of what he was seeing.

If Everington sat and talked with his patients and really listened, he felt that their pain made sense - they were often profoundly lonely, or financially insecure. He wasn’t against chemical antidepressants. But he felt that they were not responding to the underlying reasons his patients were depressed in the first place. So he tried a different approach - and ended up pioneering a fresh approach to fighting depression.

A patient named Lisa Cunningham came to Everington’s surgery clinic one day. She’d been basically shut away in her home, crippled with depression and anxiety, for seven years. She was told by staffers at the clinic that they would continue prescribing drugs to her if she wanted, but they were also going to prescribe a group therapy session of sorts. There was a patch of land behind the clinic, backing onto a public park, that was just scrubland. Lisa joined a group of around 20 other depressed people, two times a week for a full afternoon, to turn it into something beautiful.

On her first day there, Lisa felt physically sick with anxiety. It was awkward to converse with the others. Still, for the first time in a long time, she had something to talk about that wasn’t how depressed and anxious she was.

As the weeks and months - and eventually years - passed, Everington’s patients taught themselves gardening. They put their fingers in the soil. They figured out how to make things grow. They started to talk about their problems. Lisa was outraged to learn that one of the other people in the group was sleeping on a public bus - so she started to pressure the local authorities to house him. She succeeded. It was the first thing she had done for somebody else in a long time.

As Lisa put it to me: As the garden began to bloom, the people in it began to bloom too. Everington’s project has been widely influential in England but not rigorously analyzed by statisticians, who tend to focus on drug-centered treatment. But a study in Norway of a similar program found it was more than twice as effective as chemical antidepressants - part of a modest but growing body of research suggesting approaches like this can yield striking results.

This fits with a much wider body of evidence about depression: We know that social contact reduces depression, we know that distraction from rumination (to which depressives are highly prone) has a similar effect, and there is some evidence that exposure to the natural world, and anything that increases exposure to sunlight, also has antidepressant effects.

Everington calls this approach “social prescribing,” and he believes it works because it deals with some (but not all) of the deeper social and environmental causes of depression.

Economic stress can lead to depression

A study last week showed that anti-depressants work better than placebos. But many people who take

them remain depressed, or return to a depressed condition.

I searched out other radical experiments with different kinds of social and psychological antidepressants, often in unexpected places. (Some of these were not designed as antidepressants but ended up serving that purpose.) In the 1970s, the Canadian government embarked on an experiment in a rural town called Dauphin, in Manitoba. They told the population there: From now on, we are going to give you, in monthly installments, a guaranteed basic income. You don't have to do anything for it - you're getting this because you are a citizen of our country - and nothing you do can mean we will take this away from you. It added up to roughly \$17,000 in today's US dollars (if they had no income from other sources).

Many things happened as a result of this three-year experiment, but one of the most striking is a big fall in hospitalizations - 8.5 percent in three years, according to Evelyn Forget, a professor in the department of community health services at the University of Manitoba and the leading expert on this experiment. Visits for mental health reasons accounted for a significant part of that drop, Forget says, and visits to doctors for mental health reasons also decreased.

"It just removed the stress - or reduced the stress - that people dealt with in their everyday lives," she says. There is evidence that if you have no control at work, you are significantly more likely to become depressed (and to die of a stress-related heart attack). A guaranteed income "makes you less of a hostage to the job you have, and some of the jobs that people work just in order to survive are terrible, demeaning jobs."

The scientists I spoke with wanted to keep chemical antidepressants on the menu, but also to radically expand the options available to depressed and anxious people. Some interventions are things individuals can do by themselves. One is taking part in groups dedicated to rediscovering meaning in life (anything from a choir to a campaign group). Another is practicing a form of mindfulness called "loving-kindness meditation" (an ancient technique for overcoming envy in which you train yourself to feel joy not just for your friends but also for strangers and even for people you dislike).

But many of the most effective social antidepressants require us to come together to fight for big social changes that will reduce depression, like changing our workplaces to reduce the amount of control and humiliation that happens there.

As a 39-year-old gay man, I have seen how people can band together to fight for seemingly impossible goals - and win, radically reducing the amount of unhappiness gay people face. I have also seen how, in one sense, the struggle is the solution: The act of banding together, identifying that you are being mistreated, and fighting for something better restores dignity to people who felt they had been defeated.

Is there a type of depression utterly unconnected to life circumstances?

As I absorbed all this evidence over three years, a persistent question kept coming to me. Yes, there are these deep causes of depression, but what about people who have nothing to be unhappy about, yet still feel this deep despair descend on them?

There is a debate among scientists about whether there is something called "endogenous depression" - a form of despair that is triggered purely by biology. The most detailed research into this, by George

Brown of the Institute of psychiatry at the University of London and his colleague Tirril Harris, in the 1970s, found that people diagnosed with this problem in fact had just as many life challenges as people whose depression was supposed to be a response to life events. (They had spent years studying how long-term stress can radically increase depression.)

This could mean that endogenous depression does not exist - or it could mean that scientists were not good at spotting the difference back then. The scientists I spoke to agreed on one thing: If the condition does exist, it affects a tiny minority of depressed and anxious people.

But I only really felt I made a breakthrough in my own thinking - in understanding the mystery of why some people seem to become depressed “for no good reason” - when, by coincidence, I started reading some feminist texts from the 1960s.

At that time, it was common for women to go to their doctors and say something like: “Doctor, there must be something wrong with my nerves. I have everything a woman could want. I have a husband who doesn’t beat me, two kids, a house, a car, a washing machine - but I still feel terrible.” Doctors would agree that they had a problem and would prescribe them drugs like Valium. (The locus of the problem only migrated from the “nerves” to the brain in the 1990s.)

Now if we could go back in time and talk to those women, we would say, “Yes, you have everything you could possibly want by the standards of the culture.” But the standards of the culture are simply wrong: You need much more than this.

In the same way, today, when people tell me they must be biologically broken because they have “everything they could want” yet they are still depressed, I say: Tell me what you have. They talk about having money, or status, or expensive consumer goods. But these are not what people need to have meaningful lives.

If I start to ask about the social and environmental factors of depression and anxiety I’ve mentioned, I have yet to find a depressed person for whom at least some are not playing out. Perhaps some of us are simply biologically broke, but the idea that a purely biological story describes the vast majority of depressed and anxious people is by now, it is fair to say, discredited.

The lesson the psychiatrist took back from Cambodia

After he had completed his work in Cambodia, and after he had heard the story about the farmer who was given a cow as an antidepressant, Summerfield returned to London, where he worked as a psychiatrist, and he realized something he had never quite seen so clearly before. He thought about when he had most helped his depressed and anxious patients. Most often, it occurred to him, it was when he helped them to get secure housing, or to fix their immigration status, or to find a job. “*When I make a difference, it’s when I’m addressing their social situation, not what’s between their ears,*” he told me.

Yet we have, as a society, built our responses to depression and anxiety almost entirely around changing brains, rather than changing lives. Every year we have done this, our depression and anxiety crisis has got worse. When, I began to wonder, will we learn the lesson that those Cambodian doctors understood intuitively, and that the World Health Organization has been trying to explain to us: Our

pain makes sense.

[Lost Connections](#) – Uncovering the Real Causes of Depression – and the Unexpected Solutions By Johann Hari

“Yes, I understand why things had to happen this way. I understand his reason for causing me pain. But mere understanding does not chase away the hurt. It does not call upon the sun when dark clouds have loomed over me. Let the rain come then if it must come! And let it wash away the dust that hurt my eyes!” Jocelyn Soriano

3] [I Now Suspect the Vagus Nerve Is the Key to Well-being](#) By [Edith Zimmerman](#)

Have you ever read something a million times only to one day, for no apparent reason, think “Wait, what is that?” This happened to me the other day for “the vagus nerve.”

I kept coming across it in relation to deep breathing and mental calmness: “Breathing deeply,” Katie Brindle writes in her new book [Yang Sheng: The Art of Chinese Self-Healing](#), “immediately relaxes the body because it stimulates the vagus nerve, which runs from the neck to the abdomen and is in charge of turning off the ‘fight or flight’ reflex.” Also: “Stimulating the vagus nerve,” per [a recent Harvard Health blog post](#), “activates your relaxation response, reducing your heart rate and blood pressure.” And: Deep breathing “turns on the vagus nerve enough that it acts as a brake on the stress response,” as an integrative medicine researcher [told the Cut](#) last year.

I liked this idea that we have something like a secret piano key, under our skin, to press internally to calm us down. Or like a musical string to pluck. At this point I was envisioning the vagus nerve as a single inner cord, stretching from the head to the stomach. In reality, the vagus nerve is a squiggly, shaggy, branching nerve connecting most of the major organs between the brain and colon, like a system of roots or cables. It is the longest nerve in the body, and technically it comes as a pair of two vagus nerves, one for the right side of the body and one for the left. It’s called “vagus” because it wanders, like a vagrant, among the organs. The vagus nerve has been described as “largely responsible for the [mind-body connection](#),” for its role as a mediator between thinking and feeling, and I’m tempted to think of it as something like a physical manifestation of the soul. Also: “When people say ‘trust your gut,’” as one [Psychology Today writer](#) put it several years ago, “they really mean ‘trust your vagus nerve.’”

I became increasingly enchanted with this nerve, even as it felt like I understood it less and less. How does this all work? How does activating a nerve calm us down? Is this why I get so needlessly upset about things?

“Stimulating the vagus nerve to the heart has a really powerful effect on slowing the heart rate,” said [Lucy Norcliffe-Kaufmann](#), associate professor of neurology at NYU-Langone. And this, specifically, is what relaxes us. The vagus nerve is basically listening to the way we breathe, and it sends the brain and the heart whatever message our breath indicates. Breathing slowly, for instance, reduces the oxygen demands of the heart muscle (the myocardium), and our heart rate drops.

The vagus nerve is essentially the queen of the parasympathetic nervous system - a.k.a. the “rest and digest,” or the “chill out” one - so the more we do things that “stimulate” or activate it, like deep breathing, the more we banish the effects of the sympathetic nervous system - a.k.a. the “fight or flight,” or the “do something!” stress-releasing adrenaline/cortisol one.

Put another way, “Your body senses your breathing and adapts its heart rate in response,” Norcliffe-Kaufmann told me. When we breathe in, she explained, the sensory nodes on our lungs (“lung stretch receptors”) send information up through the vagus nerve and into the brain, and when we breathe out, the brain sends information back down through the vagus nerve to slow down or speed up the heart. So when we breathe slowly, the heart slows, and we relax. Conversely, when we breathe quickly, our heart speeds up, and we feel amped, or anxious.

I was surprised by the idea that it’s specifically the exhale that triggers the relaxation response, but Norcliffe-Kaufmann confirmed: “Vagal activity is highest, and heart rate lowest, when you’re exhaling.” She mentioned that the ideal, most calming way to breathe is six times a minute: five seconds in, five seconds out. She also noted that in [the study that determined this rate](#), researchers found that this style of slow breathing is also what practitioners naturally lapse into during meditation with mantras, and during the Ave Maria prayer with rosaries. “Each time you do either the rosary prayer or a meditation mantra,” Norcliffe-Kaufmann said, “it naturally synchronizes your breathing at six times per minute.” (“That’s fascinating,” I said. “It is!” she said.)

It made me wonder if there are ways of measuring the quality of the vagus nerve, or “vagal tone,” as Norcliffe-Kaufmann described it. This is basically how healthy, strong, and functional the nerve is. One way, she said, is to measure heart rate variability (HRV) - it’s a sort of “surrogate” for measuring actual vagal tone (barring open chest surgery). Heart rate variability is the amount that the heart rate fluctuates between a breath in (when it naturally speeds up) and a breath out (when it naturally slows down). That is, heart rate rises on the inhale and falls on the exhale, and the difference between those two rates essentially measures vagal tone. Athletes are known to have higher vagal tone, for example, whereas people who experience extended periods of bed rest - and astronauts in no-gravity situations - are known to have lower vagal tone. (How quickly your heart rate slows after exercising is also a good marker of vagal tone.) Vagus nerve stimulation has also been [proposed](#) as a way to treat addiction (some heavy drinkers, for instance, have [low vagal tone](#)).

Certain devices measure HRV - and I’ve personally tried a chest strap and a wristband, but I got stumped on what to do with the data - although Norcliffe-Kaufmann is skeptical about their reliability. “Those technologies are coming,” she said, “but it’s more important to focus on breathing and feeling calm and balanced, rather than on a number.” Some other practices believed to improve vagal tone (beyond deep, slow breathing) include [laughing](#), [singing](#), [humming](#), [yoga](#), [acupuncture](#), and splashing the face with [cold water](#) - or having a full-body [cold rinse](#). (Stimulation of the vagus nerve, [both manually and with electricity](#), has also been used to control seizures in epilepsy patients, reduce inflammation, and treat clinical depression.)

Writing this story, and after talking with Norcliffe-Kaufmann, I found myself breathing more slowly and feeling calmer. Not necessarily happy, but steady. Slow breathing is boring, but it’s almost sad how effective it is. I’d usually rather spend hundreds of dollars to get a gadget to track myself than do this free and more-effective thing.

“If you’re in a stressful situation,” Norcliffe-Kaufmann said, “and you’re like, *How do I respond, how do I respond?* - if you consciously slow down your breathing just for one minute, or even a few seconds, you can put yourself in a calmer state, to be able to better communicate.”

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“Do unto others as you would have others do unto you.” Matthew 7:12

“No one is useless in this world who lightens the burdens of another.” Charles Dickens

4] [Keyon Dooling Breaks His Silence About His Childhood Sexual Abuse on Red Table Talk](#) w/ Jada Pinkett Smith – WDKX written by DJ Sight

Jada Pinkett Smith’s show Red Table Talk has been picking up steam since her latest episode with former NBA player, Keyon Dooling, who discusses his experience of being sexually abused as a young boy.

There’s a statistic that says 1 in 6 males have been sexually abused growing up. It’s crazy how the discussion about men being sexually abused is never really brought up, compared to how much it’s discussed when it comes to women and young girls.

I understand a lot of males don’t talk a lot about their private life and the things they’ve experienced growing up. I do see a change coming though, men are becoming more comfortable with stepping forward and talking about the abuse they dealt with growing up.

Hopefully this interview will help a lot more men come forward and get the help they may need as well as raise people’s awareness on this issue.

[See the full episode here:](#)

“Thousands of candles can be lighted from a single candle, and the life of the candle will not be shortened. Happiness never decreases by being shared.” Buddha

“There is no exercise better for the heart than reaching down and lifting people up.” John Holmes

5] [In Our Brutal Modern World, Science Shows Our Brains Need Craft More Than Ever](#) by Susan Luckman, Professor of Cultural Studies, University of South Australia [The Conversation](#)

At a time when many of us feel overwhelmed by the 24/7 demands of the digital world, craft practices, alongside other activities such as colouring books for grown-ups and the up-surge of interest in cooking from scratch and productive home gardens, are being looked to as something of an antidote to the stresses and pressures of modern living.

Crafts such as knitting, crochet, weaving, ceramics, needlework and woodwork focus on repetitive actions and a skill level that can always be improved upon. According to the [famous psychologist Mihaly Csikszentmihalyi](#) this allows us to enter a "flow" state, a perfect immersive state of balance between skill and challenge.

With what is increasingly referred to today as "mindfulness" being a much-desired quality for many people, it's not surprising crafts are being sought out for their mental and even physical benefits.

Craft as therapy

For over a century, arts and craft-based activity have been a [core part of occupational therapy](#) that emerged as a distinct health field around the end of the first world war in response to the needs of returned soldiers.

This includes many suffering from what we now refer to as post-traumatic stress disorder, but then referred to as "shell shock".

Knitting, basket weaving, and other craft activities were commonplace in the repatriation support offered throughout much of the English-speaking world to the returned veterans of the two world wars.

This was as both [diversional therapy](#) (taking your mind off pain and negative thoughts), as well as [skills-development](#) geared towards re-entering the civilian workforce.

More recently, research is seeking to better understand just how craft is so beneficial for the body and mind. Interestingly, [much of the focus](#) has been on the [mental health](#) and well-being brought about by [knitting](#).

The benefits of craft according to science

A [large-scale international online survey of knitters](#) found respondents reported they derived a wide range of perceived psychological benefits from the practice: relaxation; relief from stress; a sense of accomplishment; connection to tradition; increased happiness; reduced anxiety; enhanced confidence, as well as cognitive abilities (improved memory, concentration and ability to think through problems).

In [more clinical contexts](#), introducing knitting into the lives of hospital patients with anorexia nervosa led to a self-reported reduction in anxious preoccupation with eating disorder thoughts and feelings. Some 74 percent of research participants described feeling "distracted" or "distanced" from these negative emotional and cognitive states, as well as more relaxed and comfortable. Over half said they felt less stressed, a feeling of accomplishment, and less likely to act on their "ruminating thoughts".

In [another study](#), knitting was found to reduce workplace stress and compassion fatigue experienced by oncology nurses.

Quilting has been found to enhance participant's experiences of well-being as they move into older age.

[Research reports](#) quilters find the work challenging, cognitively demanding, it helps to maintain or generate new skills, and working with colour was found to be uplifting, especially in winter.

In studies of people with [chronic fatigue syndrome](#) (CFS/ME), [depression](#) and [other long-term health problems](#), textile crafts were found to increase sufferers' self-esteem, their engagement with the wider

world, and increase their personal sense of well-being and their ability to live positively with their condition.

While knitting and other textile-based activities tend to be female-dominated, similar benefits have been found for men in the collective woodworking, repair and other productive tinkering activities of the [Men's Sheds movement](#).

[Participants reported](#) reduced levels of depression.

Why does craft make us feel good?

What unites almost all of these studies, is that while the practice of craft, especially those such as knitting, quilting, needlework and woodworking, may at first appear to be relatively private activities, the benefits also substantially arise from the social connections craft enables.

These have even been reported across whole communities impacted by disaster, such as the recovery following the [2011 Christchurch earthquake](#).

One of the strengths of craft practice, especially as a contributor to well-being, is precisely that it can be both solitary and collective, and it's up to the individual to decide.

For the shy, the ill, or those suffering from various forms of social anxiety, this control, as well as the capacity to draw away any uncomfortable focus upon themselves and instead channel this into the process of making, is a much valued quality of their craft practice.

The research into the physical and mental health benefits of craft remains largely qualitative and based on self-reporting.

And it especially explores its capacity to generate positive health outcomes through positive mental health.

While there's much more work to be done here, it's clear craft continues to play a key role in enhancing the quality of life of those who participate in its practices.

“It’s not enough to have lived. We should be determined to live for something. May I suggest that it be creating joy for others, sharing what we have for the betterment of person-kind, bringing hope to the lost and love to the lonely.” Leo Buscaglia

“An effort made for the happiness of others lifts us above ourselves.” Lydia M. Child

6] [Sentenced to Life](#) – Mental Health Podcast

Life is a Trip - Join co-hosts Dr. Jason Lahood and Kendall Alaimo as they smack down some real talk about mental health in the Sentenced to Life podcast.

The content in this podcast will necessarily engage with discussion of complex trauma, suicide and stories of trauma survivors. The content of the show may be emotionally challenging to engage with.

We will do our best to flag especially graphic or intense content that discusses or represents trauma and traumatic loss. Our hope is to create a space where we can engage bravely, empathetically and thoughtfully with difficult content every week.

To listen to our first 7 episodes visit our website at sentencedtolifepodcast.com

Find us on:

Apple Itunes

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Stitcher

TuneIn

If you have an Alexa you can say " Alexa play Sentenced to Life Podcast" 😊 :)

A big thank you to all my friends who have cheered me on in my recovery and supported me in my activism. Thank you 😊

[Drop Us A line](#) - We connect with Doctors, researchers, recovery experts, trauma survivors, and everyday folks just waking up on the wrong side of the head.

Share your story with us today.

“When a person is down in the world, an ounce of help is better than a pound of preaching.” Edward G. Bulwer

“Criticism, like rain, should be gentle enough to nourish a man’s growth without destroying his roots.” Frank A. Clark

7] [Scientists quash claims about single 'depression genes'](#) – Medical News Today, By [Catharine Paddock PhD](#)

[Fact checked](#) by Carolyn Robertson

After completing an enormous study, scientists have dismissed claims that single gene variants, or even a small group of them, can dictate susceptibility to depression. Instead, they suggest that any genetic risk for depression likely arises from very large numbers of variants, each contributing a small effect.

Researchers at the University of Colorado Boulder (CU Boulder) reviewed hundreds of investigations that, over the last 25 years, had singled out "candidate genes" for [depression](#). They found that 18 such genes had featured at least 10 times in previous studies.

Then, using data from hundreds of thousands of people, they showed that the influence the 18 candidate genes had on depression was no stronger than that of genes they could pick out at random.

In an [American Journal of Psychiatry](#) paper, the team concludes that early theories about "depression candidate genes" are wrong and that studies identifying them have likely done no more than produce "false positives."

The findings dispel the notion that people will soon be able to take a test that identifies a few genes for depression, and then it is just a matter of drug developers producing new medications that target them.

"This study," says first study author Richard Border, who is a researcher and graduate student in CU Boulder's Institute for Behavioral Genetics, "confirms that efforts to find a single gene or handful of genes which determine depression are doomed to fail."

8] [We need to treat borderline personality disorder for what it really is – a response to trauma](#) - The Conversation, Academic rigor, journalistic flair

Authors, Jayashri Kulkarni, Professor of Psychiatry, Monash University & Patrick Walker, Adjunct Research Associate, Monash University

"If we started thinking about it (BPD) as a trauma-spectrum condition, patients might start being viewed as victims of past injustice, rather than perpetrators of their own misfortune."

Borderline personality disorder (BPD) is a highly stigmatised and misunderstood condition. Australians with BPD face considerable barriers to accessing high-quality and affordable care, according to [new research](#) published today.

For every 100 patients we treat in inpatient psychiatric wards, [43 will have](#) BPD. People with this condition are [vulnerable](#), impulsive, and highly susceptible to criticism – yet they continue to face [stigma and discrimination](#) when seeking care.

We have come a long way since the days of viewing mental illness as a sign of weakness, but we are lagging behind in our attitude towards BPD. At least part of this stems from the way we frame the condition, and from the name itself.

Rather than as a personality disorder, BPD is better thought of as a complex response to trauma. It's time we changed its name.

How common is BPD?

BPD is strikingly common, [affecting between 1% and 4%](#) of Australians. It is [characterised by](#) emotional dysregulation, an unstable sense of self, difficulty forming relationships, and repeated self-harming behaviours.

Most people who suffer from BPD have a [history of major trauma](#), often sustained in childhood. This includes [sexual and physical abuse](#), extreme neglect, and separation from parents and loved ones.

This link with trauma – particularly physical and sexual abuse – has been [studied extensively](#) and has been shown to be near-ubiquitous in patients with BPD.

People with BPD who have a history of serious abuse [have poorer outcomes](#) than the few who don't, and are more likely to self-harm and attempt suicide. Around [75% of BPD patients attempt suicide](#) at some point in their life. One in ten eventually take their own life.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) does not mention trauma as a

diagnostic factor in BPD, despite the inextricable link between BPD and trauma. This adds to viewing BPD as what its name suggests it is – a personality disorder.

Instead, BPD is better thought of as a trauma-spectrum disorder – similar to chronic or complex PTSD.

The [similarities](#) between complex PTSD and BPD are numerous. Patients with both conditions have difficulty regulating their emotions; they experience persistent feelings of emptiness, shame, and guilt; and they have a significantly elevated risk of suicide.

Why the label is such a problem

Labelling people with BPD as having a personality disorder can exacerbate their poor self-esteem. “Personality disorder” translates in many people’s minds as a personality flaw, and this can lead to or exacerbate an ingrained sense of worthlessness and self-loathing.

This means people with BPD may view themselves more negatively, but can also lead other people – including those closest to them – to do the same.

Clinicians, too, often [harbour negative attitudes](#) towards people with BPD, viewing them as manipulative or unwilling to help themselves. Because they can be hard to deal with and may not engage with initial treatment, doctors, nurses and other staff members [often react](#) with frustration or contempt.

These attitudes are [much less frequently seen](#) from clinicians working with people suffering from complex PTSD or [other trauma-spectrum disorders](#).

What could a name change do?

Explicitly linking BPD to trauma could alleviate some of the stigma and associated harm that goes with the diagnosis, leading to better treatment engagement, and better outcomes.

When people with BPD sense that people are distancing themselves or treating them with disdain, they may respond by self-harming or refusing treatment. Clinicians may in turn react by further distancing themselves or becoming frustrated, which perpetuates these same negative behaviours.

Eventually, this [may lead to](#) what US psychiatric researcher Ron Aviram and colleagues call a “self-fulfilling prophecy and a cycle of stigmatisation to which both patient and therapist contribute”.

Thinking about BPD in terms of its underlying cause would help us treat its cause rather than its symptoms and would reinforce the importance of preventing child abuse and neglect in the first place.

If we started thinking about it as a trauma-spectrum condition, patients might start being viewed as victims of past injustice, rather than perpetrators of their own misfortune.

BPD is a difficult condition to treat, and the last thing we need to do is to make it harder for patients and their families.

[The Conversation](#) aims to rebuild trust in experts and promote more informed public debate. Our independent fact-based journalism is essential for a healthy democracy. Your support

enables us to keep our content free and accessible. Beth Daley Editor and General Manager

“Love one another and help others to rise to the higher levels, simply by pouring out love. Love is infectious and the greatest healing energy.” Sai Baba

9] PS [Watching America](#) From WHRV [NPR]

Hosted by British born host Dr. Alan Campbell, Watching America combines interviews, engaging audio, and deep dive talks in to our local and national culture through the eloquent and ever-curious lens of a 'Brit' who has spent over two decades 'figuring it all out'; Watching America.

[Male Suicide Web Extra: Michael Skinner](#) - Listen to our conversation with musician Michael Skinner, a suicide attempt survivor who shares his strategies for dealing with depression.

FYI, I also get to share a few of my songs, show opens up with “Black Rain” and closes with, “Songs For The Keys To Your Life”.

Please note, this show covers some tough topics, part of me wants to share and part of me wants to hide it, but as Amy Goodman says, *“Go to where the silence is and say something.”*

To be honest, honored when asked to participate in events like this to raise awareness, but still feel the pain of this, very deeply, and the depression demons have been playing havoc these past several months. The post concussive symptoms and the heart medication I've been on have created a true whirlwind to navigate through, but I'm re-positioning the sails to my ship to sail out of these stormy seas. *Take care, Michael*

10] [Watching America](#) From WHRV [NPR] - Male Suicide: Dr. Narketta Sparkman-Key & Sergeant Kevin Briggs w/host Dr. Alan Campbell

Dr. Narketta Sparkman-Key provides psychological insight into the reason middle-age white men are the most at-risk population for suicide. Sergeant Kevin Briggs shares his experience working for the California Highway Patrol on the Golden Gate Bridge--saving upwards of 200 would-be jumpers. He now works exclusively on suicide prevention and intervention at www.pivotal-points.com

“Did I offer peace today? Did I bring a smile to someone's face? Did I say words of healing? Did I let go of my anger and resentment? Did I forgive? Did I love? These are the real questions. I must trust that the little bit of love that I sow now will bear many fruits, here in this world and the life to come.”
Henri Nouwen

Thank you & Take care, Michael

PS. Please share this with your friends & if you have received this in error, please let me know – mikeskinner@comcast.net

Our lives begin to end the day we become silent about things that matter. Martin Luther King, Jr.

A diagnosis is not a destiny

[The Surviving Spirit](#) - Healing the Heart Through the Creative Arts, Education & Advocacy - Hope, Healing & Help for Trauma, Abuse & Mental Health

[The Surviving Spirit Facebook Page](#)

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"BE the change you want to see in the world." Mohandas Gandhi