



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 November 2019

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"I may not be where I want to be but I'm thankful for not being where I used to be." Habeeb Akande

"At times our own light goes out and is rekindled by a spark from another person. Each of us has cause to think with deep gratitude of those who have lighted the flame within us." Albert Schweitzer

1] [The Isolation of Healing - Rebuilding Wellness](#) by Sue Ingebretson

Have you ever felt alone in your chronic illness? Is there isolation in your healing? As though no one else has a clue what you're going through? Maybe your fibromyalgia doctors don't listen. Your family nods, yet you know they're tired of hearing. What if I told you that you're not alone? In fact, what if you discovered that you have everything you need – right now – to heal ... from the inside out?

This past weekend, after attending the funeral of a good friend, I dug through some old files on my hard drive. I didn't know what I was looking for, but I felt pulled to sort through old posts, articles, and bits of writings that were so important to me a decade or so ago.

What surprised me was this.

I'd forgotten about the isolation. I'm now surrounded by positive people and, more importantly, the positive dialogue inside my own head.

But, it wasn't always that way.

Here's a scrap of something I wrote years ago. I think I wrote it shortly after finishing my book, [FibroWHYalgia](#). I want to share it with you now, because I know that the emotions described still hold true today.

I used to feel alone with my negativity, hopelessness, and isolation. I was surrounded by people – traditional medical professionals – yet, I couldn't deny that gnawing, empty feeling. I had no faith in their words. They made no sense to me. Was I really supposed to accept a life of constant, unrelenting pain?

Living with chronic illness is isolating. It's hard to focus on relationships, family, friends, and careers when your body's pain receptors shriek with every move. It's tough to ignore. But, who was I to also ignore the advice of established authorities? I was told by countless doctors to go home, lie down, take my medications as prescribed, and review my legal options for disability. I already walked with a cane ... how long until I needed the scooter chair they recommended?

Doubt persisted. My inner voice urged me to ignore conventional wisdom and look elsewhere. I was a natural researcher – the daughter of parents who read, absorbed, and taught what they knew. I collected

volumes of study materials and developed a profound fascination for how the body works. I studied nutrition, physiology, and psychology. Time and again, I tripped over information that went against the grain of what I'd been told. Through my education, I transformed from a nutritionally illiterate mom to one who voraciously read books on the digestive system, the nutritive value of natural foods, and the relationship between foods, moods, and healing.

I left behind a rheumatologist who said, "What you eat doesn't matter" and instead followed my own inner wisdom. I learned that food does matter. I learned that fitness and physical strength matters. Above all, I learned that what and how we think matters. All three components — what I call the Restoration Trio — braid together forming a bond of ultimate lifestyle balance. They are, nutrition, body movement, and emotional wellness.

Rebuilding my body from the ground up didn't happen overnight, although some changes occurred quickly. Nearly a decade ago, I'd never heard of wheat free, gluten free, or dairy free diets. I had no game plan to remove foods that were toxic; I only planned to add foods that were healing. I ate more salads, more veggies, and drank more water. No rocket science involved. But traditional science couldn't explain my rapid improvements. The pain in my hands and wrists noticeably diminished within just a week or so. My digestive troubles and foggy thinking improved over time. I pressed on eating a balanced diet of fresh, whole, fiber-rich and nutrient-dense foods.

My body said, "Thank you."

Feeling much better, I added a fitness regimen to my routine. I joined a local gym and worked out regularly. Yes, my body pain still existed, but as I built muscle strength, my pain slowly ebbed away. My cane gathered dust in the trunk of my car.

The toughest challenge on my wellness journey was to heal my thoughts. I discovered that my body felt and experienced every negative emotion. My inner guide again kicked in, telling me to have patience with my progress. Healing takes time. I found far healthier ways to deal with stress than the negative self-talk I was accustomed to. Wonderfully healing practices such as tai chi and restorative yoga became lifesavers for me.

Restoring my physical health is nothing short of miraculous, but that's not the most important discovery made. The real miracle was learning to trust my inner wisdom. I've healed my body from the inside out and guide others, through my books and coaching, to do the same. By trusting in myself – even against conventional wisdom – I've developed a community of friends, colleagues, and even strangers who share their experiences and thoughts with me

I am not alone.

I now know that I'm no longer isolated. I've discovered that reaching out begins by reaching within.

Sue Ingebretson is an author, speaker, a certified holistic health care practitioner, and the director of program development for the Fibromyalgia and Chronic Pain Center at California State University, Fullerton. She is a Fibromyalgia Editor for ProHealth.com, as well as a Patient Advocate and the Fibromyalgia Expert for the Alliance Health community of health conditions website.

Her #1 Amazon chronic illness bestselling book, [FibroWHYalgia](#), details her own journey from illness to wellness. She is also the creator of the [FibroFrog / FrazzleFrog](#) – a therapeutic stress-relieving tool which provides powerful healing benefits with fun and whimsy.

1a] [FibroWHYalgia: Why Rebuilding the Ten Root Causes of Chronic Illness Restores Chronic Wellness](#): Susan E. Ingebretson: **eBook** Kindle Store

“I love the author’s determination, wit, and resilience to find answers to heal herself – despite a medical system that provides little hope.” -- C. Jessie Jones, PhD, professor, Health Science, director, Fibromyalgia Research and Education Center, California State University, Fullerton.

“I consider FibroWHYalgia a first-aid kit for anyone dealing with long-term health issues.” -- Diane Wendell, ND, CNM, nutritionist, Tustin, California.

“If you’re sick and tired of being sick and tired, the upbeat suggestions in this book will provide the encouragement needed to seek positive change.” -- Mollie Marti, PhD, JD, performance psychologist, Cedar Rapids, Iowa.

1b] [FibroWHYalgia](#) – Book

FibroWHYalgia book, 218 pages by Susan E. Ingebretson, Author ISBN #978-0-9843118-0-4. Written with wit, wisdom, and warmth, FibroWHYalgia is a complete toolbox that guides the reader on the road to wellness. It contains an abundance of encouragements making it enjoyable and easy-to-read. Included are detailed descriptions for making nutritional, fitness, and stress-relieving lifestyle changes.

“Kindness can transform someone's dark moment with a blaze of light. You'll never know how much your caring matters. Make a difference for another today.” Amy Leigh Mercree

“Be kind whenever possible. It is always possible” Dalai Lama

2] [Fibromyalgia Linked to Gut Bacteria for First Time - Technology Networks](#)

Scientists have found a correlation between a disease involving chronic pain and alterations in the gut microbiome.

Fibromyalgia affects 2-4 percent of the population and has no known cure. Symptoms include fatigue, impaired sleep and cognitive difficulties, but the disease is most clearly characterized by widespread chronic pain. In a paper published today in the journal *Pain*, a Montreal-based research team has shown, for the first time, that there are alterations in the bacteria in the gastrointestinal tracts of people with fibromyalgia. Approximately 20 different species of bacteria were found in either greater or are lesser quantities in the microbiomes of participants suffering from the disease than in the healthy control group.

Greater presence or absence of certain species of bacteria

“We used a range of techniques, including Artificial Intelligence, to confirm that the changes we saw in the microbiomes of fibromyalgia patients were not caused by factors such as diet, medication, physical

activity, age, and so on, which are known to affect the microbiome,” says Dr. Amir Minerbi, from the Alan Edwards Pain Management Unit at the McGill University Health Centre (MUHC), and first author on the paper. The team also included researchers from McGill University and Université de Montréal as well as others from the Research Institute of the MUHC.

Dr. Minerbi adds, “We found that fibromyalgia and the symptoms of fibromyalgia – pain, fatigue and cognitive difficulties - contribute more than any of the other factors to the variations we see in the microbiomes of those with the disease. We also saw that the severity of a patient’s symptoms was directly correlated with an increased presence or a more pronounced absence of certain bacteria – something which has never been reported before.”

Are bacteria simply the markers of the disease?

At this point, it’s not clear whether the changes in gut bacteria seen in patients with fibromyalgia are simply markers of the disease or whether they play a role in causing it. Because the disease involves a cluster of symptoms, and not simply pain, the next step in the research will be to investigate whether there are similar changes in the gut microbiome in other conditions involving chronic pain, such as lower back pain, headaches and neuropathic pain.

The researchers are also interested in exploring whether bacteria play a causal role in the development of pain and fibromyalgia. And whether their presence could, eventually, help in finding a cure, as well as speed up the process of diagnosis.

Confirming a diagnosis and next steps towards finding a cure

Fibromyalgia is a disease that has proved difficult to diagnose. Patients can wait as long as 4 to 5 years to get a final diagnosis. But this may be about to change.

“We sorted through large amounts of data, identifying 19 species that were either increased or decreased in individuals with fibromyalgia,” says Emmanuel Gonzalez, from the Canadian Center for Computational Genomics and the Department of Human Genetics at McGill University. “By using machine learning, our computer was able to make a diagnosis of fibromyalgia, based only on the composition of the microbiome, with an accuracy of 87 per cent. As we build on this first discovery with more research, we hope to improve upon this accuracy, potentially creating a step-change in diagnosis.”

“People with fibromyalgia suffer not only from the symptoms of their disease but also from the difficulty of family, friends and medical teams to comprehend their symptoms,” says Yoram Shir, the senior author on the paper who is the Director of the Alan Edwards Pain Management Unit at the MUHC and an Associate Investigator from the BRaiN Program of the RI-MUHC. “As pain physicians, we are frustrated by our inability to help, and this frustration is a good fuel for research. This is the first evidence, at least in humans, that the microbiome could have an effect on diffuse pain, and we really need new ways to look at chronic pain.”

How the research was done

The research was based on a cohort of 156 individuals in the Montreal area, 77 of whom suffer from fibromyalgia. Participants in the study were interviewed and gave stool, blood, saliva and urine

samples, which were then compared with those of healthy control subjects, some of whom lived in the same house as the fibromyalgia patients or were their parents, offspring or siblings.

The researchers' next steps will be to see whether they get similar results in another cohort, perhaps in a different part of the world, and to do studies in animals to discover whether changes in bacteria play a role in the development of the disease.

This article has been republished from the following [materials](#). Note: material may have been edited for length and content. For further information, please contact the cited source.

Reference: Minerbi, A., Gonzalez, E., Brereton, N. J. B., Anjarkouchian, A., Dewar, K., Fitzcharles, M.-A., ... Shir, Y. (2019). Altered microbiome composition in individuals with fibromyalgia. PAIN, Articles in Press. <https://doi.org/10.1097/j.pain.0000000000001640>

“Not all scars shows. Not all wounds heal. Sometimes you can't see, the pain someone feels.” Ritu Ghatourey

“Knowledge is knowing what to say. Wisdom is knowing whether or not to say it.” Unknown

3] [Parenting Well After Childhood Abuse: Be a Great Parent Even if Yours Were Crap](#) - It's Write Now by Geanne Meta

This book is for You...

Would you like some good parenting advice and tips?

Are you struggling with pain, shame and anger leftover from your childhood?

Were you afraid to have kids because you felt too damaged?

There are many books on recovering from the trauma of child abuse but not many that focus on the job of parenting afterwards. This groundbreaking, self-help book reinforces the importance of healing the damage to be the best parent you can be.

While the subject is heavy, there are many light and humorous moments throughout the book. Especially in the parenting scenarios. This is a parenting book, with helpful tips whether you came from abuse or not.

Parenting well is a daunting endeavor for anyone. You're faced with more challenges when you had a crappy childhood. Of course, you don't want to do what was done to you but it's easier said than done.

While there's no quick fix, this book gives encouragement to seek help and a roadmap of steps to take. Geanne Meta's story sets an example of transcending the harm done in childhood to reach a life full of hope and healing.

Part 1 – Healing Yourself, is about the journey to become whole; while **Part 2 – Raising Good Kids**, is based on the author's quest to find helpful parenting resources.

The author lived with the pain of childhood sexual abuse but didn't seek help until she became a parent. She courageously describes her struggles along the emotional journey of healing from sexual and emotional abuse. She went from small victim to resilient survivor by working on the root causes of her shame, denial, pain and anger.

As a survivor you'll relate to many of the same thoughts and negative feelings that the author had about herself. Her story takes you through the steps of breaking the cycle, recognizing denial, finding self=love and maybe even forgiveness.

New parents, or those at any stage who are looking for answers, can find ways to make life better for themselves and their children.

Included tools:

- Worksheet to Help You Connect With Your Inner Child
- Questionnaire: What You Want to do Differently Than Your Parents
- Group Discussion – Individual Work Guide

“Choose your words wisely, and be sure that everything that you say or do can be used for construction rather than destruction.” Anurag Prakash Ray

3a] [Geanne Meta – Author](#) * Advocate * Speaker

By sharing some of my story and my insights about parenting, I hope to inspire and give hope to those struggling with similar issues. I want others to know that they can get help, change their ways of thinking about themselves and become much happier and healthier for their family.

I'm passionate about helping children have better lives. I hope that by talking about abuse issues and getting it out of the shadows, it will give children courage to speak up and tell someone when they are being hurt.

Survivors have trouble just getting out of bed sometimes and then can find that their emotions are out of control. Both issues will be very unhelpful to parenting effectively. You must “be there” for your kids, get your anger and sadness under control to be a good role model.

There is no quick fix or a short answer to healing yourself. Everyone has different struggles that are personal to their situation. This book includes worksheets and practical guidance to help you along your journey of healing.

There is a light at the end of the tunnel.

There is happiness and love that you deserve.

Parenting is hard for everyone – raising kids to be happy, good people is a long road. You don't have to travel it alone. Unfortunately, there are millions of people who had destructive childhoods and we can all learn a little from each others failures and successes.

The book is a guide for survivors of childhood sexual, physical or emotional abuse who are seeking help to be better parents than theirs were.

“Sometimes the greatest growth comes through pain, but it's not the pain that helps me grow, it's my response to it. Will I suffer through the experience and continue as before or let the pain inspire changes that help me grow?” The choice is mine. Al-Anon

4] [How this Nashville women’s recovery home blends business with bonding](#) - PBS News Hour Video clip – 6:36 minutes

Nashville’s Thistle Farms is no ordinary business - it’s a nonprofit staffed by women who have survived addiction, sexual abuse or trafficking. The organization’s two-year program offers participants housing, free therapy and medical care, as well as opportunities to work on its line of home and body products or in its adjoining cafe. John Yang reports on this sisterhood-based community.

4a] [Thistle Farms](#) - Natural Body & Home Products

Love is the most powerful force in the world. Because love has the power to heal.

Women who have survived trafficking, prostitution, and addiction deserve a second chance at life.

That’s why we provide:

[A Safe & Supportive Place to Live](#)

Our 2-year residential program, based in Nashville, Tennessee, provides housing, food, healthcare, therapy and education, without charging residents.

[A Meaningful Job](#)

Residents and graduates of our residential program are employed in one of our social enterprises. Here the women can learn new job skills and make a living wage to support themselves.

[A Lifelong Sisterhood of Support](#)

Similar to an alumni network, after the women leave our program, they still have access to counseling, education opportunities and emergency financial assistance.

*“This is the place where we get second - and third and fourth - chances. It’s where we can show our families and our kids that it is possible to regain our lives. I think I’m living proof that it happens.”
Chelle, 2005 graduate, Account Manager*

*“All our resolves and decisions are made in a mood or frame of mind which is certain to change.”
Proust*

“Real learning opens us up to the fear of uncertainty and the embarrassment of incompetence, as well as the vulnerability of needing each other.” Peter Senge

5] [National Native American Heritage Month](#)

November is National American Indian Heritage Month, The Library of Congress, National

Archives and Records Administration, National Endowment for the Humanities, National Gallery of Art, National Park Service, Smithsonian Institution and United States Holocaust Memorial Museum join in paying tribute to the rich ancestry and traditions of Native Americans.

What started at the turn of the century as an effort to gain a day of recognition for the significant contributions the first Americans made to the establishment and growth of the U.S., has resulted in a whole month being designated for that purpose.

One of the very proponents of an American Indian Day was Dr. Arthur C. Parker, a Seneca Indian, who was the director of the Museum of Arts and Science in Rochester, N.Y. He persuaded the Boy Scouts of America to set aside a day for the “First Americans” and for three years they adopted such a day. In 1915, the annual Congress of the American Indian Association meeting in Lawrence, Kans., formally approved a plan concerning American Indian Day. It directed its president, Rev. Sherman Coolidge, an Arapahoe, to call upon the country to observe such a day. Coolidge issued a proclamation on Sept. 28, 1915, which declared the second Saturday of each May as an American Indian Day and contained the first formal appeal for recognition of Indians as citizens.

The year before this proclamation was issued, Red Fox James, a Blackfoot Indian, rode horseback from state to state seeking approval for a day to honor Indians. On December 14, 1915, he presented the endorsements of 24 state governments at the White House. There is no record, however, of such a national day being proclaimed.

The first American Indian Day in a state was declared on the second Saturday in May 1916 by the governor of New York. Several states celebrate the fourth Friday in September. In Illinois, for example, legislators enacted such a day in 1919. Presently, several states have designated Columbus Day as Native American Day, but it continues to be a day we observe without any recognition as a national legal holiday.

In 1990 President George H. W. Bush approved a joint resolution designating November 1990 “National American Indian Heritage Month.” Similar proclamations, under variants on the name (including “Native American Heritage Month” and “National American Indian and Alaska Native Heritage Month”) have been issued each year since 1994.

Executive and Legislative Documents - The Law Library of Congress has compiled guides to commemorative observations, including a comprehensive inventory of the [Public Laws, Presidential Proclamations and congressional resolutions](#) related to Native American Heritage Month.

About this Site - This Web portal is a collaborative project of the Library of Congress and the National Endowment for the Humanities, National Gallery of Art, National Park Service, Smithsonian Institution, United States Holocaust Memorial Museum and U.S. National Archives and Records Administration.

Other Dedicated Web Sites:

- [National Endowment for the Humanities \(EDSITEment\)](#)
- [National Archives](#)
- [National Park Service](#)

- [Smithsonian Education](#)

5a] [The Native American Heritage Month Book List](#) - Penguin Random House

Celebrate National Native American Heritage Month by reading with us! This list features award-winning contemporary and classic fiction to nonfiction and young adult.

Fourteen books posted, including – [Almanac of the Dead](#) by Leslie Marmon Silko

Almanac of the Dead weaves ideas and lives, fate and history, passion and conquest in an attempt to re-create the moral history of the Americas, told from the point of view of the conquered, not the conquerors.

“Being Indian is an attitude, a state of mind, a way of being in harmony with all things and all beings. It is allowing the heart to be the distributor of energy on this planet; to allow feelings and sensitivities to determine where energy goes; bringing aliveness up from the Earth and from the Sky, putting it in and giving it out from the heart.” Brooke Medicine Eagle

“If you talk to the animals they will talk with you and you will know each other. If you do not talk to them you will not know them and what you do not know, you will fear. What one fears, one destroys.” Chief Dan George

6] [Risk factors for involuntary psychiatric hospitalisation](#) - The Lancet Psychiatry – authors - Lisa Broph, Cath Roper & Kellie Grant

In *The Lancet Psychiatry*, Susan Walker and colleagues[1] report findings of a systematic review, meta-analysis, and narrative synthesis of 77 studies from 22 countries, providing valuable data on risk factors for involuntary psychiatric hospitalisation. These findings will substantially contribute to addressing gaps in knowledge about international and intranational variations in use of involuntary psychiatric hospitalisations and to development of interventions to reduce these hospitalisations.

Walker and colleagues identified that previous involuntary hospitalisation and diagnosis of a psychotic disorder present the greatest risks for further compulsory treatment, which is a very helpful finding because it highlights opportunities for preventive interventions. The experience of coercion, or being subjected to restrictive interventions associated with involuntary admission, can lead to disengagement with mental health services, setting up an ongoing cycle of involuntary admissions. Interrupting this potentially spirit-breaking[2] cycle demands attention. The UN Convention on the Rights of Persons with Disabilities recommends that involuntary treatment should be ceased because it constitutes discrimination on the basis of disability.[3] Regardless of the rationale for its use, there is growing recognition that involuntary treatment poses a risk to the dignity, human rights, and equality before the law of those affected.[3] Hooff and Goossensen [4]analysed 22 reports on involuntary treatment, in which the views of detained patients were examined, and the most common theme of qualitative studies was that patients experienced feelings of not being listened to. They concluded that listening to patients and actively eliciting their views on treatment is essential. Attempting to understand how people experience their own involuntary treatment is not legislated as part of the involuntary treatment process, and this omission warrants reflection.

Walker and colleagues report that risk of harm to others was associated with involuntary admission, despite inconsistency in how risk was assessed between studies (with many studies not reporting how risk was measured) and low use of formal scales. Although this lack of transparency poses a problem, we caution against the view that the solution lies in greater standardisation between studies and consistent use of formal risk assessment scales, particularly in the context of evidence to suggest that risk of harm to self and others cannot be usefully assessed. [5], [6] Bigger questions need to be addressed, such as whether a focus on risk prediction in psychiatry is truly beneficial. [6]

In Walker and colleagues' study, poor adherence to treatment and poor compliance with medication before admission were associated with involuntary rather than voluntary admission in six of eight studies that reported on treatment adherence. Non-adherence to treatment can, arguably, be seen as a facet of insight: who decides what constitutes an acceptable treatment approach? Eight studies of moderate to high quality reported an association between lack of insight and involuntary hospitalisation. Of these, only half reported how insight had been measured, and variance in assessment approaches occurred. The idea of insight in clinical assessments has been critiqued on the grounds of imprecision and pathologisation of disagreements and non-medical understandings of people's experience, as pointed out in the lived-experience commentary by Rachel Rowan Olive and Patrick Nyikavaranda in Walker and colleagues' Article. When the concepts of insight and incapacity are used together they can instigate involuntary status and nullify an individual's own worldview—how they think, speak, and understand - if it does not accord with a clinical view. [7] Dispensing with the current concept of insight in favour of remaining curious and cultivating a lay sense of insight could be a fruitful way forward. [8]

The perspectives raised in the lived-experience commentary were especially useful and authoritative. Co-production of research with people who have lived-experience is imperative, particularly when service users' rights are at stake. [9] Involving people with lived-experience in the identification of problems and conduct of research is vital to developing high-quality and relevant solutions.

Walker and colleagues' findings offer valuable perspectives that could guide population-level interventions. In view of what is known about the effect of structural-level inequalities in power, money, and resources within countries, it is worth pausing to consider whether tackling diseases or risk factors at the individual level is the best approach. [10] Walker and colleagues' findings suggest a need to target the social determinants of involuntary treatment, with three studies examining area-level deprivation and all finding that greater area-level deprivation led to increased rates of involuntary admissions. We concur that more fine-grained research is needed in this area.

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[Risk factors for involuntary psychiatric hospitalisation - Pdf](#)

“I swore never to be silent whenever and wherever human beings endure suffering and humiliation. We must always take sides. Neutrality helps the oppressor, never the victim.” Elie Wiesel

Today's Reminder – I will remember that a decision I make in a time of crisis might not be the one I would make when the crisis is past. I will not rashly take a step which I may afterward regret. Al-Anon

7] [Sexual abuse survivors are not emotionally doomed, per new research](#) By [Tracey Anne Duncan](#)

The effects of childhood sexual trauma are daunting. They range from anxiety and depression to a plethora of physical health problems. Because this type of trauma affects the most vulnerable of us, children, and the stigma is so great, it can be hard for survivors to feel hopeful. But new research suggests that [sexual abuse survivors](#) are not necessarily tied to a future of mental health issues.

A recently released study suggests that the majority of [survivors of childhood sexual abuse](#) are able to achieve what the study calls “complete mental health.” Complete mental Health (CMH) is defined, [in the study](#), as, “the absence of mental illness in combination with almost daily happiness.” In the findings, 65% of childhood sexual abuse survivors who participated were reported to have CMH, compared to 77% of the general population.

What helped them heal and manage their emotions successfully? Support. Having a close confidant increased a survivor’s reported CMH sevenfold.

“Support is so crucial,” says Adam Brown, clinical assistant professor in NYU Langone's department of child & adolescent psychiatry who specializes in childhood trauma and is unaffiliated with the study. “If you have the right environment, resilience can be developed,” he says.

The presence of a trusted person, presumably an adult, makes it more likely for a survivor to achieve CMH,” says Matthew Mutchler, psychotherapist and associate professor of counseling psychology at Delaware Valley University, who is also unaffiliated with the research. “We need to believe and support people when they tell us of their experiences.” In other words, in order for children who have experienced abuse to heal and go on to navigate social interactions functionally, they need an adult in their lives who will listen to them and believe them.

On the surface, the findings of this research seem great, and Brown says the study confirms a lot of what we already know - that people have natural resilience. That confirmation is important, though. The more research we have that proves it, the more likely we are to develop intervention protocols when it comes to processing sexual abuse.

Brown points out that the study controlled for a lot of common factors related to childhood sexual abuse, which dims the optimism of the data a bit. The odds of a survivor achieving CMH decreased for folks with a history of substance abuse and people with anxiety or chronic pain.

Also, the study controlled for people with a history of depression and for people who had multiple traumas. “It’s very common for people who had sex abuse to have multiple kinds of abuse,” says Brown. “We know that children with multiple abuse have more negative outcomes.” In other words, the study factored out a lot of people who would likely have less positive outcomes, so the findings appear a little unrealistically bright.

The psychologists I spoke with were also concerned about how many ways the phrase “complete mental health” could be interpreted by laypeople. “That kind of terminology portrays a sense of finality. ‘I’ve achieved complete mental health – I’m all good now and forever!’ It’s just not realistic,” says Mutchler.

There was also concern that the publicity of this sort of hopeful, but potentially misleading, research might take our focus away from dealing with the real problems of childhood sexual abuse. “Childhood trauma is such a concern,” Brown says. “We need to understand how common and devastating it is.” He stresses that we can’t deviate from research being done by organizations like the [National Child Traumatic Stress Network](#), who are working to develop assessments and treatments for the impact of child trauma.

It’s important for us to foster evidence-based hope - and to recognize that abuse survivors do not need to be slaves to their past - but we also need to remember what it takes to achieve positive outcomes. All my experts agree that early intervention is critical to healing. “The earlier one intervenes the more hopeful we can be,” Brown says “Research on resilience shows that it’s not something you have or don’t have. It can be developed.”

7a] [National Child Traumatic Stress Network](#) - **OUR MISSION** is to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States.

“The greatness of a community is most accurately measured by the compassionate actions of its

members.” Coretta Scott King

“Shame is a soul eating emotion.” C.G. Jung

8] [Outlawed Grief](#) – The Gottman Institute by [Jonathan Trotter](#)

Have you ever seen grief outlawed? Have you ever felt like grief was just simply not allowed? Like it was wrong and breaking some unwritten rules?

People outlaw grief through pithy (and useless) sayings: “He’s in a better place,” or, “It will all work out in the end,” or, “At least it wasn’t any worse,” or, “Don’t be sad about what you lost, be grateful for what you had.” Basically, folks communicate to the griever that they should not be sad—that their grief is not right or welcome.

Sometimes, we outlaw our own grief, failing to give value to our feelings; seeing the tears as intruders that must be defended against. But grief is not on a timetable and doesn’t always run on schedule. Sometimes it even leaves the station, only to double back and park again. And stay.

I’ve known this erratic, unrelenting, grief.

My baby sister died when I was six years old. I can still remember holding her in the hospital, smelling the antiseptic, excited, and wondering what those funny tubes in her nose were for. I remember her tiny casket and the white lace. I remember the August sun that shone so brightly at her graveside, creating vivid colors and casting deep shadows.

My mother got the diagnosis when she was pregnant with my little brother. Breast cancer. She had a c-section and a mastectomy in the same surgery, and I’ll never forget the irony of bottle feeding a newborn in the oncology department, waiting for mom to finish her radiation. I remember her back spasming as I drove her home, with an infant crying in the backseat. She died that year.

I was in my clinical rotations at a mental health facility when I got the call. Dad was gone. We had expected the brain cancer to wait a few more days, and I was planning to visit him one last time after my rotation. I was going to play guitar and sing for him. I never made it.

After some of those losses, memories were allowed, and even encouraged. Grief was given space to breathe, space to weep. We were given space to heal. In other cases, photos were taken off the walls, memories were redacted, and the deceased became a persona non grata.

Grief was outlawed, and it was horrible.

So what happens when grief gets outlawed? Often, it doesn’t just disappear, it goes underground. It becomes a tectonic plate, storing energy, swaying, resisting movement, and then exploding in unanticipated and unpredictable ways. Have you seen this?

A tectonic plate can store a heck of a lot of energy. Sort of like grief, once it’s outlawed. It descends below the surface and everything looks fine - until it’s not. Because once it’s triggered, once it slips, all that stored energy has to go somewhere, and heaving tectonic plates can cause destruction far, far away.

So please allow grief, in your own heart and in the hearts of others. Don't send it underground. If you're uncomfortable with other peoples' grief, you might want to look deep, deep down in your own soul and see if there's some long-outlawed, long-buried grief. If you find some, begin gently to see it, vent it, feel it.

It's a terribly difficult thing, walking with someone through the darkness. Bearing witness to another's pain tends to erase language, making us unsure of what to do or what to say. We think we have to say something, but we just don't know what to say. It feels like a minefield and we're terrified of stepping off the well-worn path of cliches.

So what are we to do? What are we to say?

Don't outlaw, do this instead

I recently took a stroll back down into my own valley of grief and asked some questions: What was helpful during my mother's terminal illness? What wasn't? What were great things kind people said to me after my dad passed away? What things could have been (and should have been) left unsaid?

As I journey back, it occurs to me that the most helpful people were those who were not afraid of me. They were comfortable enough in their own skin that they didn't seem uneasy around me. They didn't expect me to "get over it" and "move on," but they also didn't expect me to cry all the time. They treated me with grace and dignity, acknowledging that I was still, in fact, me. I am forever grateful for their wisdom and kindness.

Here are a few observations gleaned from my time spent trudging through the valley; here are some lessons learned from those who comforted and those who tried.

- Don't be afraid of me. Yes, I might cry. And I might laugh. And those might happen in the same sentence (although one does not necessarily precede the other, and I might switch the order around randomly just to mess with you.) Crying does not always indicate that you did or said something wrong.
- Give me the freedom to "go there." Or not. Tell me that you care and that you want to be sensitive to where I'm at, but feel free to say something like, "Hey, you want to just go out and have some fun? If you want to talk about it, that's fine, and I'll listen, but if you don't want to go there, no problem." A good friend gave me this type of permission after my mom died. We were both teenagers, but I still regard his statement as one of the most helpful, most healing, and most loving things anyone's ever said to me.
- Don't be afraid to talk about it. Feel free to ask me about her favorite time of year (summer) or his favorite food (ice cream), or what I miss about "home." Please listen when something random reminds me of something random. Smile with me. Cry with me. Just please, don't be afraid of me.
- Encourage me to remember. Memories are gifts, not to be shunned or outlawed.
- Remember that grieving people are often expected to deal with their own grief on top of family members' grief, church members' grief, the neighbor's grief. Keep that in mind. Be sensitive about how you expect the grieving person to comfort you. Your loss may be very real too and

allowing the grieving person to comfort you might be healthy for both of you. But it might not be helpful for both of you. Just be aware and recognize if the roles of mourner and comforter flip.

- Remember that grief isn't forever, but it is. I won't always sob, but I will always feel this loss deeply. I won't always cry when that song comes on the radio, but I might. Certain songs will be forever linked to my mom's illness and death. Every griever will have songs or places or foods or things or events like this. (It should be noted here that the type of deep sadness and grief that incapacitates the griever for long periods of time, or greatly interferes with normal, daily life and functioning, should be processed and felt with the help of a professional counselor.)
- Lastly, remember that comforting another person is a highly spiritual endeavor; when it's done with love and purposeful awareness, you can bring deep comfort and visceral help.

The next time you come across someone who's grieving a loss, remember that they probably don't need a lecture or a pithy saying. They don't need a cliché or a vapid truism. They certainly don't need you to outlaw their grief.

They do need freedom. They need freedom to cry, or not to cry. They need to know that you care about them and their memories.

And they could maybe use a hug.

Jonathan Trotter lives in Phnom Penh, Cambodia, providing pastoral counseling and training events at Living Well, a local counseling center. Before moving to Asia with his wife of eighteen years and their four kids, he served as a youth pastor in the Midwest for ten years and as an inner-city ER/trauma nurse for three years. He is also a licensed attorney. You can learn more about his adventures [here](#).

8a] [The Trotter Family](#) - just trying to live all for ONE...

Episode 3: Anxiety and OCD November 6, 2019

In this episode, Jonathan and Elizabeth discuss their experiences with anxiety and OCD, what helped, what didn't, and why there's hope.

Listen in via [iTunes](#), [Stitcher](#), or Listen to Episode 3 [here](#) or [The Trotter Family](#)

8b] [The Gottman Institute](#) - A research-based approach to relationships

"If you want to go quickly, go alone. If you want to go far, go together." African Proverb

"All glory comes from daring to begin." Eugene F. Ware

9] [America's Largest Health Insurer Is Giving Apartments to Homeless People](#) A radical fix for the U.S. health-care crisis. By [John Tozzi](#)

In 1986, Congress enacted a law to bar hospitals from turning away patients who are unable to pay. Any hospital with an emergency room that participates in federal health programs must evaluate and stabilize every patient who comes through the door, including those who are uninsured, indigent, addicted to drugs, or mentally ill.

No institution has a similar obligation to ensure that those people have a safe place to sleep. As a society, we've effectively decided that people shouldn't die on the street, but it's acceptable for them to live there. There are more than [half a million](#) homeless in the U.S., about a third of them unsheltered - that is, living on streets, under bridges, or in abandoned properties. When they need medical care or simply a bed and a meal, many go to the emergency room. That's where America has drawn the line: We'll pay for a hospital bed but not for a home, even when the home would be cheaper.

Jeffrey Brenner is trying to move that line. He's a doctor who for more than 25 years has worked largely with the poor, many of them homeless. Recently, his place in the health-care system has shifted. After decades in shoestring clinics and nonprofits, he's become an executive at [UnitedHealth Group Inc.](#), America's largest health insurer. Brenner is expected to contribute to its bottom line. He plans to do it by giving people places to live.

The research and development lab for this experiment is a pair of apartment complexes in a down-at-the-heels corner of Phoenix called Maryvale. Here, Brenner is using UnitedHealth's money to pay for housing and support services for roughly 60 formerly homeless recipients of Medicaid, the safety-net insurance program for low-income people. Most states outsource their Medicaid programs to private companies such as UnitedHealth, paying the insurer a per-head monthly fee - typically \$500 to \$1,000 - to manage members' care. The company's 6 million Medicaid members produced \$43 billion in 2018, almost 20% of total revenue.

It's a profitable business overall. But the most expensive patients, who often present a complex blend of medical, mental health, and social challenges, cost UnitedHealth vastly more than it takes in to care for them. "Can you imagine people living on the street with these disorders? Heart failure, COPD. They're rolling around with oxygen tanks, crazy stuff," Brenner says. It isn't hard to find people living in similar distress around Phoenix or any other American city. And despite their extreme costs, these patients often get poor care. "This is just sad. This is just stupid," Brenner says. "Why do we let this go on?"

Sitting in a vacant studio apartment on the second floor of one of the complexes, Brenner shows me data on a patient named Steve, a 54-year-old with multiple sclerosis, cerebral palsy, heart disease, and diabetes. He was homeless before United Health got him into an apartment. In the 12 months prior to moving in, Steve went to the ER 81 times, spent 17 days hospitalized, and had medical costs, on average, of \$12,945 per month. In the nine months since he got a roof over his head and health coaching from Brenner's team, Steve's average monthly medical expenses have dropped more than 80%, to \$2,073.

After testing the idea in Phoenix, Milwaukee, and Las Vegas, United Health is expanding Brenner's housing program, called MyConnections, to 30 markets by early 2020. It's a business imperative. In January, after the company announced a \$12 billion profit for 2018, Wall Street analysts pressed Chief Executive Officer Dave Wichmann on the performance of its Medicaid business. The return, he acknowledged, was "not at our target margin range of 3% to 5%." Wichmann said it would hit the target next year.

Patients like Steve wind up in the ER because they don't fit into the ways we deliver health care. The

U.S. system is engineered to route billions of dollars to hospitals, clinics, pharmacies, and labs to diagnose and treat patients once they're sick. It's not set up to keep vulnerable people housed, clothed, and nourished so they'll be less likely to get sick in the first place.

The U.S. spends 18% of its gross domestic product on health care, vs. 8.6% in the other 35 countries in the Organization for Economic Cooperation and Development. America's outside spending on health care contrasts with much paltrier investments in social support- housing, food, education, cash assistance, and care for children and the elderly. Other nations in the OECD spend \$2 on social services for every \$1 they spend on health care, according to [The American Health Care Paradox](#), a 2013 book by Elizabeth Bradley and Lauren Taylor. In the U.S., each dollar of health spending is matched by only 60¢ of social support.

That a for-profit conglomerate like UnitedHealth is in the business of taking taxpayer money to care for poor people reflects the peculiarity of U.S. social policy. Medicaid was created in 1965 in tandem with Medicare- public insurance for older Americans. Congress has since expanded eligibility for Medicaid, most recently through the Affordable Care Act, and the program now insures [72 million people](#), more than 1 in 5 Americans. It pays for [42% of all births](#).

States split the cost of Medicaid with the federal government, but it takes up an ever-larger [portion of their budgets](#)- after education, it's usually a state's biggest expense. To keep down costs and avoid the difficulty of running a health-care system, most states contract with UnitedHealth and its competitors to establish what are called Medicaid managed-care programs. In 2017, [\\$264 billion](#), almost 50¢ of every Medicaid dollar, went toward care for the [54 million people](#) on private Medicaid plans.

Few entities outside the government exert as much influence over health care as UnitedHealth, based in Minnetonka, Minn. The company's health-insurance unit, UnitedHealthcare, provides benefits to 43 million Americans. About 50,000 physicians work for its health-services unit, [Optum Inc.](#) UnitedHealth also owns pharmacies and a bank and Brazilian hospitals. Its revenue last year, \$226 billion, surpassed that of all but five U.S. companies; it's told shareholders to expect long-term earnings growth of 13% to 16% annually.

Brenner, a smiley and cerebral 50-year-old, is an unlikely insurance company man. He studied neuroscience at Robert Wood Johnson Medical School in New Brunswick, N.J., and anticipated a career in research. After a stint at a free student-run clinic that served homeless people and undocumented Central American refugees, he switched to the less prestigious field of family medicine. He did his residency in Seattle and then moved in 1998 to Camden, N.J., at the time the poorest city in the U.S. Brenner started at a small practice with three exam rooms and eventually split off to practice solo. Almost all his patients were on Medicaid. He'd get up in the middle of the night to deliver babies. Brenner also treated victims of violent crime, which led to an interest in developing an accurate picture of Camden's crime. It wasn't going to come from the city government, he learned, because so many victims didn't file police reports. He went to the hospitals instead.

The data he saw there illuminated a gross imbalance in health-care spending: A tiny sliver of patients accounted for a large part of spending. In Camden, 1% of patients made up 30% of the cost. Brenner spotted patients who went to the ER hundreds of times a year, including a handful of individuals who cost the system millions of dollars each. "Like, for 1% of the spending here, we could open up 10

primary-care offices all over the city,” Brenner says.

He had to shutter his solo practice when he was unable to sustain it on Medicaid’s payment rates. (Medicaid pays doctors and hospitals about 30% less than Medicare does; Medicare in turn pays significantly less than private insurers.) Meanwhile, hospitals were expanding. “The system had become so distorted that it felt like a microcosm of what was going on in America, which is if you don’t take good care of people, they’ll get sick,” Brenner says. “Then you’ll need more hospital beds and hospitals to take care of them.”

In 2002 he founded the nonprofit [Camden Coalition of Healthcare Providers](#). The group used hospital claims data to identify outlier patients and hot spots of medical spending, then tried to help people before they landed in the most costly settings, ERs and hospital beds. That work brought Brenner national prominence, including a [New Yorker profile](#) by Atul Gawande, the surgeon and MacArthur “genius” grant recipient, in 2011. Two years later, Brenner [received a MacArthur fellowship](#) himself.

UnitedHealth supported the nonprofit and eventually approached Brenner about a job helping the company with its own strategy to address patients’ social needs. “I said no, and said no a couple of times,” he says. But in 2017, convinced that UnitedHealth’s commitment was serious, he joined to test his ideas on a vastly larger stage. The company has 80 times as many Medicaid members as Camden has people.

Brenner, whose title is senior vice president for clinical redesign, manages a staff of 65. The team was a bit larger before a recent broad round of company layoffs; UnitedHealth says the reduction won’t affect the housing program. By early next year the company expects to house 350 homeless Medicaid patients whose annual health-care spending, while they’re on the streets, exceeds \$17 million. The goal is for them to “graduate” within a year to paying their own rent. (Most get a disability check; those who don’t get help from MyConnections to apply.)

Insurers, including UnitedHealth, generally try to reduce costs by restricting medical care. They require prior authorization for expensive procedures, deny claims for care deemed inappropriate, and limit the drugs available on prescription plans. This is partly why the industry has a bad reputation - the perception that insurers are middlemen that profit by withholding needed care without adding value. It’s behind the argument Senators Bernie Sanders and Elizabeth Warren make for replacing private insurance with “Medicare for All.”

Brenner aims to reduce expenses not by denying care, but by spending more on social interventions, starting with housing. How to do it is still largely uncharted. “I don’t think we’ve figured any of this out,” he says. “We’re at a hopeful moment of recognizing how deep the problem is.” A trip to any big-city ER reveals the magnitude of the challenge.

Kara Geren is trained to detect what’s about to kill you. The 40-year-old attending physician pulls eight-hour shifts in the emergency department at Valleywise Health Medical Center, a 325-bed public hospital north of the Phoenix airport. The unit has a low dropped ceiling, Formica countertops, and a motley collection of curtains that separate beds packed close together. Geren has the kind of calm yet focused demeanor you’d hope to encounter if you found yourself wheeled into the ER. She isn’t rushing, nor is she wasting any time.

“In emergency medicine you always assume the worst,” Geren says. “What’s going to kill this person in the next five minutes? What’s going to kill this person in the next hour?” Valleywise has two trauma bays and a landing pad for medevac helicopter ambulances. As a Level 1 trauma center, it has to be prepared for any unexpected medical crisis that might arrive at any hour of any day.

That vigilance makes it one of the most expensive places to get health care, and many patients who visit the Valleywise ER shouldn’t be there. Some are immigrants who don’t know how to navigate the U.S. system, so they walk into the hospital for routine treatment. Some are uninsured, so other doctors won’t see them. Some come to get out of the summer heat; temperatures in Phoenix can top 100F for weeks on end. The city’s growing homelessness crisis exacerbates the burden. The number of unsheltered homeless people in Maricopa County, which includes Phoenix and its suburbs, [has almost doubled](#) since 2016, to about 3,200.

Some patients are combative, especially if they come in drunk or high. Others are simply seeking shelter and a meal, and complaining of chest pain at an ER is a sure way to get both. Frequent flyers, as nurses and doctors call them, may visit a few times a week or daily. “Sometimes in the same shift, you’ll have a patient come back who you discharged a few hours earlier,” says Heather Jordan, Valleywise’s nursing director for emergency services. “They get a medical screening exam and maybe get a sandwich and a Powerade, and they go back out to where they started.”

Homeless patients have few good options when they’re ready for discharge. Sometimes the hospital pays to send them in taxis to city shelters, which are often full when they arrive. Some go to behavioral health centers for further treatment of mental illness or substance-use disorders. Others go to a respite center run by a nonprofit called Circle the City, where they get medical care along with a bed in a shared dormitory. There are never enough beds to meet demand.

Some people who no longer require hospital care stay at Valleywise simply because more appropriate quarters aren’t available. “There’s a couple of patients who live upstairs that have been here for months and months and months, because we can’t find a place, a safe place, to put them,” Jordan says. The cost for their care—\$3,825 a day—is paid by Medicaid or, for those with no insurance, absorbed by the public hospital and ultimately the taxpayers who fund it. “We could put them in a residence for a fraction of that, and then we can keep ourselves available for that burn patient, that ICU patient, the people, the patients that need us critically,” says Kris Gaw, chief operating officer for Valleywise Health.

Valleywise has been able to place a small handful of homeless patients with MyConnections in Maryvale. The developments were known for drugs and prostitution before UnitedHealth and its nonprofit partner, Chicanos Por La Causa, took them over a couple of years ago. The insurer gave the nonprofit a \$21 million low-interest loan to purchase, rehab, and manage the 500 units. Fixing it up was a challenge. One property manager says she got death threats for evicting drug dealers. Eventually, the frequency of police calls dropped sharply, and kids started playing in the courtyards and using the pools.

Most of the apartments rent to the public at market rates, starting at \$609 a month for a studio. But up to 100 units are set aside for formerly homeless UnitedHealth Medicaid members. One empty studio with new wood floors at the end of a row on the second story is an office for five “health coaches.”

They serve as case managers, counselors, and companions who look after the patients in the program.

One of the coaches, Ray Torres, 50, used to work as a case manager at a county-run clinic for the homeless. Some of his current clients are people he knew from his old job. He'd refer them to services, but they'd frequently just disappear back onto the streets. "Here, we're on-site, we connect them, we knock on doors," he says. Torres keeps the medical appointments for his 18 clients in his calendar. He calls taxis for them and occasionally goes with them to the doctor. Sometimes a knock on the door is critical. The week before we spoke, one client had forgotten about an appointment for kidney dialysis. The man had no phone, and Torres's check-in likely prevented him from going into kidney failure in his apartment.

Torres and his colleagues bring a reservoir of patience deeper than what the homeless typically encounter. Much of the U.S. social safety net conditions assistance on certain behaviors, in an effort to inspire or force people to change. In homeless shelters, people are often required to earn privileges such as a locker or a larger space, eventually to be rewarded with placement in a group home or further housing assistance. Many programs are predicated on first kicking drug habits or adhering to medication. If people act out, they may end up back on the streets. "It's a little like playing Sorry," Brenner says. "You go back to the beginning and start over again."

Brenner, by contrast, advocates a model known as Housing First, which recognizes that getting off the streets is often a necessary first step for people to adhere to treatment for addiction or mental illness - not the other way around. Many of the patients he's concerned with have experienced early trauma, which has lasting health consequences. Exposure to adverse childhood experiences is a strong predictor of problems such as chronic illness, obesity, smoking, substance abuse, and, not incidentally, health-care spending.

"There's a whole thread in health care around personal responsibility that this work evokes in people. As though scolding them, they're going to go, 'Oh, you're absolutely right,'" Brenner says. "All of these things that we talk about, you know, people not taking personal responsibility—things happen to people. And what we've learned is that if you're very young and you're exposed to toxic stress, that brain formation is very different. The way that you navigate the world is different. Literally some of your circuits are different."

One of Brenner's greatest challenges is deciding who should benefit from the program. Giving patients housing sounds beguilingly simple, but the economics are a high-wire act. Medicaid isn't paying UnitedHealth anything directly for housing assistance. The company spends from \$1,200 to \$1,800 a month to house and support each member, so it must save at least that much to break even on Brenner's program.

On average about 60 members are enrolled in the Phoenix sites at any given time. Once a week, Brenner and his team get on the phone to evaluate potential candidates—anywhere from 2 to 14 people whose names have surfaced in UnitedHealth's data. They want patients who are homeless and whose medical spending exceeds \$50,000 annually, with most of that coming from ER visits and inpatient stays. People living on the streets with less extreme medical costs may need a home just as much, but it doesn't pay for UnitedHealth to give them one.

For patients above the \$50,000 threshold, the reductions in medical costs should let the company at least break even on its investment in housing and services. But it's not as simple as running the numbers. Brenner is looking for people who not only need help but are ready to accept it. "We want a storyline around, Why is the housing going to make a difference? What's going on in there? And then what's the exit strategy?"

It's a difficult judgment, made more complicated by a statistical concept called reversion to the mean. Simply put, an outlier will tend to go back to the average over time. Some of the most expensive homeless patients spontaneously become less expensive. Maybe they move in with family or get help from another program; maybe they stop visiting hospitals after being mistreated. Brenner says that his team doesn't fully understand the phenomenon and that the rate at which spending on high-cost patients declines is different in each city. Either way, the housing units he's allocating are scarce resources, and he doesn't want to give them to people who would have reduced spending on their own.

He also wants to make sure the program actually does help people reduce their hospital use, and it doesn't work on everyone. Some people resist it and continue going to ERs even after UnitedHealth puts them in housing. Brenner shows me an analysis of the first 41 patients in Phoenix to get the intervention. The housing and support services proved cost-effective for the 25 most expensive patients, reducing their overall costs dramatically. For the other 16, total spending increased. "The return's only going to work out if we target the right people," Brenner says. That's why UnitedHealth is starting with just 10 subsidized apartments in each new city where it's introducing the program, even in places where there might be hundreds of homeless Medicaid members on its rolls.

Brenner's bet is that he can break the cycle for people like Cathy, a 56-year-old who was homeless for several years. She remembers "moving around like a giant turtle," with her belongings stuffed into bags latched to her electric wheelchair, which she'd plug in to charge overnight at the Sun Devil Auto repair shop in downtown Phoenix. For months, she visited ERs almost daily. One night she left St. Joseph's Hospital after eight hours and went directly to another emergency department a few miles away. "I was going to keep going every day if I had to, because I was having pain in my chest, and they couldn't tell me why," says Cathy, who asked that her last name be withheld.

Her long list of ailments includes diabetes and asthma. A heart attack left her with a stent, and a series of infections almost claimed her foot. That's on top of depression, post-traumatic stress disorder, and what she describes as "extreme anger issues." Two years ago, Cathy moved into a subsidized apartment in Phoenix. Torres has witnessed her transformation. "She had that wall put in front of her," he says. "She had no trust with anybody." Now the two share wry jokes. "Ray kind of kept trying to be positive, be all sweet and nice, like he is," Cathy says.

Housing hasn't solved all her problems. She still has depression, and another heart attack left her hospitalized again earlier this year. But it's made a profound difference. For one thing, she no longer makes a stop at the ER part of her regular routine. That's good news for UnitedHealth. And then there's this: "I feel human again," she says. "Before, I didn't."

9a] [Miami-Dade County - Homeless Trust](#) - Helping the homeless

"A man should never be ashamed to own he has been in the wrong, which is but saying, in other words,

that he is wiser today than he was yesterday.” Alexander Pope

“There is no power for change greater than a community discovering what it cares about.” Margaret J. Wheatley

10] [A Lifetime of Adversity Dampens the Brain's Dopamine Production](#) - Technology Networks - Original story from [eLIFE](#)

People exposed to a lifetime of psychosocial adversity may have an impaired ability to produce the dopamine levels needed for coping with acutely stressful situations. These findings may help explain why long-term exposure to psychological trauma and abuse increases the risk of mental illness and addiction.

“We already know that chronic psychosocial adversity can induce vulnerability to mental illnesses such as schizophrenia and depression,” explains lead author Dr Michael Bloomfield, Excellence Fellow and leader of the Translational Psychiatry Research Group at University College London, UK. “What we’re missing is a precise mechanistic understanding of how this risk is increased.”

To address this question, Bloomfield and his colleagues used an imaging technique called positron emission tomography (PET) to compare the production of dopamine in 34 volunteers exposed to an acute stress. Half of the participants had a high lifetime exposure to psychosocial stress, while the other half had low exposure. All of them undertook the Montréal Imaging Stress Task, which involved receiving criticism as they tried to complete mental arithmetic.

Two hours after this stress task, the participants were injected with small amounts of a radioactive tracer that allowed the scientists to view dopamine production in their brains using PET. The scans revealed that in those with low exposure to chronic adversity, dopamine production was proportional to the degree of threat that the person perceived.

In people with high exposure to chronic adversity, however, the perception of threat was exaggerated whilst their production of dopamine was impaired. The researchers found that other physiological responses to stress were also dampened in this group. For example, their blood pressure and cortisol levels did not increase as much as in the low-adversity group in response to stress.

“This study can’t prove that chronic psychosocial stress causes mental illness or substance abuse later in life by lowering dopamine levels,” Bloomfield cautions. “But we have provided a plausible mechanism for how chronic stress may increase the risk of mental illnesses by altering the brain’s dopamine system.”

“Further work is now needed to better understand how changes in the dopamine system caused by adversity can lead to vulnerability towards mental illnesses and addiction,” adds senior author Oliver Howes, Professor of Molecular Psychiatry at MRC London Institute of Medical Sciences and King’s College London, UK.

Reference

Bloomfield *et al.* (2019) The effects of psychosocial stress on dopaminergic function and the acute

stress response. *eLIFE*. DOI: <https://doi.org/10.7554/eLife.46797>

“May the sun bring you new energy by day, may the moon softly restore you by night, may the rain wash away your worries, may the breeze blow new strength into your being, may you walk gently through the world and know it's beauty all the days of your life.” Unknown

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

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