Developing Compassion for the Homeless

Desarrollando Compasión por la Gente sin Hogar

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Abstract

The author describes how he developed compassion for the homeless through working as a psychiatrist in an inner city health clinic that serves the homeless and poor populations. He documents moving from a position of wanting to avoid contact with the homeless, to a position of compassion for their suffering and situation in life. He emphasizes that a large percent of the homeless are victims of childhood abuse and devastating circumstances, which tend to evoke a strong experience of compassion in those caretakers who work with them intimately. The compassion and prosocial behavior of the poor and homeless, relative to the wealthy, is documented. Compassion is seen as essential to bringing healing to the homeless, poor, and caretakers alike. Two case studies of conglomerate patients are utilized to emphasize how childhood abuse and Posttraumatic Stress Disorder are common in this population, but often go unrecognized and undiagnosed by health care providers and mental health practitioners due to a failure to take an abuse history, trauma history, or review symptoms of Posttraumatic Stress Disorder. As a result, this population is frequently misdiagnosed as bipolar or suffering from only Major Depression. This result in both mistreatment and the tragic failure to treat abuse related conditions that are readily responsive to compassionate psychotherapy based on a compassionate understanding of the life and difficulties of the person being treated. The high incidence and prevalence of physical health problems in this population is documented.

Keywords: compassion, homeless, abuse, posttraumatic stress disorder

Resumen

El autor describe cómo desarrolló su compasión hacia las personas sin hogar, a través del trabajo como psiquiatra en una clínica de salud de una ciudad del interior, que sirve a las poblaciones indigentes y pobres. Documenta su paso desde una posición de querer evitar el contacto con las personas sin hogar, a una posición de compasión por su sufrimiento y situación en la vida. Hace hincapié en que un gran porcentaje de las personas sin hogar son víctimas de abuso infantil y otras circunstancias devastadoras, que tienden a provocar una fuerte experiencia de compasión en aquellos cuidadores que trabajan con ellos íntimamente. Se describe la conducta prosocial y la compasión de los pobres y sin hogar, en relación con la de la gente pudiente. La compasión es vista como algo esencial para procurar la sanación de las personas sin hogar, pobres, y cuidadores por igual. Se emplean dos estudios de caso de pacientes conglomerados para enfatizar cómo el abuso infantil y el trastorno por estrés postraumático son comunes en esta población, pero a menudo pasan desapercibidos, y no diagnosticados por los cuidadores y los profesionales de salud mental debido a un fallo al no recoger un historial de abusos y trauma, o de no revisar los síntomas de trastorno por estrés postraumático. Como resultado, esta población se diagnostica con frecuencia como bipolar o solamente con depresión mayor. Esto da como resultado una falta de tratamiento y el fracaso para tratar condiciones relacionadas con el abuso, condiciones que responden sensiblemente a la psicoterapia compasiva basada en una comprensión compasiva de la vida y las dificultades de la persona que está siendo tratada. Finalmente, se documenta la alta incidencia y prevalencia de problemas de salud física en esta población.

Palabras clave: compasión, gente sin hogar, abuso, estrés postraumático

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Introduction

In February of 2007, I was invited to join the staff of the Staywell Health Center in Waterbury, Connecticut. Staywell is a federally-qualified health clinic whose mission is to serve people who cannot find any willing provider, sometimes because of lack of insurance, undocumented immigrant status, or because no provider was willing to accept their Medicaid or Medicare insurance. Staywell conducts outreach programs to serve the homeless and HIV positive populations. My job would be to serve as the psychiatrist for the Behavioral Health Clinic, located at the Staywell South Main Clinic. My role was to do initial diagnostic evaluations, medication management and work with the staff who would be conducting individual psychotherapy, group therapy and cognitive behavioral therapy with the clients.

In 2007 I had a full time private practice in New Milford, CT, having assumed the private practice of M. Scott Peck, M.D., of *The Road Less Traveled* fame (Peck, 1978) in 1984, and had been doing psychotherapy with his former patients and others who wished to see him. In time, I increasingly functioned as a local psychotherapy-oriented psychiatrist. I accepted the job at Staywell two days a week because I was finding private practice isolating, and the patients repetitive and less interesting, mostly because they were increasingly interested in medications for symptom relief rather than transformative psychotherapy. I thought working with a poor and homeless population would be an enlivening challenge, as well as balancing my perspective on the health care system, which would assist my ongoing advocacy for a single payer health care delivery system for all residents of Connecticut.

I consolidated my private practice and began working at the Staywell South Main Clinic in July of 2007.

On my first day, I was struck that the waiting room of the Clinic was a bustling open space with about 20 chairs full of children and adults, people of all ages and ethnicities, speaking several languages. All of the receptionists were local Hispanic women who conversed with the clients in Spanish and English. As I discovered, the South End of Waterbury is mostly Hispanic, the home of a large Puerto Rican population. However, there are also many African-Americans, Albanians, and South-American immigrants, as well as Euro-American families, the descendents of Waterbury's boom days around the second World War when it was a major manufacturing hub and attracted a wide variety of European immigrants.

The Clinic building has two long hallways. On one side is the dental clinic, a large open space with a dozen or so dental chairs. The other side is a general medical clinic. My office was half-way down the medical clinic hall, just past the nursing station. All the other doctors were Indian, Filipino, or from the Caribbean islands. Of the 150 or so employees at Staywell, at most 20 were Euro-American. As a designated area of medical need, health care practitioners can work there to have their student loans forgiven, or obtain a Green card allowing them to be employed in the US until they become qualified to apply for citizenship or permanent resident status.

At Staywell I shared my office with Jackie R., a nurse who did outreach to the homeless in shelters. There, she would take blood pressures, test blood sugars and perform other basic screening functions. If a resident of the shelter did not have outpatient care providers she would make appointments for them to be seen at Staywell for all their health care needs.

I knew the homeless population had a high prevalence of mental health and substance abuse problems, but had never treated a homeless person after finishing my training at the University of California, San Francisco Medical Center. The only non-clinical contact I had had with the homeless over that 35 year period was a single night, many years before, when my wife and I had volunteered to serve as the overnight staff at the Dorothy Day Homeless Shelter in Danbury, CT. I remember meeting a young woman with children who had come there to escape domestic violence, and another intelligent man who had become homeless after losing his job and been unable to pay his rent. While no one owned a car, they were forced to leave the shelter in the morning on foot, and come back in the late afternoon to line up for a meal and bed, if available. Once in the shelter, their main motivation was to wash their clothes, take a shower and sleep. I subsequently learned that the homeless in Danbury, whether in a shelter or on the street, had nowhere to go during the day, and were often kept out of even the library and risked being picked up for vagrancy if they wandered the streets. I remember the attitude I commonly had toward the homeless I met on the streets back then. I didn't want to be bothered. I wanted to avoid their asking me for money because I was conflicted about giving money to them. My wish to not interact was mixed with sorrow for them, sometimes fear, disgust or pity, but certainly not compassion

in the sense of being willing to be open to them and share in their life, pain, sorrow and suffering. I was cynical when a homeless person would say, "God bless you" whether I gave him or her money or not.

First Case

On my first day of work at Staywell, I met Alejandra, a 35 year old Puerto Rican woman who was living at the St. Vincent De Paul Homeless Shelter, consequent to being thrown out of the Waterbury apartment of a older man she had known in Puerto Rico who had assisted her leaving Puerto Rico because he was lonely and wanted company. He suddenly made her leave after a couple of months, saying he was "tired of her ugly face." Sadly, she had fled Puerto Rico to be with this man after the physically and sexually abusive man she had been living with in Puerto Rico stripped her naked one night and threw her into the garbage dump, leaving her utterly humiliated and ashamed.

Regretfully, her face was unattractive, marred by coarse facial features and large white splotches, which contrasted sharply with her dark skin. Her demeanor was of a sad sack, shy, deflated, defeated, as if she expected rejection, and would be unable to defend herself if mistreated. She said she always felt sad and depressed, and couldn't remember a time she had not felt sad and depressed. I was moved by her grief, desolation, and horrific abuse history.

I asked her about the splotches on her face and arms. She said they had begun as a child and caused her to be rejected, both at home and in school. In addition, she said her mother had always hated her because she reminded her of her father, a man whom her mother hated for his alcoholism and physical abuse of her.

Her mother was living with a different man at the time of Alejandra's birth. She never knew her biological father. Her "step-father" rejected her too, later sexually and physically abusing her. She remembered her mother beating her and then forcing her to go into a closet, sometimes for days, giving her a bottle of water and a bucket to use as a toilet. Her mother and step-father forced her to quit school so she could work for them.

I asked if she had ever seen a physician about the splotches. She said no, her parents had refused to take her, but she had been told they were eczema. I told her to be sure to speak with her primary care provider at Staywell about the blotches, which I thought might be vitiligo, and wrote down "vitiligo" for her. She asked if they could be cured, as people on the street avoided her, were frightened by her, or ridiculed her, calling her names and making her life even more frightening, alone and miserable. I said I didn't know if they were curable, but her primary care provider would evaluate them and determine what might assist her.

I asked if she ever had intrusive memories of the abuse she had experienced. "Yes, every day", she said. "Nightmares and flashbacks also." I asked if she had ever spoken with anyone about the abuse. She said no, she has never had anyone she could speak to or trust. We spoke about how it would be important for her to speak with a therapist at Staywell about her abuse. However, the first step would be to feel safe and trust that she could speak about her life without her therapist turning against her and using her as others had done.

And so I began to develop compassion for the homeless, the people I came to think of as the "invisible people." People who were often alone and whom no one wanted to see or care for. So often abused, mistreated, sad, lonely and chronically depressed, misunderstood and rejected. It is well documented that working with people who have suffered through no fault of their own evokes compassion in others (Goetz, Keltner and Simon-Thomas, 2010). This certainly was the case for me.

Although, Alejandra was the first homeless person I met who suffered from Posttraumatic Stress Disorder (which is characterized by a history of trauma/abuse, intrusive memories of the trauma/abuse, nightmares or flashbacks about the trauma/abuse, attempted avoidance of thinking about the abuse/trauma, avoidance of people and places associated with the trauma/abuse, a persistent negative emotional state, disrupted sleep and hypervigilance, as well as a number of other possible symptoms), she certainly was not the last. In fact, over the years it became clear the majority of the homeless and underclass patients who were seen at Staywell suffered from Posttraumatic Stress Disorder, typically from early childhood physical and sexual abuse, but also from witnessing violence, or tragic deaths caused by shootings, fires or "life circumstances", as when a child or sibling suddenly died, or died because of inadequate or unavailable health care.

I remember over the few years Alejandra remained in treatment what a lovely, gentle and thankful woman she became. She learned to trust and rely on her therapist, as well as myself. She joined a church, developed friends, a social support system, and even started a relationship with a boy-

friend. After she became eligible for public assistance and public housing, living on her own in her own place for the first time in her life, she was so appreciative she proudly made a special Puerto Rican flan to thank her therapist and all the staff for being so helpful and kind to her.

One of the rewards of helping the homeless and the poor comes from how appreciative and accepting they are. When I have made mistakes or when these patients experienced side effects to medication, they rarely complained. I assume this is the result of appreciating whatever attempt is made on their behalf, having spent most of their life not being heard and waiting hours for inadequate, insensitive, and often poor health care in hospital emergency rooms. These people, who have little or nothing, have given me more material gifts than all my private patients combined, all things they made by hand, themselves. In fact, recent studies (Stellar, Manzo, Kraus, Keltner, 2011; Piff, Kraus, Cote, Cheng, Keltner, 2010) have shown that the poor have more compassion and give a greater percentage of what they have than the wealthy. In addition, the wealthy are more likely to engage in antisocial and unethical behavior than the poor (Piff, Stancato, Cote, Mendoza-Denton & Keltner, 2012). It appears the very wealthy often have the most disdain for the poor and homeless, blaming them for their situation, rather than understanding they are most frequently the victims of circumstance, and that "there for the grace of God" they go.

Many, if not most, middle-class Americans are a pay check away, or one major illness away, from losing everything they have and becoming homeless, unless they have a supportive family or a support system. Once you are homeless, with no car, particularly if you are poorly educated, have limited English, no skilled trade, it is very difficult to make your way out, particularly if you have dependent children. What such people most want, more than anything, is a job and a steady source of income. They want to become more independent.

Second Case

Adolfo came to see me for his initial evaluation, stating "I don't want to kill someone. I need medication." He was a gigantic hulk of a man, very fit and muscular. His intimidating size and intensity made me somewhat frightened of him. He had been released from jail the week before, after serving six months of a three year sentence for punching out his boss at work. He was living in a squatters encampment, too proud to go into a shelter. He explained he was married, had children, and had worked all his life, but after he had gone to jail his wife returned home to Puerto Rico because she couldn't afford to stay in Waterbury. She also was disgusted by his violence and didn't want to be near him. I asked what had led to his punching out his boss. He told me his boss was mistreating one his coworkers at the power plant where they worked, pushing his coworker to do more than he was capable of and calling him a *chocho maricon* (pussy fagot). He said he just "lost it", punched him in the chest, causing him to fall over backwards, knocked unconscious. I asked if he had ever done something like that previously. He said that one other time he had punched out a man on the street who was screaming at and hitting that man's son. He said that he wanted to kill that man, and ended up in a local hospital after he told the police what had happened and how he felt. He was diagnosed as having a bipolar disorder and placed on an antipsychotic and mood stabilizer, which he had been taking sporadically ever since. I asked if they helped him with his violent impulses. He said the antipsychotic calmed him to some degree, but the mood stabilizer appeared to have no effect, so he stopped it. He stated he frequently becomes agitated, has racing thoughts and trouble calming himself. In addition, he stated he suffers from terrible insomnia. He denied traditional manic symptoms, and his aggressive, agitated state was ongoing, not episodic like in a bipolar disorder. He also denied a history of attention or school problems which might have suggested an underlying attention deficit disorder, which can sometimes present as racing thoughts and impulsive angry outbursts. Unclear what was going on, I asked him what happened when he was incarcerated. He said he was given large doses of Zyprexa, a very sedating antipsychotic, to try and calm him down and let him sleep. He said the Zyprexa helped some, but the only thing that had really worked was heroin, which he had been addicted to for years, before stopping in the recent past after an ultimatum from his wife and family. He was scared that without medication he would relapse in order to sleep and end up killing someone. When he was in jail, on more than one occasion he had confronted other inmates who were abusing fellow prisoners, threatening to kill them if they didn't stop. He says he would have done it, but they stopped. I told him it sounded like his violent urges were precipitated by him perceiving someone was being abusive and wanted to protect the person being abused. He agreed. I asked if he knew how he had developed such a strong urge to protect people who were being abused. With some

trepidation, fear, and obvious shame, he told me he had been raped as a boy on several occasions by his uncle in Puerto Rico. He was too ashamed to tell anyone, including his wife, fearing they would think of him as a homosexual or simply despicable. In response to the rapes he took up weight lifting and boxing. Within a year his uncle stopped coming near him, knowing full well he would beat his uncle if he tried. He said he hated his uncle, would like to see him die at his own hands for what he did. Though he denied flashbacks, nightmares, or even intrusive memories about the abuse, any abusive situation he witnessed would evoke the murderous rage and hatred that were obviously undigested and caused him daily agitation and restlessness.

Over the two years I knew him, Adolfo found a job, saved money, brought his wife and children back from Puerto Rico and learned to manage his anger, as well as digest the emotions from his childhood. I came to be very fond of Adolfo. He was kind, very gentle and sweet once he learned to trust me. I came to understand that part of his embracing hard work, love of family and honesty was in response to the years he had spent involved in crime to pay for his drug habit. When he swore off heroin he also swore off crime and was trying to make up for all the bad things he had done previously. At the end of our time together Adolfo told me he and his family would be honored to have me visit his family home in Puerto Rico, a small cabin in a very rural area near the coast.

I have included the case of Adolfo in this paper because it is one of many examples of the abused homeless and poor being wrongly diagnosed and treated as bipolar, which has rarely been recognized in clinical or scholarly writing (Salzbrenner, & Conway, 2009). The psychiatric evaluations that homeless and poor people receive at emergency rooms and clinics associated with hospitals are shockingly poor. It is obvious that these "evaluations" have neglected asking about their abuse history, Posttraumatic Stress Disorder symptoms, or learning difficulties, although Posttraumatic Stress Disorder and attention deficit disorders are quite common among this population. Almost all these patients are poorly educated, some illiterate, unable to read street signs or sign their name. They are in no position to question the word, diagnosis or treatment of "doctors." If doctors look for bipolar disorder —the diagnosis du jour— they certainly will find it by focusing on affirmative answers to questions about mood variability, irritability, staying up all night, and an increased sex drive. However, if they would take the time to ask and question, they would find these symptoms rarely occur together and episodically as is characteristic of manic states. In addition, asking about staying up for days on end is commonly confused with the depressive symptom of being unable to sleep, not the decreased need for sleep which is common in manic states. Almost all the homeless and underclass have been seriously depressed at some point in their lives. Often they report psychotic experiences (Morgan, C., Reininghaus, U, et al., 2014) such as hearing voices or seeing shadows, but if you pursue this, typically you will find this to be a symptom of Posttraumatic Stress Disorder rather than a true psychotic disorder, although many people with Posttraumatic Stress Disorder can be appropriately diagnosed as suffering from Major Depression with Psychotic Features. Despite this, false or misleading diagnoses of psychotic disorders often result from a failure to recognize and treat their underlying abuse. I try to think the best of other mental health professionals, and think that the misdiagnoses that are made are a function of cultural insensitivity and the pressure to see more patients than is humanly possible. Still, the toll that misdiagnosis and inappropriate treatment have on people is truly tragic, particularly when the underlying issues are amenable to therapy and or can be ameliorated with appropriate medication.

Although there are many dedicated and competent health care providers who work with the poor, many of the providers in medically underserved areas of need are poorly trained, culturally insensitive, and inadequately supervised. Hence, they deliver a poor quality of care. Nonetheless, the homeless are a very physically ill population. Poverty, abuse, the stress of growing up poor and living in very toxic environments, all result in serious illness at a young age, so much so, that hypertension and Type Two diabetes is typical, rather than the exception for a 30 or 40 year old homeless or impoverished person. I have seen people at 40 who have had strokes and heart attacks. A high percentage of this population suffer from HIV and hepatitis. The long-term negative health care consequences of childhood abuse is well documented in the medical literature (Irish, Kobayashi, Delahanty, 2010; Leserman, Drossman, Li, Toomey &Nachman, 1996).

Conclusion

I feel a great compassion for the homeless because they, and the poor, accept their situation,

and bear witness to our disregard and frequent lack of concern for their welfare. I do not mean to idealize the poor. I have met many homeless and poor people who are seeking drugs, disability and trying to scam the system. But the poor and homeless are human beings who make up the "body of Christ", the good, the bad, the ugly. The prostitutes, thieves, gang members, murderers all have stories and lives that deserve our compassion and understanding. When respect, receptivity and attention are given, it is appreciated and they respond. In the process, we ourselves are opened and learn how to be with an other and share in their lives. In so doing, both patient and health care givers are healed, by compassion (Shonin, Van Gordon, Compare, Zangeneh, & Griffiths, 2014; Shonin, Van Gordon & Griffiths 2014), even as the world and the structure of our society remain terribly broken and dysfunctional.

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