In 2006 a delegation hosted by the National Health Policy Institute in Washington DC included the Village in its tour to learn about health care access problems and focus on the new approaches mental health is taking. I thought this was a good time to hassle them about our problems with MediCal (my letter is in Chapter 6), but it turned out they didn't have any power over MediCal. They did tell me, though, that the staff at the public health clinic was complaining about the same issues we were with their diabetes patients. It turned out that MediCal's version of the "medical model" wasn't problematic because I was treating people with mental illnesses. It was problematic because I was treating people with chronic illnesses. The diabetes doctors were trying to figure out how to include patient education, collaboration, self-help and peer support too. They weren't being pressured into doing those things because of a recovery movement. They wanted to do them because they were good medical care for people with chronic illnesses.

At the time I was getting more requests to talk to "resistant" professional staff, especially psychiatrists, to get them "on board" with recovery. I added a few slides about acute vs. chronic illnesses and encountered less resistance. The psychiatry residents I lectured to wondered why they hadn't been taught to treat chronic illnesses before.

As I wrote this I was surprised how far this line of thought could get us. We may have a better chance approaching professionals (and maybe even MediCal regulators) through chronic illness treatment than through "recovery journeys to meaningful lives."

We Treat Chronic Illnesses, Don't We?

(2006)

(How dare I include in the title the politically incorrect "chronic illnesses"? Because this paper is not designed to reach out to politically correct recovery champions and consumer advocates. I've written plenty of other stuff for you. This paper is designed to engage our professional staff who, like me, were trained, in long, expensive, professional programs that taught us to help people by treating their illnesses. We're the people you turn to in an emergency, who shoulder the legal and clinical responsibilities in our system, who treat people who need it even if it means coercing them. A successful system, including a recovery based system, must include us. I'm "meeting them where they're at" and trying to bridge the gap between us so we can become collaborative coworkers.)

When the various medical professions as we know them and the "medical model" emerged about a century ago the vast majority of patients had acute illnesses, mostly infections and injuries. The average life span was about 45 years. As we became more effective treating those illnesses the prestige of medicine grew and people started living long enough to get chronic illnesses. At the present time the vast majority of medical patients have chronic illnesses, but medical practice hasn't been transformed to meet patients' changing needs. Psychiatry, seeking similar prestige and funding levels, has increasingly sought to model our practice on the acute illness medical model used by our medical colleagues. Public psychiatry patients almost all have chronic illnesses, both because we target our efforts on people with serious, persistent mental illnesses and because there is so much stigma attached to mental illnesses

that people rarely seek help until after they've been struggling on their own unsuccessfully for a long time. There are significant differences between how acute illnesses should be treated and how chronic illnesses should be treated that I will discuss in this paper. I believe that public psychiatry is not likely to meet our patients' needs more effectively while adhering to an acute illness model instead of a chronic illness model.

Chronic illnesses differ from acute illnesses in several important ways:

1) With acute illnesses it's reasonable to withdraw from life while being treated, whereas, with chronic illnesses the patient should try to maintain their "normal" life while being treated.

2) The ongoing symptoms of chronic illnesses often make it hard to maintain a "normal" life, necessitating rehabilitation to increase function, personal adaptations to cope, and community adaptation to maintain access to life.

3) Chronic illness more often than acute illnesses effect people's self identity.

4) Hope is more difficult to maintain for both patients and professionals with chronic illnesses because the symptoms resist treatment and helplessness settles in.

5) Recovery from acute illnesses usually results from symptom relief, whereas, recovery from chronic illnesses usually results from being able to maintain wellness and responsibility for self-care and being able to replace professional supports with natural supports while rebuilding a meaningful life.

These differences have important treatment implications that have never been adequately addressed by our professions, our education, our helping roles, or our funding system. The premise of this paper is that if we seriously address the care of chronic illnesses we will arrive at almost all of the "recovery model" without ever really leaving the "medical model."

The treatment for most acute illnesses can be done to the patient, whereas, the treatment for most chronic illnesses must be collaborative.

Patients with acute illnesses can literally turn their lives over to professionals to be treated, even living in a controlled hospital environment for awhile if needed, confident they will retake control over their lives once they are well again. All the patient is expected to do is "follow doctor's orders."

Treating patients with chronic illnesses the same way, whether they have asthma, diabetes, sickle cell anemia, AIDS, schizophrenia, or alcoholism is rarely successful. Long term "treatment compliance" is amazingly low with all chronic conditions. We simply can't expect people to put their lives on hold indefinitely or stay living in hospitals for long periods waiting for treatment to work. They'll choose to drop out of treatment rather than drop out of life. Acute hospitalizations tend to become "revolving door" because the condition continues long after the "stabilization" achieved in the hospital is long gone.

Instead, the patient must make chronic changes to impact their chronic illness while going on with their lives. The changes they need to make fall into two categories: Self-help and wellness. Self-help involves actively engaging in the treatment process, learning about your illness and how to deal with symptoms when they occur either on your own or with professional assistance. Wellness involves knowing what's needed to prevent symptoms from occurring and how to keep symptoms from disturbing your overall sense of wellbeing and ability to go on with your life. Both include recognizing your warning signs, exacerbation signs, and crisis signs, knowing what to do about each, and having the self confidence and self responsibility to make the necessary decisions and take action.

Neither self-help nor wellness can be achieved by relying on a "follow doctor's orders" model. A more empowering, collaborative model is needed.

> *The treatment for chronic illnesses requires more teaching and usage of self help techniques than the treatment of acute illnesses.*

Teaching people about their condition and how to help themselves can take a lot of time, but if we don't take the time to do it we'll find ourselves taking care of them in the same situation over and over again (Think teaching to fish instead of giving a fish). We often find ourselves taking care of someone over and over again in the hospital without them really learning what changes they'll have to make in their life to stop being hospitalized. Similarly, we work with people who stop taking their medications over and over again without really getting through to them to stay on their pills. Without really realizing it, we're acting as if every hospitalization and every relapse is basically a new acute illness. We don't often help patients learn from their past.

Many people with chronic mental illnesses are not appealing students. Some were in special education classes or did poorly in school. Some have poor concentration or are irrational. Some are wrapped up in their own worlds, slowed down by depression, or confused by anxiety or mania. Some people even reported that people with schizophrenia have a "failure of historicity" meaning they can't learn from their pasts. One look at UCLA's skill training modules with their pervasive repetitiveness can give us some idea how hard teaching them can be. It's not impossible, but sometimes it's a lot of work.

The most overwhelming obstacle to teaching many people with chronic mental illnesses is that they "lack insight." They refuse to agree with us that they have an illness at all, so how can they learn about their illness and how to help themselves? There is a way around this blockage. Remember when they did the meta-studies of psychotherapy? It turned out that for a therapy to succeed, it didn't have to have the "right" explanation for the person's pathology. We could succeed with psychoanalytic explanations, behavioral explanations, interpersonal explanations, or a host of others so long as it was a "shared" explanation – one both therapist and client could agree to base their work on.

Our present dominant explanation, that a neurochemical imbalance causes most chronic mental illnesses, suffers from an impressive lack of "face validity" or "intuitive appeal." It just doesn't feel true to most people. It's a hard explanation for people to share with us. We can widen the number of people we can teach if we have at our disposal a wide array of plausible explanations we can chose

between depending on which one our client is most likely to believe. After all, most people with chronic mental illnesses think something is wrong. They just don't think it's a neurochemical mental illness. Just like they're sure they're not crazy.

Would you be willing to teach someone that they're drowning in the same deep waters that Saints swim in and need to take medications and keep themselves grounded because they aren't prepared to use their spiritual gifts? Would you be willing to someone people to go on a "thought diet" like John Nash did in "A Beautiful Mind" to return to reality from the seductions of his unfettered thoughts? Would you be willing to teach someone to take medications and avoid using speed to strengthen his brain to fight off rays from a machine in outer space? Would you be willing to teach someone to create a "mother angel" to care for the "baby angels" whose cries have been keeping her awake for several years since her children were taken away from her? It makes for strange "informed consents," but I've used all of these "shared explanations" to teach people to take care of themselves who lacked insight.

Another problem with our prevailing neurochemical model is that it offers only limited opportunities for self help. Generally our advice boils down to, Take your meds and avoid stress." That's barely hopeful and definitely not empowering or engaging.

We have been taught Cognitive Behavioral Therapy, that's proven for both depressive and psychotic conditions, and a variety of relaxation and anxiety reduction techniques, but in actual practice we don't use them much. We claim we're including them in our individualized supportive therapy instead of using the "manualized" procedures because most of our chronically ill patients just don't seem to be responsible enough for the "real thing" but, in reality, we're far more likely to resort to problem solving, care taking, case management, structuring, and making decisions for people than teaching. The overt decision to individualize and include teaching within support is probably correct. The covert decision to abandon teaching probably isn't correct.

There are a wide variety of other self-help techniques that have evolved out of the consumer movement (for example from the National Empowerment Center). Even though some of these like WRAP (Wellness Recovery Action Plans) have attained national prominence, virtually none of them have been included in professional curriculums or CEU conference trainings because of their non-professional origins. Many of these are more suited to our patients than the professionally created products and easier to use.

On the face of it, it would seem that all of this would require more motivation and participation from the patients, not less. It would seem easier to be dependent on professionals and cooperate with being taken care of than to learn to take care of yourself and work collaboratively with professionals. If we're already having problems with compliance, why make things worse? Because one of the main reasons patients aren't compliant is that the treatment doesn't "work" in the way they expect it to work. They expect to be made well rapidly by the professionals and that doesn't happen if they have a chronic illness. When that doesn't happen they often withdraw. The expectations and the nature of the helping relationship need to change from the outset if we're going to get more collaboration. The patients have to change models too.

The treatment for chronic illnesses, unlike acute illnesses, requires actively engaging the person in their own treatment process.

Attempting to engage people in the ways we've been taught, within the structures of our "auditor friendly" systems, who may be impaired by their mental illnesses and may not even believe they have a mental illness has been incredibly frustrating. The most common recommendation to address this problem unfortunately has been to recommend increased coercive powers to make people receive treatment whether they're engaged or not. That might work for acute illnesses but not for chronic illnesses. Long term engagement is essential for people with chronic illnesses.

There are those who claim that forced treatment can achieve engagement by reducing symptoms and "restoring people to sanity" which will help people regain "insight" and then engage in treatment. While this may occasionally be true, far more often it leads to inadequate engagement and the "need" for further involuntary treatment.

The way out of this dilemma is to achieve engagement with people who are actively symptomatic and "unreachable." A recovery based system approaches long term engagement very differently than our usual system. Many of their techniques are more effective than our usual ones. Here are some concrete examples:

1) Our system builds treatment on a good diagnosis. Our initial contact is normally an extensive assessment. (Common poor results of this approach are people avoiding us saying, "I don't want to have to tell my whole story all over again," and an incredibly high rate of no shows for second appointments.)   A recovery based system builds treatment on a good relationship. Their initial contact, which may be an "outreach" contact, normally focuses on welcoming and engagement incorporating charity, benefits assistance, sharing stories with peers to build hope, lowering boundaries by being "friendly," finding shared interests and backgrounds, and building emotional connections through extended non-judgmental listening.

2) Our system builds expectations that people will have lower symptoms and feel well as a result of successful treatment. We normally assess symptom relief. (A common poor result of this approach is that people withdraw when they don't feel better fast.) A recovery based system builds expectations that people will achieve goals they set and rebuild a meaningful life. They normally assess quality of life outcomes (like housing, employment, finances, avoiding legal problems, etc.) that can often be achieved when services are focused on them.

3) Our system hires licensed professionals and expects us to be able to connect with people within professional roles and boundaries thus avoiding any negative personal reactions we may have. (A common result of this approach is that people feel distanced, looked down on, and not really cared about; just part of doing our jobs.) A recovery based system hires lots of people with experiences with mental illnesses many of whom want to "give back" and asks them to use their past experiences to connect with people.

4) Our system tends to prescribe treatments based upon the illness being treated. (A common poor result of this approach is that people feel invisible, like "an interesting case" and disconnected from us.) A recovery based system tends to view treatment as supporting people on their very individual journey of recovery. It highly values their subjective experience of their illness and their search for meaning within a cultural context.

We can reasonably expect as a result of these changes to be asked to work without resorting to coercion with a variety of people we haven't been well connected to before. Many of them won't meet our usual criteria for collaborative treatment. They may not believe they have a mental illness. They may abuse drugs. They may not be responsible, missing appointments, not take medications "as ordered," and not be able to give informed consent. It's not that we haven't tried working with some of these people before. It's that we haven't been very successful. The recovery model expects us to succeed now. The pressure here is that, unlike in the past when we could blame the patient or the insufficient involuntary treatment laws, now we'll be held accountable for helping people we may regard as untreatable. An escape hatch is closing.

We'll be asked to be more flexible and less authoritarian than ever before, more willing to work collaboratively with our patients, more willing to take risks with people working outside the norms and protections of standard medical care, and more willing to rely on nonprofessional and mentally ill colleagues.

The treatment for chronic illnesses requires including its effects on the person's ability to live successfully.

There's an old study that determined that the correlation between schizophrenia and poverty wasn't due to poverty causing schizophrenia. It was due to schizophrenia causing poverty. They documented that people with chronic mental illnesses tend to experience "downward social drift." Their reasonable conclusion was that the symptoms of mental illness get in the way of making money. We can argue that it's not really the symptoms themselves that are so destructive, but actually stigma, segregation and loss of opportunity, civil rights reductions, treatment effects, institutionalization, etc., but basically we'd all agree that having a chronic mental illness is likely to hinder your life. We just don't like dealing with that reality.

Psychiatrists, psychologists, and nurses tend to push off life problems on social workers. Social workers tend to push them off on case workers and community workers. The entire mental health field tends to push them off on other social service agencies. We all want to stay focused on treating the illnesses themselves. Unfortunately, that just doesn't work very well. Most of our patients with chronic mental illnesses still lead impoverished, heavily restricted lives.

Why should we believe that we could do better if we got more involved? After all, we didn't learn much about housing, employment, education, finances, avoiding jail, or family preservation in school. Because "supported services" (like supported housing, supported employment, supported education) actually work when they're integrated into mental health services. Some are even proven "evidence based

practices." It turns out, for example, if a supported employment worker is added to an ACT team many more clients get employed than if they're referred to the local Department of Vocational Rehabilitation. Why? Some would claim it's just a matter of reducing interdepartmental red tape and improving access, but I don't think that gives us enough credit. I think that if we focus on employment we're able to use our understanding of people's illnesses and treatment effects to design effective individualized support plans and I think that if we focus on using our ongoing treatment relationships with people we can help motivate them to implement these plans.

There's a lot of variation in what supports people need and how to motivate them to move forwards. Someone whose concentration is affected by intrusive voices is different from someone who uses marijuana regularly. Someone whose moods are unstable because of manic-depression is different from someone with a borderline personality disorder. Someone who's slowed down from a major depression is different from someone who's on high dosages of sedating medications. Our expertise can help us move from "placement" and generic "training" to more effective individualized supported plans.

The treatment for chronic illnesses often requires including rehabilitation and personal adaptation.

Most of our positive experience with rehabilitation and personal adaptation is, strangely enough, with acute illnesses. For example, many of us have personally experienced dramatic positive effects from a time limited course of physical and/or occupational therapy and a set of crutches helping us to recover from a broken leg. Our experiences of the effectiveness of rehabilitation with chronic illnesses, like muscular dystrophy or chronic heart failure tend to be less compelling.

Perhaps our best outside source of inspiration for effective rehabilitation with chronic illnesses could be special education for learning disabilities: Before special education was mandated, it was routine to consider many children "retarded," not bother to understand them too carefully, segregate them away from normal children, give up on them as "unteachable," and take care of them indefinitely. Despite numerous confounding administrative, legal, and fiscal issues, we've made substantial progress since then including Individualized Education Plans based on multidisciplinary assessments, "mainstreaming" them into normal classrooms with extra support, and including social and employment skills training to help them become productive adults.

But we don't really have to look outside mental health for inspiration. There are striking examples of successful rehabilitation within our own fields ranging from UCLA's early work with "unteachable" patients at Camarillo State Hospital, to Boston University's inclusion of people with serious mental illnesses in the normal college population using a "chose, get, keep" support model, to Fountain House and numerous other clubhouses helping people who were stuck in patient roles to succeed in a variety of other meaningful roles.

I only really embraced rehabilitation and personal adaptations for chronic mental illnesses (like a Walkman to block out the voices or crocheting a blanket to cope with chronic insomnia or getting a dog to help go outside despite agoraphobia) when I changed my focus from treating illnesses to helping people with chronic illnesses have better lives. We're not using rehabilitation like the Orthopedists are

to help broken legs heal faster. We're using rehabilitation like the special education people are to help build lives. If you can shift focus from treating illnesses to rebuilding lives – and this is the most important shift that the recovery model requires of us – than you'll value and learn to use rehabilitation and personal adaptation techniques.

Chronic illnesses affect people's self-identity more than acute illnesses do.

Very few people become "influenzics" but many people become "epileptics" or "asthmatics" or "schizophrenics." It takes a chronic illness to internalize truly destructive identities like "cripple" or "retard" or "loony" or "stoner." A good doctor treating a patient with a chronic illness over the course of many years is likely to become increasingly personal over the years. He remembers your name and not just the medical details of your case. He's likely to talk about how your life is as much as how your illness is. He gets to know your family. This has the effect of stopping the illness from swallowing you up. The message is, "You may have to come see me because of your illness forever, but that doesn't mean that's all there is to your life." The illness doesn't have to define who you are even with the professionals treating you. They can relate to you in a friendly way instead of a strictly professional way.

Mental illnesses and substance abuse disorders have a particularly virulent ability to rapidly destroy our self-identity and our public-identity. Even a short live postpartum depression, for example, where a mother had thoughts of killing her infant, is likely to permanently and profoundly alter her view of herself as a good mother. If she tells someone else about her symptoms they're likely to call DCS and have her child taken away entirely. Even one drug conviction for an adolescent can make them ineligible for federal financial aid to go to college and make them feel like a social reject. Mental illnesses and substance abuse disorders are strikingly "crippling."

We have quite a number of people for whom even if we gave them a medication or a therapy that made all their symptoms disappear, they would still remain on our caseloads crippled for life. In fact, there are many people for whom we've already given them a medication or therapy that made all their symptoms disappear on our caseloads now.

By contrast, Moral Treatment institutions in the 1800s had striking recovery rates. About two thirds of psychotic people admitted to these small, compassionate, God faring institutions were discharged back home recovered within 6 months. We can't even really imagine results like that with our present treatment programs. Why are things so different now? I think mostly because even when we've "stabilized" people they're not really well again; they're still crippled. The illness (including both positive – like financial benefits - and negative effects) has become an ingrained part of who they are.

Moral Treatment didn't focus on treating illnesses. Most of the staff weren't even professionals. They focused on helping you feel whole again, on helping lost souls find their way back to God again, on building you up so you could make a contribution again. Some would argue that this is a good treatment for mental illnesses, but that's not my point. My point is that when the symptoms go down for whatever reason recovery results much more often if you're self-identity has recovered instead of

been crippled. (Many recovered people, like John Nash, report that their symptoms aren't gone. They're just easier to ignore, not so urgent, easier to detach from.)

It's important not to focus on the self-identity effects only after acute treatment has achieved stabilization and the underlying crippling has emerged. We must focus on it throughout our treatment process (even when they're tied down, yelling in the ER, yet still able to remember how we treated them). There are too many ways in which we inadvertently contribute to their crippling throughout our treatment process. I've met many people who say they were devastated when a hospital staff told them they had schizophrenia and would never recover and would have to either live with their parents or in a Board and Care forever. Others have never tried to return to work even when they felt better because their old psychiatrist told them they were permanently disabled, work would be too stressful for them and cause a relapse, and because they didn't want to risk their Social Security benefits. The effects of being tied down, mostly naked with cameras watching you, or being called a "dirt bag" in detox, or being told, "Why don't you just get it over with and really kill yourself next time?" can be lifelong.

We need to incorporate a secularized version of Moral Treatment into our daily practice. Some of this will be accomplished by including paraprofessionals who are particularly compassionate, accepting, and hopeful in our treatment teams. Some of this will be accomplished by consumer advocates and "language police" harassing us to change our stigmatizing and traumatizing habits. Some of it will be accomplished by us becoming more personal and friendly, lowering the professional walls, remembering their names, asking about their lives and not just their illnesses, and getting to know their families.

It all comes back to hope.

The reason the phrase "chronic mental illness" is considered politically incorrect is because it carries the implication of hopelessness (and therefore was replaced by "persistent mental illness" which can be persistently fought). The words, "There's nothing more I can do for you" can't be far behind. Indeed about half of all clients in our clinics receive "meds only" – brief doctor visits every month or two for unending refills.

We become very defensive when confronted with our pervasive hopelessness and begin looking around for someone else to blame: It's the underfunded system's fault. It's the paperwork and MediCal. It's incompetent, senseless, or out of touch administrators. It's restrictive involuntary treatment laws. It's "low functioning" patients, unresponsive illnesses, ongoing substance abuse. It's low quality psychiatrists or lazy county staff who don't really care about people. It's codependent, sabotaging, exploitative, or crazy making families. The list goes on and on as we descend into a maelstrom of frustration.

I'm casting blame in another direction, on our acute illness model. If successful recovery is symptom relief and cure and treatment is limited to what we can do to compliant patients we're likely to become frustrated and hopeless. If, instead, we use a chronic illness model other versions of recovery emerge (including self responsibility, wellness, and rebuilding function, roles, and a meaningful life) and other treatment approaches emerge (including engaging through shared explanations, teaching self help,

rehabilitation and personal adaptations, and restoring self-identity) and we're likely to become less frustrated and hopeless. The recovery based system transformation gives us the opportunity (and in California some funding) to incorporate these approaches.

Rachel Remen writes movingly of her experiences as a doctor in the book "Kitchen Table Wisdom." She followed in the footsteps of numerous other family members into medicine, but she turned out differently because she has struggled with severe Crohn's disease since her teens, a recurrent inflammatory bowel illness that caused her recurrent diarrhea and required numerous surgeries to treat. She says she became a "wounded healer" and has gone on to work with people with chronic and terminal illnesses to help them find meaning and with burnt out doctors to help them find meaning.

She tells one story of a man she was working with who had cancer and was receiving chemotherapy. Every week he would come into the clinic and sit talking with his oncologist for twenty minutes while the chemotherapy flowed into his vein. After awhile it became clear that his cancer was not going to respond to the chemotherapy and his doctor told him he didn't need to keep coming in any more. The patient asked if he could keep seeing the doctor anyway, but the doctor told him that there was no point. There was nothing more he could do for him. The patient felt such a loss he would've been willing to have continued to take highly toxic, ineffective chemotherapy just to spend time with his doctor. As chance would have it, the oncologist was also working with her because he felt he didn't have anything to offer his incurable patients. He never realized the impact he was having on their lives.

An acute illness model tends to blind us to many ways of helping people, and it tends to hinder us from finding meaning.

The recovery movement has grown rapidly (and resisted efforts to change its name) because recovery is hopeful. Many people – patients, families, even staff – are desperately thirsty for hope. Unfortunately, most professionals don't feel the hopeful about recovery. We equate recovery with cure and most of our patients have incurable illnesses. We consider the entire recovery movement to be unrealistic, naïve, or even manipulative. Recovery with chronic illnesses is not dependent on cure. Patients can recover from a heart attack without their cardiac muscle regrowing. Patients can recover from a stroke without their neurons regrowing. And patients can recover from schizophrenia without their neurochemicals regaining balance. They recover when their lives are rebuilt not when their illnesses are cured. We can help them rebuild. There's hope after all.

There's a catch to all this: Illnesses don't recover, people do. We can directly cure illnesses, but we can't directly "recover" people. They have to be the center of their own recoveries. We can help give them hope, empower them, promote self responsibility, and create opportunities for meaningful roles, but they have to do the actual work of rebuilding. That's why the recovery model is "consumer centered" and "consumer driven." They have the starring roles. We're the supporting cast.

I included a variety of approaches to recovery in this chapter for two reasons (even though my favorite is still the Kubler Ross' stages approach in "A Road to Recovery"): First, because different insights and

practices are highlighted from different approaches, and second, because in my role as a recovery promoter it's good to have paths from a lot of different directions to bring people in.

But it goes further than that. I was trained as a scientist at Caltech and learned the value and usage of organizing theories like evolution, plate tectonics, molecular genetics, and quantum physics. I believe that recovery is also an organizing theory for mental health services (and human growth and transformation more generally). Like any good theory recovery should be derivable from a variety of approaches. Observations from different places and people with different backgrounds and biases should lead to the same conclusions. This chapter contains enough converging lines of thought to reassure me.

Now it's time to move on to the next feature of any good organizing theory: It should be applicable to specific issues and problems within the field where it hadn't been tried before. It should bring clarity and organization to the issue, make accurate predictions, and suggest solutions. Let's see if that actually happens in Chapter 3.