

# THE PHOENIX FILES

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# The Phoenix Files

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**These files are not the final word on AMD management and rehabilitation, much still needs to be done for a truly comprehensive text to be completed, not least the systematic survey of the opinions and experiences of AMDs themselves.**

**However, we trust that the information that follows will prove informative, useful, and supportive, to those for whom it has been written.**

**A truly comprehensive Manual would cover these points and many more. We live in hope that one day such an important co-operative effort will be made. Can you help? Do you know interested, qualified and dedicated people who can?**

**How different would the situation be, now, if Dr. Kraepelin had the knowledge and insight, then, to have identified AMD/MDP as just another physiological and/or metabolic disorder, with both cognitive and physical consequences, rather than 'the other major psychosis'. The whole history of research, treatment, patient history, public perception, etc., all would have been so different. But this did not happen, and so, even now in modern times, the misdiagnosis, misunderstanding, mismanagement, crude medications, and labeling, plus lack of research and thus postponement of more enlightened treatment, still all regrettably subsist. If YOU want to be the one to write that PhD thesis, bear in mind the terrible consequences and history of Kraepelin's (unwitting) Curse, and how important it is for all those with the illness, now and in the future, to ensure that this 'curse' is at least eased. If only this awful illness could finally be removed from the human genome, that is the last and best resort! Until then, there is only good management and rehabilitation to make the real difference between optimal lives, (and freedom from talking cures and other spurious ideas), or still more misery and ever-preventable deaths.**

**AMDs are, therefore, thrice damned if the genetic origin and physiology of the illness are not understood, coupled with being told that it is all 'in their mind', with consequent useless 'cognitive therapy' and/or inappropriate medication being foisted on them. Also, as yet there is no coherent universal AMD management system in place, because that comprehensive management and rehabilitation manual still needs to be written before there is any real hope of lifting Kraepelin's Curse!**

## THE PLIGHT OF THE PHOENIX.....

Phoenix, the legendary bird who rose from the ashes to fly again, is a popular metaphor relevant to the fluctuations of human endeavours. Singed tail-feathers are a humorous footnote in our folklore, and are an apt analogy for a painful learning process, or a narrow escape. However, there is another, more real life human phoenix who also rises and falls, singeing feathers in what is too often a temporary escape from the flames; becoming progressively more scarred, enervated, and diminished by the recurring attrition.

In reality, it is phoenixes plural too, because there are approximately 1%, (depending on variability and clinical severity), of any given population thus afflicted, or who suffer related conditions with similarly distressing and debilitating symptoms. Sadly, despite the help available, (basic and under-funded as it is), too many of these usually intelligent and creative, though tormented, beings suffer lives of thwarted potential and not so quiet desperation. Equally sad is their capacity to blight the lives of others, however inadvertently. Many brilliant and notable historical figures have soared and crashed and risen again, powerful and despairing by turns in the grip of their emotional torment, and often in the harsh glare of publicity.

Great creative talents have been blunted or destroyed by the sustained attrition of overwork, personal problems, and even substance abuse that dulled the pain and sustained the soaring above an ever-looming void, just that little bit longer. A high price to pay for the extra intensity of life and emotion so unknowable by ordinary people. How many others have there been throughout history, of lesser notoriety or fame, who have suffered thus in their turn?

As understanding of the illness has progressed, so terminology has varied over time, reflecting popular perception of the problem as well as increased medical understanding of it. The nomenclature ranges from the opprobrious, to the euphemistic, to the clinical. 'Melancholia' was the romantic view (for non sufferers anyway), of the 19th. Century, and still only told half of the story. The 20th. Century saw the use of manic depression, mood-swing, bi/uni-polar affective disorder, and the practical term 'manic depressive psychosis' or MDP, which is quite definitive and preferable to the more euphemistic terms. The collective term for the range of related conditions in modern times is 'Affective Mood Disorders', AMD.

Unfortunately, the poorly informed make much of the term 'manic' and the supposedly fearful connotations. It should be stated, here and now, that the ordinary population has more to fear from so-called normal members within its own ranks, than from MDP\AMD sufferers. This would apply to mental illness sufferers in general; Hollywood and others have much to answer for in this respect! The MDP Phoenix is the classic AMD model, but the other forms must not be forgotten, and newer and more rigorous classification of AMD syndromes ensures that all AMD sufferers get recognition, medically and socially.

Previous to the 19th. Century, 'lunatics' who were sufficiently affected were incarcerated regardless of causes or symptoms. There has been a long dark age of mental health care in human history that has still not been fully displaced by enlightened attitudes, and earlier AMDs suffered accordingly. Wealth may have provided a cushion for some at a time when treatment and conditions of care were minimal, but public institutional incarceration was indiscriminate.

During the later 19th. Century, more rigorous observation identified one particular group who had remissions, and MDP as a separate and distinct mental illness was recognised in its basic form. (Thank-you, Dr. Emil Kraepelin, if not for the inadvertent curse...) Continuing stability was also observed in some MDP sufferers who 'took the waters' at particular spas.

In the early 20th. Century, the stabilising element responsible, in the form of soluble salts, was identified as lithium. After some problems with toxicity, therapeutic doses were finally developed in 1947, in the form of lithium carbonate. (Thank-you, Dr. John Cade.) Since then, other formulations have been developed, including slow-release in the 1980's; lithium remains the standard medication and prophylaxis, though its effects are more marked on the manic form of MDP\AMD. Blood levels are regularly monitored, as well as other metabolic functions. Other medication may be taken concurrently and/or in conjunction as necessary. Lithium holidays may be possible, or even medically necessary, under supervision, and with reliable carer support. Lithium Information:

<http://medsafe.govt.nz/CMIPage.htm>

A genetic origin has been established, epidemiologically and empirically, that ensures MDP\AMD sufferers can spurn, with authority, purveyors of quack cures and false hopes; anything from herb teas and religious conversion-cum-exorcism, to money wasting talking cures, and smug psycho-social theories, revealed truths, and pop psychology. A well earned relief, a victory for common sense for the individual AMD, and a new perspective for all AMDs seeking and utilising improved rehabilitation methods. However, a definitive, authoritative, and up-to-date

'Manual of AMD Rehabilitation' is yet to be commissioned and funded; emphasis on AMD rehabilitation potential must precede this.

Increasingly, AMD is postulated to be closely associated with other disorders such as OCD, ADD/ADHD, Dyslexia, some so-called neuroses, and Asperger's Syndrome, all of which have concomitants of metabolism/physiology, mood, and other related functional or cognitive dysfunction, as well as discernable genetic links. The research continues, and no doubt improved knowledge and better insights will also mean re-definition and re-classification of other 'mental' disorders, even as to what actually constitutes a 'mental illness', with consequent re-appraisal of treatment.

Sadly, the Mental Health dollar still attracts too much of the wrong attention from the spuriously motivated and qualified. Patients who do not successfully 'heal', (a serious misunderstanding of the disease itself), are expediently their own scapegoats, and the frauds go on unpenalized, profiting from straw-clutching. These abusers of trust include ideologies, religious lobbies, and so-called professionals of poor conscience and intellect. Also, ill-informed, empire-building, or budget-conscious politicians and public servants do their share of damage, with expedient or ill-founded value judgments and priorities; a problem solved is a budget lost, perhaps?

Much still needs to be done to overcome these problems. Too often, the fact of the diagnosis is used expediently as a weapon against the AMD, especially those who try to speak out against prejudice and shabby treatment. The mentally ill, ipso facto, have no valid opinions. Such heedless labelling is just victimisation, emphasising social vulnerability, and enabling, if not justifying, expedient discrimination. Whether from a personal, or worse, an institutional source, these attitudes are based on ignorance and prejudice, and are reflected in their worst form by authorities who still subscribe to the principle that reduction, where possible, to the status of hopeless case is still seen as optimum health care planning.

Such attitudes are reprehensible in supposedly socially enlightened times, and would be anathema to any disadvantaged group seeking social justice and recognition. More direct involvement of patients themselves is thus necessary at all levels of care, plus the use of properly trained AMD social workers. Support groups need scrutinising for effectiveness and professional liaison. All AMDs and carers need detailed information on the illness; this is one medical situation when, from a patient point of view, comprehensive knowledge of the problem is vital to successful rehabilitation.

Ideally, separate hospitalisation and rehabilitation for AMD/MDPs should be common policy. At present, conventional hospitalisation may mean patient condition is worsened by surroundings that reinforce the realisation of ignominious and even abject dependence on the system. Repeat admissions under the same conditions, without proper treatment and rehabilitation, can only diminish the quality of life and prospects for the patient. To reiterate, a comprehensive text on AMD/MDP rehabilitation has yet to be written, and needs a multidisciplinary approach from motivated and interested professionals to complement input from patients and carers alike. Any other than an integrated approach will be insufficient to successfully address the issues, and government backing is essential.

Similarly, public awareness and acceptance could be improved, without making AMD\MDP 'buzz' concepts, and liable to novelty fatigue. Genetic counselling should also be discussed, as a sensible modern issue. Genetic engineering may yet effect alleviation, if not cure. It may facilitate public acceptance and education. A gene suite will be found to be involved, with other related mental illnesses manifesting themselves as a result. DNA testing will aid early screening, and more certain diagnosis.

Diagnosis at present may require a period of observation, because the diagnostician is seeking a pattern or syndrome among symptoms common to other mental illness, and to normal stress patterns of everyday life. As well, the illness may be present in atypical or incomplete form eg, manic without depression, or vice versa; both stages may occur, though with unequal intensity, or there may be cyclothymia or hypomania etc. Hence the need for a collective term like AMD to acknowledge the scope of the syndrome, although MDP is still relevant, and more specific to the classic bipolar form.

Physiologically, the illness is characterised by biochemical imbalance in brain function; lithium in correct concentration helps to restore and maintain this balance. Research has so far shown that cellular ionic transfer mechanisms, plus neuro-endocrinal and neurotransmitter functions may be involved. Also, a gene has been found that blocks action by a cell protein governing signal transmission, and lithium functions similarly to that gene. There is also the inositol recycling process that can be controlled by therapeutic lithium, **which is also the reason why non-AMDs are unaffected by lithium intake.** Serotonin regulation is also involved, most importantly in depressive stages. All the factors are not known or understood, and the picture will become clearer as research continues. Further mapping of the human genome will doubtless make a contribution as bio-genetics and microbiology make contributions. Meanwhile, orthodox treatment and common sense are the best options offering at the

present time, and advances in the treatment, or even elimination of AMD, are yet in the future. For reference purposes, rely only on current, mainstream, and reputable, texts and journals, plus comparative use of similar Internet resources.

Essentially, classic MDP\AMD is characterised by periods of increasing mania and super-confidence, heightened creative or sexual activity, seemingly endless energy expenditure, altered sleep patterns, (usually less rather than more), spending money, absenteeism, travelling, grandiosity, fluctuations in academic or other applied activities, pronounced mood variations, poor stress and other stimulus resistance, possible substance abuse, thrill-seeking, shortened attention span, incongruent plans and ambitions, over-committment and unsolicited giving of advice or help to others, weight loss due to hyperactivity or irregular food intake, brightness and intensity of visage, manner, and physical deportment, etc. Having a mind like a badly-tuned radio is one description of the mental life of a manic phase.

With time and stress, this affective condition could become increasingly more brittle, (not all highs are happy), characterised by hyper-irritability, before a descent into depression that may last for months. During this latter period, expert supervision may be required, as suicide may be a possibility **even when least expected**. Responsible persons should see that extreme, cyclical, atypical, and not necessarily socio\psychopathic behaviour is properly investigated by a psychiatrist; it follows that these are very general details and supplied only as a guide.

Physical concomittants of depression include extreme lassitude, physical weakness, and overall low energy levels, daytime sleeping with consequent broken night sleep. Also, diminished sex drive and other altered or diminished reactions to everyday stimuli, and even irritability associated with such stimuli as bright lights or noise. Inability to filter external stimuli can be a characteristic of both AMD extremes, especially in acute phases, and intellectual performance may noticeably dwindle, while a frightening seemingly anoetic mental state may cause further distress during a depressive phase. Flashbacks, usually distressing, may also manifest during depression. There will also be bad mornings, worse days, and a lifting of mood during afternoons, classic signs of deep, clinical depression. Dietary changes may manifest as diminished appetite, but also include a craving for protein and for sugar, other carbohydrates, and the need for heavier, fattier 'comfort' foods, which will result in weight gain if exercise is not maintained at this time.

**For either high or low states, commonsense support, including insight-oriented training towards self-awareness of changing mood states, is important. Cathartic-style 'psychotherapy' is to be avoided at all costs to avoid worsening the mood changes, furthermore, any stress and adrenalin rushes are a dangerous for any stage of AMD, jeopardizing already-fragile judgement, as well as promoting increasing instability and further patient alienation from continuation of management and rehabilitation.**

A new problem that may inhibit early diagnosis of juvenile AMD is the possible misdiagnosis of ADD, (Attention Deficit Disorder), both as a genuine mistake, or when unwilling to confer an AMD 'label'. Particular care must be taken to see that this misdiagnosis does not occur. Proper education and acceptance of the patient and their support network should counter bias against an AMD diagnosis, although ADD/HDAD may also prove to have origins in that suite of genes mentioned above. As always for any AMD patient, differential diagnosis is of paramount importance.

An important aspect of the classic form of AMD/MDP is its cyclical nature, from rapid cycles even to the point of long remissions, knowledge of which are essential to diagnosis. (Sadly, these remissions are often seen as cures by the unscrupulous or the over-optimistic). NB, other forms of AMD are generally variations on these themes. Also, poor resistance to sensory overload or general stress are common to AMDs, and may provoke extremes of irritability or withdrawal, relative to specific patient condition, and irrespective of original onset signs.

The greatest enemies of AMDs are the trivializers and dissemblers, well-meaning or otherwise, who seek to play down the importance of the illness because superficially, the signs represent problems of relatively lesser importance in the general community.

But, however self-indulgent or subjective the complaints of the sufferers, they are relating symptoms which must be accepted as such, in conjunction with patient history, when considering diagnosis and treatment. AMD underlies all of life for sufferers, careful screening, management and rehabilitation are necessary, with a modicum of commonsense. There may be remissions, but there must always be preparedness for the next episode.

**Remissions are not cures, and likewise, quack remedies and talking cures that attempt to trade on remissions do not eliminate genetically derived illnesses, they are both a dangerous waste of time, and most reprehensible.**

True manic episodes must be distinguished from mere irritability or excitability, and similarly, endogenous depression from reactive, and cyclothymia from temperamental. Ill-informed or inexperienced carers can also be a

hazard at this crucial stage. Objective diagnosis, quality care, and comprehensive rehabilitation must prevail. Failure to understand these factors will cause unnecessary suffering, and should be regarded as irresponsible and negligent.

Reality for the AMD sufferer is distorted by intensity of feeling and emotion that affects judgment more than perception. This is quite different to the reality problems of the schizophrenic, which are not part of this discussion. (However, for the sake of schizophrenics everywhere, the loose usage of the term in everyday life should be discouraged, because it is basically incorrect and misleading, and thus inappropriate).

Only in the severest cases of mania do MDP\AMDs suffer from problems of perceptual reality; physical conditions may contribute to this, such as lack of sleep or food. No link between MDP\AMD and Schizophrenia has been established. ('Schizo-affective' relates to symptoms that indicate a combination of both major psychoses. For expert diagnosis only.) As regards AMD rehabilitation, social and environmental factors are important, as well as medical treatment, and all aspects need to be systematically developed. Also, with classic MDP, it may be difficult to convince a soaring phoenix to land before crashing.

But when applied, therapy should be firm but fair; from initial damage control, to stabilization, to ongoing stability. The AMD/MDP must learn self-regulation by these standards also, and the goal must be to change from active MDP to potential MDP, and render the illness more incidental to the mainstream of life. AMDs in general should be similarly advised and encouraged. **NB**, substance abuse and an irregular lifestyle may trigger destabilisation. **Long-term** stability is important, with stable and healthy lifestyle, and support and monitoring by family and friends; even reappraisal of occupation or ambition may be necessary. **To repeat, regular medical monitoring is necessary, for lithium blood levels and other metabolic functions.** Monitoring should accompany all medication.

For MDPs, the temptation to soar again should be avoided where applicable, drug therapy should be maintained, and remissions should be seen for what they are, in all types of affective mood disorders. Essentially, controlling highs is the key for the classic MDP syndrome. The MDP\AMD will learn self-regulation with time; a diary is useful for charting the patterns of life of mood disorders in general, and aids the referring GP, **and** specialist diagnostician.

A motto for the stabilized MDP\AMD could be 'the price of peace is eternal, though benign, vigilance.' Carers should always maintain the firm but fair approach; 'empathy rather than sympathy' would be an appropriate motto for them. Over-solicitousness is counter-productive, and role-playing carers and those who exploit sufferers for their own egos, or in the name of ideology, are dangerous and should be avoided at all costs.

Similarly, attend only support groups with a common sense approach, medical and legal support, and no hidden agendas. 'In the name of' so easily becomes 'an excuse for.....', independence is lost, with the consequence of worthy ideals and resources being subverted to less worthy causes. Avoid those in any position of authority who plead or justify that they are only following orders or policy, and are thus abdicating any personal responsibility for what they do. Lives may depend on awareness of these conditions of care. Educate others in these matters.

### **The care network must be strong, dependable, and enduring.**

Initial acceptance of the diagnosis and treatment is important, as this is the beginning of full recovery, and the early foundation of renewed emotional stability. Lithium and dissembling alone will never initiate optimal rehabilitation. Nor will false hopes and wishful thinking. During rehabilitation, concentrate on allowing the original stable personality to emerge; perspective obfuscated by the illness must be redefined, however painful this may be. Common sense is always important; as is the careful pacing of recovery. The 'DESIDERATA' of popular note could have been written with AMD rehabilitation in mind.

More research needs to be done on AMD, which now needs a higher public profile. Drug abuse and AIDS have also jumped the funds queue over mental illness. However, with what knowledge is available, much can be done in the way of early identification of the AMD sufferer, and much hope for genetic research in the future. **There are two major onsets**, at adolescence and middle age, with others scattered between as part of a continuum; these onsets may or may not have discernible early signs, a typical manifestation of the genetic origin pattern of AMD.

Physiological and/or hormonal changes may potentiate the illness in those susceptible, but the illness is always just below the surface, and the concurrent life events contribute to the severity and consequences of an untreated and thus uncontrolled. **Essentially:** always look for and observe carefully, those individuals whose cycles of behaviour, positive and negative, could be described as larger than life, and whose overall life pattern may seem self-defeating. **So typical of an undiagnosed Phoenix, in fact.**

Early life onset is the hardest to deal with, as atypical behaviour may go in the grab bag of adolescent behaviour, or be masked by the current trend to indiscriminately confer syndrome diagnoses such as ADD, OCD, narcissism, neuroses or 'abuse' on problem cases, etc. The label of psychotically ill would still appear to be the least desirable of all! Without vital early diagnosis, stabilisation, and rehabilitation, the young AMD may simply drop out, and prime productive years, both personally and socially, may be lost. Recurrence of the illness over the years when/if this occurs, is wearying, enervating and personally and socially damaging. Long-term AMDs can still have rehabilitative potential, of course, but the younger AMD has the most potential of all, and this must be urgently addressed.

Equally sadly, AMD seems to be a disease of intelligent people; undiagnosed, or improperly treated or rehabilitated, their resource and industry are wasted so fruitlessly on coping with, and compensating for, the effects of their illness. Yet so much can be done to make their lives stable and useful again: early identification, treatment, and rehabilitation are the keys, with common sense the dominant theme.

**Finally, given the continuing indifference of society at large towards this genetic illness, it is also a sad irony that the more rehabilitated and seemingly normal the AMD becomes, the less sympathy and/or empathy they can expect, and, as the less 'visible' the illness becomes, credit for, and understanding of, the struggle to survive and overcome the extremes of the illness is never usually acknowledged.**

**There will never be a Special Olympics or Big Fundraisers for the mentally ill, and any System's Duty of Care, if one actually exists, does not mean an AMD will ever be networked. Most likely the more severe cases will be regarded by many in society as just more nimby scapegoats on Welfare. But the rehabilitating AMD must persevere, and endure, for personal survival, setting an example for others in need, always contributing to societal education about mental illness, and trusting that one day there will be better acceptance and understanding, or even better, elimination of the illness itself from the human genome. Until then, the good news is that, given early diagnosis of AMD/MDP, optimal management and rehabilitation, plus a healthy lifestyle with no substance abuse and/or over-medication, an otherwise normal lifespan should eventuate.**

**Dedicated to those who, in hindsight, should have survived. More importantly, this is dedicated to those in the present and future, who, with foresight and common sense help, will survive.**

## **Suggested References:**

A pamphlet is only a pamphlet, so, there must be other sources of information. Comprehensive and recommended are:

**MANIC DEPRESSIVE ILLNESS**, co-authors F. Goodwin and K. Jamison, OUP New York 1990-, 938pp. ISBN **0195039343**  
**BIPOLAR KIDS**, R. Greenburg, DaCapo 2007, 294pp. ISBN **0738210803**

New editions of reputable and mainstream medical, pharmaceutical, biological and related texts will contain updates and cross-references, and should be continually updated because of the accelerating pace of Life Sciences research. See also [Johns Hopkins Bipolar Studies](#) The definitive **AMD Rehabilitation Manual** has not yet been undertaken..? See [Phoenix PhD](#).

**Quality texts, hard copy or virtual**, should contain bibliographies and indexes to expedite research. Periodicals like The Lancet, New Scientist, Scientific American, Time, Newsweek, etc. are also topically useful. Even reportage in daily and weekly press of good repute makes an occasional contribution, and is also a good indicator of the sources and types of populist (mis)information which should be refuted and replaced by facts and common sense. Beware also of populist, 'touchy-feely' or 'guru'-style attempts at profiting from publishing 'cures' based on spurious subjective or 'revealed truth' material.

**In particular, even in reputable publications, note the paucity of data on rehabilitation for AMD;** research and clinical emphasis is still directed at diagnosis and understanding of disease types and mechanisms. (eg, Jamison et al do not feature the word 'rehabilitation' in their index.)

The potential for rehabilitation of AMDs, especially after early diagnosis, must now be recognised and acted upon, medically, socially, and politically. This is the next major challenge to rendering the illness more incidental to the mainstream of life, both for AMDs, and the other people that share their lives, and society at large, who will then collectively benefit from their considerable intelligence and realised potential.

**Good luck in the search for knowledge, understanding, and proper recognition.....**

### **PLEASE NOTE:**

**1)** For the purposes of this pamphlet, MDP stands for Manic Depressive Psychotic, bi-polar syndrome and patient; AMD stands for Affective Mood Disorder, collective syndrome and patient, generally interchangeable; MD stands collectively for Mood Disorders, as per DSM.III-R, and its use has been avoided because of the clash with 'Medical Doctor' as well as the abbreviated form of 'Manic Depression'. Bipolar is also a molecular and electronic term, to add to potential confusion.

The particular use here of the terms 'MDP', 'AMD', or 'AMDMDP' attempts to emphasize that generalization of classification, though convenient, may blur distinctions, to the detriment of AMDs themselves in their various forms. This can only be self-defeating if not acknowledged. MDP\AMDs, or 'Phoenixes', are the most obvious examples of AMD sufferers, and as such are the standard introduction to AMD, but the **collective** nature of AMD should always be implicit in the terminology. Nomenclature and classification are ongoing problems, but this is a small price to pay for the results of any change or research that invests in the future.

**2)** Lithium has not been superseded by other newer drugs, and still does assist with diagnosis, as non-AMDs are not affected by it, unless doses are toxic.

**3)** Treatment should emphasise stabilisation with lithium as required, followed by systematic management and rehabilitation to avoid or minimize dependence on any one drug therapy, as well as minimising drug side effects. **These are the central themes of the Phoenix Files.**

## **Postscript to 'THE PLIGHT OF THE PHOENIX'**

After all the years that the Phoenix pamphlet has been circulated, a certain pattern of reactions is discernible, ranging as would be expected, from the enthusiastically supportive to the scornfully dismissive. Within these reactions are positive and negative vested interests, prejudice, ignorance, genuine concern, and relief at making a friendly contact, and even greater relief when the information may affect the course of a life or lives.

**For the sake of simplicity, these reactions could be divided into three main classes:**

- 1) Those with genuine interest and support, especially from those who already have the illness, and those who have experience through relatives and friends. This group are always willing to share information, do their bit to publicise the issues involved, and overcome prejudice. This may include professional individuals or groups, (Phoenix is, after all, professionally vetted), even some that may be acting against the sentiments or policies of groups or organisations. The best professional feedback also comes from this group.
- 2) Those selectively interested, eg, for reasons of politics or community leadership, though regrettably, this may be a matter of political mileage only. There are also those who are interested because of feelings of public duty. Some professionals fall into this category, and in this case, their support may be only tacit, or polite, or constrained by bureaucracy or other forces over which they have no control. That there should be such a conflict, or grey area in matters of public policy in any area of Mental Health is a matter of regret, and emphasises that that this must be overcome in order for **public** education to take place.
- 3) Those with a negative self-interest who feel some threat from publicity, elucidation of issues, better policy, more research, and even funding and facilities for all of these. This group can include other community groups either competing for funds, or with some ideological or doctrinal prejudice against a commonsense approach to Mental Health. The greatest hazard is posed by those with an intellectual or philosophical bias against a commonsense approach to Mental Health, eg., mental illness is caused by society, or is a matter of labels, or have a vested interest in talking cures or quack medicine continuing to subsist. This third group may also have, collectively, strong media influence or access which has to be countered. Their attitude to the File is distinguished mainly by being wilfully selective, or by refusing to read the pamphlet at all....

Included, also, is anyone in a professional capacity who operates only by the book, defends a budgetary or statistical base, and has no other interest in the policies or duties assigned them. They are especially culpable, as they already enjoy considerable social privilege by being thus employed, and having other material advantages that strong lobbying can confer. Quite the opposite of the situation in which the mentally ill may find themselves; such a disparity is even more reprehensible when enjoyed by those who are directly or indirectly charged with responsibility for Duty of Care. Such people are accessories after the fact of mismanagement and resource discrimination.

This sub-group usually operates by meetings with planned attrition the main principle of operation; one 'sympathetic' staged-managed hearing at least is guaranteed to satisfy procedure. Help with dissemination of Phoenix is always refused on procedural grounds. For these functionaries, a problem solved is a budget lost.

Finally, there is the fact that the right to Mental Health resource applies equally to all, and that no lobby group should try to divide and weaken the Mental Health lobby as a whole; playing off one group against another is iniquitous. The Phoenix pamphlet assumes equal rights for all Mental Health 'consumers'; there are groups, sometimes with a professional base, who would 'prioritise' minorities to suit the purposes of hidden agendas, political correctness, or an outsider lobby group. Phoenix asks for no more than fair hearing, and fair play as to resource allocation.

In general, all the feedback, positive and negative, has enriched the Phoenix pamphlet, and enabled more comprehensive and even anticipatory points to be made. Although the main theme has been to do with AMD, the general principles of care and rehabilitation are implicitly intended to speak for all other types of mental illness. The proposed Manual is the main priority now for the future well-being of all AMDs.

## **Comments on the future of Mental Health Administration:**

Implicit in the administration of Mental Health is the fact that negative human nature and human attitudes must be countered by education and example as any society aspires more and more to the status of a civilisation.

The instinct of discrimination against the different, or the freak of nature is especially hard to overcome, based, as it is in turn, on some old group-based survival instinct. Even in enlightened times, such a primitive residue can be appealed to, subconsciously conferring 'rightness' on any prejudice.

This sort of prejudice is a handicap to progress in any area of Mental Health in general, being socially retrograde as well as affecting the morale of those with the illness. These problems are then compounded by poor public and staff education, professional disregard, inappropriate staff choices and general bureaucratic intransigence.

There must be more networking for effective referral, care procedures, rehabilitation, research, employment opportunities etc., and enlightened and motivated administration to oversee this. Common sense applied in a true liberal democracy should facilitate the achieving of these standards; without optimal mental health care and properly motivated administration, our society cannot be seen to be evolving with universal purpose for the well-being of all its members.

**The time has come to think and work in terms of what can and will be done, not to continue to evade the issues with the excuse of what cannot be done.** Mixed reactions, even to a humble pamphlet like 'The Plight Of The Phoenix', emphasises the problems, prejudices, and social divisions that remain to be overcome.

**In the case of more enlightened care for AMDs**, there is not much resource required for a very large return in human as well as financial terms, and much of what is needed is just common sense and low-tech application of some basic principles, viz:

- 1) Effective screening of possible sufferers, and public attitudes alleviated by proper education would potentiate the scope of screening, however this may be carried out.**
- 2) Separate hospitalisation of acute patients, and cottage hospitals would be sufficient for most cases, especially sub-acute cases.**
- 3) Specially trained staff for any level of AMD care or contact, see 8).**
- 4) Rehabilitation and management training for AMDs, carers, and for others who may use these skills, such as in public service interface situations. Prompt and suitable re-employment is mandatory to expedite rehabilitation.**
- 5) Ongoing networking at all levels of AMD care, including personal friends and carers.**
- 6) Drop-in centres for those needing respite, possibly as part of dedicated clinics, also for AMDs to meet and mix periodically with their own kind, also important for optimal rehabilitation, and to counter isolation.**
- 7) Effective networking to help with and promote support, employment, meetings and excursions, information and education, plus AMD input to optimise effectiveness.**
- 8) Avoidance of 'talking cures' and their ignorant and ill-educated practitioners. AMD, especially when acute, feeds on misplaced and ill-advised introspection, as well as ill-advised ambient stimuli. Thus 'cathartic therapies', role playing, and 'group therapies' are all totally wrong, and even dangerous.**
- 9) Stabilise, advise, and rehabilitate, only then introduce AMD facts, figures, and lifetime vigilance, plus, necessary re-consideration of lifestyle and career changes.**
- 10) Support for human genome research that will finally eliminate the illness, and, note that for the few who claim that they 'enjoy' the experience of AMD, there are thousands who definitely do not.**

**Profile of a Possible AMD/MDP:** For potential carers or family, or those charged with Duty of Care in responsible positions, these points may apply to the undiagnosed or the misdiagnosed, and emphasises the need for objective and careful handling:

- 1) Apparently intelligent, yet self-defeating; with financial, age, achievement or education anomalies.**
- 2) Job turnover exceeding average, possibly without seeming good reason.**
- 3) Low stress tolerance, difficulties with conflicts of interest in employment history**
- 4) CV's that do not add up or seem glossed over; gaps without adequate explanation**
- 5) Consistently under-employed in relation to ability**
- 6) Family alienation, marriage difficulties, lack of peer friends**
- 7) Uneven behaviour patterns, with or without explanation; may be evident with repeated visits. Broken appointments, emotional states with possible abrupt changes, confrontations with staff, (regardless of fault...). Difficulties with personal questions and sensitive issues**
- 8) Possible substance abuse**
- 9) Itinerant lifestyle, esp. 'starting again' etc. See also 6)**
- 10) Domiciliary arrangements, address difficulties, state of health, dress etc., observed during repeated visits may indicate anomalies.**

Note that these individuals may not necessarily be sociopathic, or be non-gregarious in demeanour. But the key to their distress may lie in discerning the sorts of anomalies as outlined above, and those not necessarily identifiable by obvious behaviour or signs of distress. Referral for proper scrutiny and diagnosis is the next step, facilitated by effective networking. Please also note that similar patterns of identification and referral networks should be developed for other categories of mental illness. In a better world, other desirable facilities for AMDs would include:

- 1) A regional halfway house, drop-in centre, or similar residential facility with appropriate staff and consultants (as per Phoenix pamphlet).
- 2) This could also provide for the needs of separate hospitalisation of sub-acute patients away from general hospitals and so speeding rehabilitation in more congenial surroundings. This is necessary for quick return of morale, and early initiation of rehabilitation.
- 3) Facilities for on-going education of families, peers, public, medical, and PS, and production and distribution of information like books, newsletters, etc. A lobbying base for the promotion of AMD/MDP interests would be thus closely associated as per 1) and 2).
- 4) Concerted multi-disciplinary effort to produce a viable, contemporary, and definitive rehabilitation procedure that may be produced in manual format. This is important, as AMD'S usually have good prospects for rehabilitation, and present rehab standards are poor to nonexistent. Indifference and negligence towards AMD has prevented progress. Constant updating of procedures is also necessary. Avoid patronising them, or trivialising their distress.
- 5) Particular ancillary services anywhere should include:
  - fast-tracking to medical specialists
  - DOC liaison, access to legal help; liaison with police
  - help with finding employment, especially interested private business
  - training and education for paramedic or administration personnel
  - support network for all AMD's who require this, including 24 hour phone and drop in facilities
  - congenial hospitalisation or sub-acute care if separate hospitalisation is not possible.

## **10 Steps to AMD Rehabilitation**

- 1) **Consent to be diagnosed -realisation of their own illness by the individual**
- 2) **Diagnosis, subsequent acute/subacute care**
- 3) **Acceptance of diagnosis, reasons, and implications for the future**
- 4) **Stabilisation, medium term: -medication routine,  
-return to optimum health  
-self-education, incl. diary keeping  
-balance internal and external reality**
- 5) **Carer and support network: -organised  
-educated  
-empathic rather than sympathetic**
- 6) **Reappraisal of lifestyle: future, career, relationships, abilities, etc.**
- 7) **Integration with other AMDs, support networks and groups,**
- 8) **Advanced personal education: -onset signs  
-stress management  
-mood identification  
-self-monitoring  
-medication holidays as necessary**
- 9) **Long term developments: -self-sustaining lifestyle  
-suitable permanent employment  
-greater independence etc.**
- 10) **Use of experience to help other AMDs, in conjunction with networks:  
-referral  
-support  
-EXAMPLE**

### **AMD Creed**

Balance Inner v Outer Reality,

Emotions Bad, Detachment Good,

Apathy Bad, Adrenalin Toxic...!

Look after yourself, practice healthy living.

Commonsense Rules, OK..!

## **12 Principles of AMD Treatment**

- 1) Early and competent diagnosis, and acceptance of same**
- 2) Medication and competent acute/post acute supervision in a specialized AMD environment**
- 3) Competent and trustworthy carer and support network**
- 4) Appropriate health regime and daily routine; avoid extremes and learn to regulate rather than feed the symptoms to avoid vicious cycles of distress developing**
- 5) Reappraisal of ambitions and lifestyle**
- 6) Self-and-carer education; ongoing, commonsense and mainstream**
- 7) Take care with relationships, personal, business, therapeutic, administrative, or Personal, choose wisely!**
- 8) Maintain or initiate ongoing employment or other constructive activity ASAP as a necessary part of rehabilitation**
- 9) Maintain medical links with one reliable and interested GP**
- 10) Render the illness incidental to the mainstream of life ASAP, but remember to be always realistic about the nature of AMD. Congenial employment is important**
- 11) Understand that TIME and PATIENCE are important factors in rehabilitation; carefully maintain momentum at all stages**
- 12) Avoid self-excusing, concentrate on learning constructive self-criticism, and self-improvement. Maintain personal vigilance and objectivity. Aspire to be an example to others of rehabilitation success**

**Along with all the preceding criteria for AMD care, rehabilitation, and management there must also be:**

- **A properly integrated and legitimate national support and information network**
- **Acceptable and universal standards of screening, care, and rehabilitation, with scientific and medical links, strong lobby connections, and overseas interface and networking, even to the extent of a UN charter if that is what it would take to see optimal Mental Health standards established and maintained.**

**To those imbued with any common sense and an understanding of AMD, or any other mental illness for that matter, such principles would seem self-evident. Any random park bench survey will bear this out!**

## **Management of AMD**

**Introduction:** Due to the variability of AMD, the following remarks are to be regarded as general, and based on the classic bi-polar model. AMD stages and individuals may vary, but the principles of AMD treatment and rehabilitation remain the same: firm but fair, medication where required, allowing TIME (as a necessary component of recovery) for the individual to respond to treatment, ongoing support networks, stable and realistic lifestyle, re-establishment of normal routines, etc. **Remember, the definitive rehabilitation text is yet to be written, especially one that contains extensive feedback from AMDs themselves about their condition and how treatment should be instituted.**

**Main points:** For the AMD and carers, the most important principle is to realize, and to hang on to, the fact that no matter what stage of the illness you are in, or how bad you feel, that this will pass. The illness is by nature cyclical, there are remissions, and you must have patience. Thus, it is important to define and distinguish symptoms of the illness, and differentiate them from the very subjective, negative, and all-pervading reality of the patient, which is itself just one symptom, even if the most obvious and painful.

This is most important in all stages. The world has not necessarily changed; try and keep perspective and treat symptoms accordingly. This is difficult, and compounded by the fact that one may find it hard to imagine what it would be like to be in a different state of mind. IE, when in one stage, it is difficult to imagine what it would be like to be in any other, including the well or normal stage. This makes for even lower morale, and the seeming impossibility of recovery.

**AMD can be a disease that feeds on, or draws strength from, its own effects and symptoms, if allowed to do so.** The inability to see past an enhanced emotional state thus makes that state so difficult to be seen objectively by the individual, and this factor reinforces that state. In turn, this makes it so difficult to stabilise a manic state or to sustain endurance of a depression, so, **avoid emotional extremes and learn to regulate rather than feed the symptoms to avoid vicious cycles of distress developing.** At these points, the objective input of a reliable support group is vital. Avoid prolonged instability that that may trigger a major state change. If the cycle is thus set to run again yet one more time, when it could have been broken, it will become more difficult to break if continually repeated.

**For some AMDs, a pattern of illness without discernible stress precursors can eventuate, requiring extra monitoring care.** An **iceberg** analogy can be invoked, in that AMD is always just below the surface, and, when rising, independent of any other factors, can then affect concurrent life, for better or worse. Happy factors will be more enjoyable, and negative factors more accentuated. Effects are not therefore triggers or causes, but signs that another cycle has begun, most likely a high that will later result in a low for classic sufferers. A good diet and sensible lifestyle will always mediate when the iceberg rises, however, so that any new cycle can be mitigated. A bad lifestyle, especially without adequate sleep and with substance abuse, will always make the episodes worse.

**Habituation** of probably inappropriate compensatory behaviours in long-term AMDs will cause even more problems, especially if this incorporates undesirable coping or escapist mechanisms, or behaviour patterns which may make establishing a diagnostic pattern difficult when help is finally sought from a specialist.

**Burnout** may eventually be a possibility for some, but must never be assumed, as this could so easily be mistaken for remission. This is the reason that burnout should not be promoted as a possible outcome, along with avoiding or not promoting unrealistic expectations about recovery. Burnout brings its own problems of enervation and withdrawal, and early diagnosis and effective management will alleviate these.

Thus, there is a possibility that burn-out is more like fade-out for those AMDs who have had fewer, or more well managed episodes, and thus less mental and physical wear and tear in the long-term. **Normal burnout means the episodes no longer continue, but the AMD is left emotionally fragile, with a nervous system vulnerable to irritability, enervation, and a personality prone to social and personal withdrawal. Cathartic style psychotherapy and other forms of mental stress are to be avoided at any stage of the illness, adrenalin is a poison whose effects are exacerbated by mood fragility in high or low states!**

However, an AMD well advanced in rehab should, with supervision, be able to go on 'medication holidays', and/or carefully expand emotional life, while maintaining the necessary vigilance. **Such holidays can help the patient identify changes and episode onsets, and make for an emphasis on stability of lifestyle, and trustworthy and objective carers.**

**But** lithium especially is not aspirin, so these tests must be undertaken with care, and only after long periods of stability taking lithium. Remember the lag period. **The idea is to lessen dependence on that, or any other, drug by more self-awareness and life style changes, not to be starry-eyed about giving drug therapy up altogether!**

There can also be a lag period between experiencing external reality and dealing with it objectively, and if there is a problem with diminishing this lag, or dealing with conflict between internal and external reality, then recourse to medication may be necessary for re-stabilisation. The AMD must learn this difference, and the help of sound carers is also important in this respect. Manic episodes are notorious for increasingly irregular patterns of behaviour, and corresponding problems with changing internal reality.

Reinforcers of mood to be aware of also include memory. Generally speaking, memory also seems to correspond to the mood, as if the chemical traces that remain from the time the memory was recorded, are reactivated by the mood of the current stage. Flashbacks are derived from such memory imprinting.

Thus, in general terms, the manic stage can be reinforced by appropriate memories of adventure or fun, and in the depressive stage the memories are more likely to be unpleasant, like being whipped around the mental legs, so to speak, and occur as repeated painful flashbacks. Also, a spontaneously occurring **series** of memories of a certain kind may be a precursor of instability, or a state change, note.

**Depression:** This particular stage is most likely to be understood or empathised with by 'normals', because it is an experience within their range of emotions. (Highs are more likely being seen as high spirits, showing off, or irresponsibility, etc.)

However, deep/clinical depression is a much more extreme condition, involving loss of appetite, morale, cognitive abilities, sex drive, energy, motivation, some higher motor functions, such as driving, and even brain waves are altered. Constant drowsiness, periods of very deep sleep, as well as altered sleep patterns are common. Bad mornings, with early hours awakenings, and days of torpidity that may improve in the late afternoon, for reasons relating to diurnal rhythms that are not yet understood, are distinctive of deep or clinical depression.

Sleep may be deep, but dreams seem not to be affected, and then the patient on waking may actually not experience depression until a certain stage of awakening is reached, when suddenly, the condition 'hits'. Consequently, the day begins again in the worst possible way, especially if this occurs in the early hours of the morning, with many hours to be endured before mood again lifts in the late afternoon. Bad mornings usually become better afternoons!

For this reason, sleep patterns must be kept as normal as possible, so that early hours awakening is forestalled, and this is made difficult by the fact that the patient tends to prolong the more bearable evening hours by staying awake as long as possible, so as to wake later the next day. Even if this does not occur, and the early pattern of waking persists, then sleeping during the day reinforces the adverse pattern. **Circadian rhythms need to be normalised as much as possible.**

Exercise is important, so that fitness is not lost, and such secondary problems like circulation or kidney and urinary infections do not develop. But most of all, exercise will help to help boost the system, promote natural endorphins, control weight while maintaining a healthy appetite, and promote normal sleep. A regular routine overall will help, and the additional habit of late afternoon or early evening exercise will help normal drowsiness to occur at bedtime. Care with diet, and forestalling of on poor food value snacking will help to maintain optimum body chemistry, which in turn will help stabilise mood, and prevent weight gain.

The phenomenon of early morning 'hits' of returning depression as the individual wakes points to triggering or switching of some kind, even to depression being a higher brain phenomenon that is dampened by sleep, a function of more primitive controls of the nervous system. However, these 'hits' of mood, and the later diurnal 'lifts', are classic symptoms of deep depression, beyond the other more common effects of depression, **so the possible advent of the pre-suicide lucid period should be anticipated by GPs, carers, etc.**

**In the near future**, as cultural and religious aversion to the more detailed study of evolution are overcome, and renewed neurophysiological research replaces quasi-philosophical and talking cure theories, the answers to understanding and managing AMD will be clearer. **Genetic screening is the great hope for early detection, and optimal management will have to suffice until genetic engineering can offer more permanent palliation, or even removal of AMD from the human genome!**

The possibility that latent suicide may be a species-wide phenomena, manifesting in the so-called altruistic gene, will cause more research into screening and prevention, also with benefits for AMD research. Genetic origins of AMD, which may yet involve latent suicide gene or genes, are not now in dispute, although the full genetic picture is not yet complete. Perhaps the altruistic gene is inappropriately triggered by clinical depression? Human genome studies will aid understanding in this matter as well, we trust.

Meanwhile, it is possible that AMD as a genetic mutation, although negative, is not sufficiently so to wipe out carriers, who survive to breed offspring. Indeed, some may not manifest the illness till well into adult life. Theoretically, more and more AMDs will survive and their offspring increase, (the propensity for sexual activity in 'high' episodes no doubt would help this trend ...?), being a natural tendency as a result of better living standards, and more medical knowledge and better management.

As a result, a proper Manual of understanding and management becomes more necessary, as does genetic counselling. Ultimately, understanding the brainpower of an AMD in a **productive** high could lead to spin-offs for 'normals', and provide insights into avoiding or eliminating brittle and depressive periods for the AMDs themselves?

### **Planning a regime of convalescence for an AMD:**

Apart from medication regimes (which can vary in terms of efficacy and delayed reaction time), symptom treatment may include such things as a shower or swim, acupuncture, visits, escapist entertainment, attention to health and regularisation of personal routine, etc. Taking the medication and turning into a couch potato is not enough to improve matters at any stage of the illness; adequate diet, an optimistic outlook, occupational therapy and light exercise are also necessary.

Anyway, reliance on drug therapy is not enough, as drugs may be slow to act, (as is the case with anti-depressants), or produce adverse reactions necessitating change, and basic health must always be maintained as the foundation of rehabilitation. Lithium may be administered in different forms, and requires an adjustment period.

Emotional excesses should be noted at occurrence, including onset signs if identifiable, (especially for the diary!), but **not** indulged. Suitable displacement activities or (healthy) escapism should be encouraged. A sleepy depressive should be left to sleep; this is a normal part of depression, and not likely to facilitate a suicide attempt...

Anyway, if sleep patterns are otherwise disturbed at night, sleep may be a welcome relief, as well as a natural easement for the depressive patient. Prolonged sleep, or other physical inactivity, however, must be monitored for physiological health reasons. Try to impose normal sleeping patterns as soon as possible, as part of overall normalisation of daily life. Restore normal routines at the appropriate times. For many AMD's, depressive phases seem to be worse in the mornings, and lift in the afternoon or early evening. This could be a basis for structuring a reasonable temporary lifestyle until the cycle changes.

**Diet** may need adjustment, eg, protein and comfort food cravings may occur in downward mood-swings. Sugar intake may also have added effects for mood-wings and states. Work needs to be done on diet as a means of ameliorating mood-swings, but under scientific conditions to get away from the quack remedy image, and the ignorance and false hopes that have been perpetrated with quack remedies. Remember, some foods and additives may cause mood alteration. Alcohol may be efficacious, but must **only** be taken like cough mixture if taken at all, for obvious reasons. Adrenalin is also a poison to AMDs in excessive amounts, emotional excesses that promote adrenalin should be limited or avoided.

**Personal cycles** must be learnt, including stress triggers, stress relievers, signs of stage change or onset, (eg rapid cycling or spiking), need to increase medication, seasonal variation, etc. Diaries do help, as well as input from support network, and contact with other AMD's through a properly constituted support group.

**Avoid boredom and/or over-stimulation; stability and equilibrium must always be kept within reasonable bounds. Congenial and useful employment is especially important, this should take advantage of the patient's abilities, but be paced to avoid stress, and always to be undertaken while in the company of co-workers who will not exploit 'difference'. A glide-time or piecework arrangement would allow for time away from work as required for rest and recuperation.**

Avoid facilitating self-centred verbalising or externalization of problems by the patient, who should also avoid the company of people who provoke or feed off this sort of introspection. This can trigger further instability, because of the direct emotional involvement feeding on itself. The more destabilised you become, the more vulnerable you become, either to another crisis, or to the exigencies of your environment, and cycling begins again. A weak baseline personality will have difficulties with balancing internal and external realities, thus needing extra carer resources, and ongoing close medical supervision. Any externalised and ungoverned AMD symptoms are destructive of patient, carer, and medical personal resources.

**Only stability in remission and a sound baseline personality will enable really successful and ongoing AMD self-management. Purposive self-management problem-solving is impossible when high, and improbable when depressed, and that is the bottom line warning when attempting and achieving optimum self-regulation. This illness is not controlled, as the Talking Cures would so disdainfully proclaim, but is rather lived with, balanced, tolerated, coped with, and manifestations always anticipated because of it's cyclical nature.**

**To reiterate**, medication holidays (supervised), will help to identify episode onsets and/or exacerbators and mood changes, and the AMD will learn to be more objective in managing the normal spans of mood stimuli in real life, and think carefully about whether they are changing, or whether it is the real world, etc.

With time, sudden mood changes can be identified and 'over-ridden' by the self-aware AMD before things get out of hand. Avoid being trapped by rapid cycles and vicious cycles. Friends or support groups will not always be present, especially when decisions have to be made. (Think of Spock, and try to emulate The Vulcan Way!! The wise AMD may then live long and prosper...)

Above all, be careful with emotional involvement of a personal nature; discernment is important in establishing personal relations. Emotion used as a band-aid can only be dangerous, and AMD's are especially vulnerable to either exploitative 'sympathy', or attending to others cries for 'help' that seem to give purpose, even of a temporary nature, to a life disrupted by AMD and all its problems and stigma. Problems feed off emotional instability or vulnerability, whether of a personal or extra-personal origin, **so care must be taken in this regard. Spurn catharsis and avoid adrenalin rushes!**

The AMD is prone to strong emotional surges that provide seeming diversion. Emotional reserves must be maintained for rehabilitation, and for the future, not tossed down someone else's emotional black hole for no good reason. As rehabilitation progresses, coherent and realistic ambitions or goals are important; changes should have coherent reasoning invoked. Know the difference between worthwhile activities or goals, and mere distractions that may lead to driven behaviour, loss of resource, and disillusionment.

There is always the danger of these factors taking over, even after lengthy rehabilitation. Change of state may potentiate the distraction 'taking over' as behaviour becomes more driven. Support networks and groups again can help. Carers must be empathic, and even somewhat detached. Appeal to whatever commonsense that the AMD displays in a stress situation, and the fact that to an AMD, any situation that may trigger mood alteration may be termed a stress situation, and that includes a happy situation. Prevent emotional 'bad habits', and the cumulative effects of attrition (cf 'kindling' in G&J). Once again, the 10 Principles of Rehabilitation must be invoked.

Remember that all stages, if severe, need recovery time, and this may be likened to convalescence after a fever, with weakness, lack of energy, etc. In some cases, there may be a lack of thought or ideas which may be very worrying to the patient, especially if contrasted to the ideas rush of a high. Bodily functions may in general be sluggish, but time, and not worrying about them, will aid natural recovery.

**Learn to cope with stages** by cultivating detachment to identify mood changes, and the effects of triggering, and see the external reality as objectively as possible. A reliable carer/monitor can help to develop this skill, until the individual can learn enough to cope alone.

Most importantly, try to prevent any mood escalation. Normal people self-medicate with mood-altering techniques, from soap opera to drugs, but the AMD must always see this as a potential hazard, **and learn and/or allow careful or minimum mood enhancement only**. Enjoy life, but remember mood enhancement not only affects perspective, but can, especially if repeatedly promoted, trigger a major and long lasting stage. What emotional latitude 'normals' enjoy may seem unfair compared to the lot of the AMD, but that is life, and remember the eternal, if benign, vigilance.

**Controlling the highs is the key to cycle management for the classic AMD, and must be practised at all times, with or without drugs. The price of peace is always benign if eternal vigilance, and this must be a fact of life, and become part of convalescent learned behaviour.**

Stress-relieving techniques must be learnt, to perhaps push problems aside, divert attention, displace, relieve tension, etc. For example, when hyperactivity is sensed, read a book, or lounge in bed, be a couch potato, then resume activities when the mood is more stable. Be careful of the obvious signs, and learn to see them as others do. Avoid conflict or stress, and restructure a sustainable existence.

**Learn your stress triggers, as episodes feed on stress and adrenalin, which itself is 'toxic' to AMDs**, so a longterm diary will help to identify stress patterns. Try and ignore negative thoughts that come with mood change, or memories with negative associations, and try not to be dragged into a vicious cycle of bad thoughts and memories, keep perspective. Think twice about what one may feel like doing, especially on impulse. This sort of introspection can only come with practice, and perspective from trusted support sources.

Here again a diary will help, as writing things down will help ease the mind. Writing about a mood may see the individual past the worst, and an attempt at analytical thinking and writing is a good displacement activity for an overactive brain. Observe and analyse mood-changes if possible, instead of just being carried along by them!

**Think Cycles, Signs, Onsets (CSO). There is a basic world reality, so do not abandon hope!** (and do not waste your time envying 'normals', life is too short....)

Endless discussion about the illness with others **will** feed on itself, and make the situation worse, so keep only the company of those trusted, but do not burden them with too much introspection and self-pity, which are symptoms of the illness, and must be alleviated by other less stressful means. Use the company of carers for displacement activity, or to help with objective decision-making, but not for endless distressing and destructive ear-bashing. Take care in this regard when in the company of other AMDs!

Physical conditions or states can be productively monitored, so that there are other references for your mental state, apart from your thoughts; temperature, pulse, breathing, blood pressure, etc. Even the act of monitoring these factors may be enough of a diversionary tactic to prevent mood elevation. Stress relief techniques for the AMD must be more purposeful and coherent than the populist material propagated for normal people.

Maintain a reasonable personal management program at all times. Complacency cannot intrude, and all aspects of lifestyle definitely need analysis, not just the stresses of the moment. Decisions should be taken with a cooling off period; any situation that may have an emotional component, especially an unexpected one **must** be approached cautiously. For long-term AMDs, renewed hopes and planning for the future may be necessary, and will be easier to overcome as life stabilises and improves. Beware of the time conundrum of the chronically-ill, that time passes so slowly just coping with the illness, yet slips away so easily, with quality life and opportunities lost so easily. Objectivity, and planning for the future are seriously impeded by this particular vicious circle.

**Helping others** is all very well, but not as a displacement activity or projection to make you feel good about or for your own problems. Help others **only** when **you** are strong and stable, and fully understand your own situation. Always refer others with problems that may or may not be AMD, just as referral is demanded of any support group members. You have done your best if you have sought good quality help from responsible people to help another AMD, and have set an example by doing so. **Your best contribution as a stable and rehabilitated AMD is by example**, and through the promotion of education, understanding, networking, and referral of those in need, and in time of need.

Depending on circumstances, personal and financial, a spell on sickness benefit or pension may be of use, if only to keep the wolf from the door while re-grouping. Remember that **time** is important to rehabilitation, and that means productively used time without undue stress; financial support and overall peace of mind contribute to this end.

**A structured programmed approach to teach AMDs about their illness must be carried out at all stages**, (in lieu of basket-weaving and staring into space, etc.) and should be fundamental to constructive rehabilitation. One day **The Book** on AMD management will be written, and self-education for the AMD will be much easier, and on firmer foundations. Then will come the rest, basic commonsense as they are: diet, lifestyle, medication holidays, suicide, dealing with the system in whatever form, diaries, support groups, medication, referrals, etc etc...

### **Analysis of AMD Cycle Progression:**

As for any stage of AMD, states are linked because of the inter-related potentiating effect, and outside influences that can exacerbate the AMD condition at any time or stage. This is the main reason for a comprehensive and co-ordinated treatment and rehab programme being needed, progressing from stage to stage, and always consistent, and with foresight. Cycle monitoring and/or breaking are important.

The most obvious signs of depression are lack of ideas, worthlessness, obsession with time, (in that it passes so slowly), lassitude, physical weakness and lack of energy, (yet so quickly, but is overall wasted, and life with it), a feeling of doom, no recovery possible, nothing pleases, and these may lead to suicidal thoughts.

Suicidal thoughts are pervaded by the rationale that nothing more can be done, the individual is doing themselves and society a favour, etc. This sort of rationale links up with the altruistic or self-sacrifice theory; at this point, a particular stage is triggered which is difficult to overcome; time and surveillance must be the main themes, as anti-depressants take so long to have an effect if not already in use.

The beginning of the depression swing may also have a sort of destructive, or cyclone phase, a phenomena of the brittle low, which is negative and destructive, characterised by hyper-irritability, and seems to consist of 'bring on the worst, get it over with, its all going to be a mess anyway.' Not a good time for plans and decisions, and marks a definite decline into deeper depression before the suicide stage, if allowed to progress too far. The resulting 'destruction' also adds to the problem.

As AMD is a cyclic illness, the cycles must be defined, learned, and broken before they become a hazard. Here, the fact of personal v. objective reality must be emphasised, because when these two realities get out of sync, that is the point at which the AMD (or carers, or both depending on rehab stage), **must** act, or risk a deteriorating problem that probably will progress to an more adverse cycle, **whether up or down. Learn to identify when the 'iceberg' is rising!**

**Highs:** On breaking out of depression, the brain seems to try to make up for lost time, and the flood of ideas can be quite marked. This may lead straight on to another high, when ideas are constantly stimulated by associations as the brain speeds up. At this stage, goals become confused, and too many ideas, of course, cannot be followed up, which causes frustration, similar to the depressed state, when too few or no ideas have the same effect.

**Cycle-breaking** for highs can be more difficult because the AMD is more proactive, and not easily dissuaded or advised, and this becomes more so as the high intensifies. Limiting highs is important, better not to let them occur at all! To break the cycle for the classic AMD, prevent or limit the highs, and thus prevent or limit the lows.

**Remember, the higher you fly, the harder and lower you fall. Even unipolar AMDs will have identifiable stressors, both internal and external that can be usefully identified, and thus cycle inhibition or prevention.**

Otherwise, firm, fair, and take care with decisions, take medication, grab a restful holiday if this is possible, and leave the credit card at home.... **This sort of regime should be practised, irrespective of medication or type of AMD, as part of a balanced approach to any AMD management and rehabilitation.**

**Problems of Long-term AMD Management:** In an ideal world, with effective screening and treatment, long-term problems need not exist. But **at the present**, there are many AMDs who could be classed as long-term, with particular problems that need to be defined, differentiated and understood.

Habituation, coping mechanisms, medication regimes or lack of, denial and other psychological effects, plus physiological and neurological effects both of AMD and medication, **PLUS** the personal and socio-economic toll, all add up to substantial long-term problems.

All of these factors make rendering the disorder more and more incidental to the mainstream of life more and more difficult, and less and less likely, and even proper fortuitous screening and diagnosis will be inhibited.

The long-term undiagnosed AMD may never have achieved recognition of a baseline personality, due to habituation and coping that may have been very strongly entrenched, and manifesting, for example, as withdrawal, unsociability, eccentricity or substance abuse. All of these manifestations make any future diagnosis less likely without consistent and expert screening by trained professionals.

Medication can cause long-term effects, definitely physical, and probably neurological as well. Unrealistic lifestyle, plus poor nutrition, and non-avoidance of stress could be causing episodes in spite of medication. Medication holidays may be a secretive matter, or there may be no useful advice from a prescribing doctor.

For example, lithium may cause such revulsion, due to side effects or loss of intellectual spontaneity, especially over the long-term, especially if non-slow-release, that the 'holiday' is taken without any planning or carer back-up. (Note that this revulsion could be as a result or sign of underlying stability, **which only careful screening could confirm**, but any medication holiday still needs careful planning, and the probability of destabilisation surveillance always emphasised to the patient.)

The long-term AMD may have been misdiagnosed, but at least be under some sort of surveillance, or else, be non-diagnosed, and be receiving no treatment or possibility of surveillance. However, the **25% Suicide Rule** would be most likely to operate in either case, given the poor understanding of reactive vs endogenous depression, publically and professionally. There is also the need to know of the suicide criticality factor in deep clinical depression, or that AMDs are more likely to suicide because of the stress of their illness than other people.

Mental and emotional enervation, high irritability and over-reaction, low stress tolerance, impatience, withdrawal, etc., will be more common with long-term AMDs, and care must be taken with life-history, and implementing rehabilitation regimes that do not cause suspicion and alienation.

**Great care must be taken not to exacerbate these existing problems**, and not to promote anti-climax or disillusionment by poorly structured warm-and-fuzzy approaches that may be appropriate for normals, but be very damaging for any AMD, especially a long-term AMD. The stabilisation period is especially crucial for these problems to be overcome and, optimally, to be rendered more and more incidental to the mainstream of life.

**The early-diagnosed AMD does not have so much to learn and unlearn as does the long-term AMD**, nor do they have the physiological, neurological and personal side effects to cope with and recover from. Such coping differences make it necessary to differentiate between the two AMD types, and to structure treatment and rehabilitation accordingly. The back-log of long-term AMDs would eventually be reduced, and 'new generation' AMDs would predominate over time, earlier with better screening procedures, but there would always be a residue of long-term AMDs requiring particular care.

Questionnaires and other survey materials should also cater for these two groups of AMDs, as well as for different forms of the illness, to ensure a full range of questions, and maximise information gathering and collating. Integration of all stages and types of AMD should not be inhibited after initial stabilisation, but differences and special needs should be carefully outlined, and concurrently implemented and supervised by the professional and the carer, who would both be educated to these special needs of each and any patient.

Of course, patient education and training is implicit in all these stages. **All AMDs should be treated among their own kind, in appropriate Centres, according to the necessary Steps and Principles**, and be mutually supportive of each other as to the setting up and implementing of respective rehabilitation regimes, and all with the help and supervision of the trained professionals or carers.

**For the right sort of motivated carer, remember empathy rather than sympathy, and the price of peace being continual, though benign, vigilance....plus firm but fair commonsense and medication.**

**Carer dangers:** would-be helpers of the wrong kind may try to get close to an AMD, then blame the AMD when the relationship gets out of hand, or else resort to petty power plays when they try to cover their own incompetence to relieve emotional pressure that they themselves have created.

**It can never be stated enough** that only experienced people should attempt to implement insights in rehab. Pet theories based on normal views of the world are counterproductive and potentially damaging. The foundation of carer support is **support, observe, report, and**, avoid promoting emotional involvement, especially when this cannot be sustained. Emotional dependence is so easy to trigger, yet so difficult for the unwary carer to handle, and resolve.

The rush of these AMD emotions is so strong, and so easily accentuated by the ordinary sympathies of normal carer; not only can the illness feed on the exchange, but also the carer will not be able to cope, causing more problems. Conflict and the resultant emotional surge, powered by adrenalin, especially in brittle periods, are a powerful combination. Perhaps this is what gives the impression of obsession, and prompts the damaging criticism that conflicts so strongly with what the patient feels. AMD episodic behaviour is **driven** behaviour rather than obsessive, but still painful and difficult to deal with, especially for the inexperienced patient or carer.

The worst damage is done by the carer or contact, themselves inadequate, who enjoys the manipulative potential of the exchange and the effect this has on the AMD, getting a kick out of the turmoil with the mistaken impression that this makes the spurious carer strong. Sadly, this is all too common in these days of pop psychology. The AMD is so easily caste as being at fault, never the meddler.

### **Notes for carers on avoidance of triggering, and promoting ongoing stability:**

If emotional disturbance is the principal problem of AMD, then emoting should be played down as much as possible, to help relieve tensions and sensory overload that work together to keep the AMD destabilised. Part of the day should be set aside for recovery and rest, and a return to baseline personality.

Preferably, the period of recovery should be as long as the period of stress. Ideally, this should be the case for everyone; the important difference for AMDs is that they cannot sustain stress like normals, and are always in danger of triggering destabilisation, or worse, due to low tolerance thresholds. Brittle periods are the most difficult.

AMD and single-mindedness can be mistaken for obsessive behaviour, but again, the emotional drive to follow something is very strong. Quitting an activity must be done at an optimal time, even when continuation would seem important. At least quitting while ahead, even if the day or activity goal has not been reached. Avoid a stress (trigger) situation when things then start to go wrong! ('A blow upon the bruise.')

Deflection of purpose by novelty and poor judgment can cause other problems as the AMD drifts from one activity to another, misguided as much by emotional forces, as by their own attempts at ratiocination. Perhaps this behaviour, involving ever more activity, fills a void when destabilisation occurs, usually at the onset of mania or toward of the onset of depression. There seems to be a period when either possibility could occur, depending on type of illness, and characterised by spikes and/or brittleness.

Developing a baseline personality, or some sort of objective reality or self-regulation aided by carers, is thus important at this stage. The efficacy of management techniques would improve with time, practice, and use, by identifying and avoiding stressors, and the avoiding the cumulative effect of factors that weaken the already low threshold of AMD tolerance. Future planning will be affected by continuing instability, and thus contribute to a lesser quality of life for the AMD, so better management means better long-term prospects, and improved quality of life.

**Dealing with stress ranges of everyday life, for carer and AMD:** The challenges that normal people face are not necessarily the same as for an AMD, and realization of this is part of the redefining of personality and goals that must contribute to ongoing stability. Avoid damaging and inappropriate comparisons with 'normals', particularly as they often get away with behaviour that would condemn an AMD.....!

Thus, **thresholds** are very important for AMDs, and where possible, the AMD must get to know their biological and psychological signs of destabilisation, especially when they seem to contradict that which is seen as favourable or acceptable to non-AMDs. Fun, excitement, parties, challenges of one kind and another that 'normals' look for must always be critically viewed before the AMD decides to participate. Here, also, beware of the ravages of pop psychologists, 'meeting challenges', 'psyching up' etc.....

**Points for carers on possible sequence of events relating to onset of AMD changes:** Although the various phases may have to run their course, or be treated by medication, there is an early point, during spiky or brittle periods when damage control or a change of scene, etc., may have been able to intervene for the prevention of greater destabilisation, depending on the threshold and the triggering relative to the individual. Remission means only absence of symptoms, the potential for re-triggering remains. Trigger/destabilisation/cycling/locked-in mood-state as a progression; this would be a fair analysis of what occurs.

**Filling the void** activities, and the increasing desperation that ensues, resembles a panic attack. Boredom, seeming anoesis, or discontent are then both a trigger for, **and**, symptoms of destabilisation. Certainly, there is a point where it all goes wrong, and judgement fails. For some reason, reference points are lost, and emotional disturbance makes continued objectivity impossible; the blow upon the bruise as the circle becomes evermore

vicious. The AMD sets about the accelerated destruction, consciously and unconsciously, of the things that cause the conflict and pain. The extreme outcome of this is the self-elimination of the individual when all else fails which is suicide.

'Filling the void' can become a matter of terrible urgency if allowed to develop unchecked; that particular void could be described as walking on the edge of a precipice in a high wind, without being able to get back to safer ground. A sure sign, in fact, of destabilisation that should be acted on quickly, with rest, careful distraction, and/or medication. Otherwise, accelerated destruction then causes the worst damage. Void-fillers may be sex, travel, spending, etc., and all help to fill the void or dull the pain. Spending money, egregious behaviour, super-confidence may make the situation worse, and judgement more faulty, the full catastrophe and the inevitable crash aftermath ensue. Avoid this vicious cycle occurring if possible!

### **Systematic AMD rehabilitation should involve:**

- 1) Rehabilitation begins with, and is facilitated by, effective early treatment and case management. This emphasises the importance of screening also, as pre-crisis intervention also makes rehabilitation easier, when trauma, social attitudes, hospital/System interaction, disruption of life, rushed carer education, etc., have a cumulative detrimental effect on early and speedy recovery. Thus, although treated as a separate topic, rehabilitation is always prospective, retrospective, and integral to any other treatment stage.
- 2) Rehab must also have an objective, general, or standard perspective, as well as being tailored to individual needs of patients, depending on the nature of their AMD, and their progress through the stages of the illness. IE, there must be a standard checklist of rehab. procedures for all aspects of AMD, but some flair for improvisation by supervisors must be inherent during the process. Standard AMD rehab must be implemented that may take into account other factors like ethnicity, but never be governed by them, and NEVER pandering to any form of political correctness.
- 3) Rehab must always have a **progressive** basis, a momentum, regardless of the condition the AMD is in when treatment begins. The illness is treatable, controllable, and can be relegated to an incidental of the AMD's life, with time, patience, and a sensibly optimistic approach that allows for the occasional setback that is to be expected with AMD. Procrastination, apathy, vacillation, etc., must not be allowed to countermand this basic optimism.
- 4) Firm but fair is the theme for AMD treatment and rehabilitation, at any stage, and this sort of regime must be adopted by the individual as their own code of self-management. The nature of the illness is that emotional wallowing is always a possibility, and a trigger for worse conditions like deep depression or suicide impulse. The AMD must not be passive at any stage of treatment or rehab., as this will postpone a return to normal everyday life, nor should progress be more than measured. An average of progress is important. Learn tolerance thresholds as well as onset signs.
- 5) Boredom and overactivity are both hazards to be avoided, as either can trigger emotional responses that in turn trigger undesirable introspection, and development of deteriorating 'states' of AMD. This must be factored into rehab, which always must progress, and be seen to progress, at a steady rate. Pathos, over-excitement and anticlimax must be avoided. Humour or irony carefully used are very effective in maintaining perspective, and quality AMD group involvement is especially useful for these.
- 6) **Time** is a major component of recovery, and of rehab., but time must not become the object of concern or obsession, like 'how long will it take', or time passes so slowly, or life passes by so quickly'. Time obsession may trigger emotional states that can then alter the perspective internal versus external reality, and precipitate emotional reactions such as wallowing, adverse introspection, poor judgement, etc., or even trigger a psychotic relapse.
- 7) Decision-making and other aspects of personal perception and judgement must be carefully and objectively analysed. This should be undertaken by carers assisting the AMD in treatment or rehab, but these steady/steady procedures should always remain a part of the AMD's life. (Legal sectioning is a separate consideration, but patient autonomy must be restored ASAP). Decisions should not be hurried, and should be reviewed over time to reach a suitable mood perspective average that indicates a fair reality is achieved by the AMD. This will be in consultation, or later, self-reviewed. Avoidance of rushed decision-making must be taught, as for any decision with an emotional component that may affect judgement, eg other people's hard luck stories, or confrontational incidents. In these, as in all things, **commonsense must prevail**.
- 8) Where possible, the mundane problems of housing, money, bills, storage, etc must be minimised or eliminated to prevent anxiety and brooding which may trigger a state-change. This is a carer, as well as an overall social

administration responsibility. An AMD with trivial worries dogging their thoughts will not be so amenable to relaxation, rest, rehab, or achieving a suitable mood perspective average, and will risk mental moribundity, or worse. As rehab proceeds, these matters can be re-incorporated into the AMD's life. Beware an accumulation of problems, 'the blow upon the bruise' effect; this will potentiate emotional vulnerability, and possible deterioration.

- 9) Education re the illness for the AMD is most important to facilitate insights, especially of a personal kind. Achieving and maintaining objective states of mind are the mainstays of AMD rehabilitation, and this starts with systematic, programmed education of the illness in all its forms, and the importance of understanding states, onset signs, remissions, emotional influences and effects, and even physiology and brain chemistry. Ancillary education on welfare, legal rights, etc., should also be incorporated in the programme, as all these matters could be important for a return to mainstream life. This education is also important for anyone who has contact with, or responsibility for any AMD, whether carer, GP, PS, or rehab ancillary.
- 10) AMDs must learn emotional detachment, self-regulation, self-regard, and self-protection to deal with as many situations as as possible. IE, to see the difference between the real world, and their perception of, and reaction to it. This can be achieved by carer and social support, even conventional therapies employed in other fields, and also by techniques like supervised medication holidays, where, in controlled situations, the AMD experiences, and identifies changes that were not easy or possible under other circumstances. This familiarisation with reactions, or emotional states, or stress triggers is important to implement self-protection or damage control, or simply to avoid a potentially dangerous problem exacerbating as episode severity as quickly as possible.
- 11) Emotion and emotive content of rehab must be monitored at all times, especially at the beginning of treatment, because of potential for triggering undesirable reactions or states. Carers, and any other management ancillaries must be of an intelligent, empathic, and truly professional kind, and exemplars themselves, wherever possible, of stable and rational behaviour. The AMD must establish a stable behavioural and emotional basis to rediscover personality, judgement, and life choices, and this must happen only in due time, and at individual rates. The AMD must be enabled to rehabilitate with dignity, and without condescension. This is an important aspect of progression, management, and maintenance of optimism.
- 12) The AMD must continue to **learn**, to build up a personal library of experiences that will provide a basis for emotional learning, and behaviour catch-up. There are similarities with autistscs, in this respect. Dairies can be of assistance, especially post-event, when mature reflection can make for better perspective. Care with interpersonal, business dealings, career, and financial choices are part of this. Beware of emotional surges that may affect judgement. **(If it feels good doesn't mean it is objectively good...)** Avoid conflicts of moral or other interests that will cause stress; never give in to the urgency of the moment in decision-making.
- 13) Be careful of comparison with, or emulation of the behaviours of so-called 'normals' in any given situation. The laws of behavioural averages, and commonsense applies. What turns on normals may be dangerous to an AMD, and emotions may affect judgement in this respect. Entertainment, adventure, substance abuse, investment, sex, require clear judgement to counter or avoid. The AMD behaviour paradigms must be carefully defined and learnt. **Back off rather than risk bugger-up.** Self-knowledge, emotional detachment, commonsense, and sound behavioural precedent, therefore, are part of the skills an AMD must learn for proper rehab. Always regard too much adrenalin as potentially toxic....
- 14) Establishment of everyday routine is important, and must not be arbitrarily affected by mood. This means sensible hours, meals, rest/relaxation/sleep periods to be maintained. A job, hobby, or even reasonably intelligent escapism must be incorporated. Dietary and sleep requirements are important, and may need individual tailoring. The best imposer of routine in everyday life is that of a job or other suitably demanding occupation; this must be initiated as soon as individually possible; also it is good for morale, and avoids the dangers of boredom, fretting about time, and financial problems.
- 15) AMDs must always be conscious of being examples of the effectiveness of rehab and management, both for social purposes, and to further provide a model for others newly diagnosed and rehabilitating in their turn. Being conscious of this double responsibility will give added incentive to achieve optimum rehabilitation, and render the illness more and more incidental to the mainstream of life.  
For this reason, no matter what sort or severity of AMD is being treated, the AMD should pass through all stages of rehab, and ensure that all AMDs have the same self-knowledge, and standards of rehab.
- 16) Contact with other AMDs, and support groups, is important at all stages, but these must be stable, supportive, legitimate, objective organisations.

- 17) AMDs should maintain a community identity, ensure their illness has a healthy profile, that standards of care do not drop, that there is always a flow of information, and attention paid to research. The fact that there is as yet no coherent or comprehensive screening, or rehabilitation programs, or even texts on the subject, is a matter of grave concern. The conditions suffered due to poor no diagnosis, or dilatory hospital or System agenda means the very conditions that cause instability in AMDs and potentiate episodes of psychosis, are not being identified and alleviated. Social non-acceptance or condescension, begrudging of funds, etc., only worsens 'the plight of the phoenix', and similarly for other mental health 'consumers', for that matter.
- 18) Some of the best brains that ever lived have suffered with, and been fuelled by, AMD. This resource must not be lost by wholesale medicating-and-forgetting. With proper screening, treatment, management and rehabilitation, lives may be made easier, yet the potential brainpower not lost or mis-used. In a future world, genetic engineering, or advanced treatment will make more advances, but only if a high profile of the illness is maintained, and the value of research demonstrated to decision-makers. This profile so far has not risen far beyond medical curiosity, or popular myth. Therefore, a sense of history and destiny must be imbued as rehabilitation proceeds, as well as a reasonable sense of mission in raising the awareness and profile of AMD, individually and collectively, that will make for that better future.
- 19) The cyclic nature of the illness must be emphasised, and treatment and rehab must allow for this. Type or pattern of AMD, onset signs, thresholds, personal v. objective or external versus internal reality, health, seasons, stress management or avoidance, must all be factored into the individual rehab and maintenance routine of the AMD. This will take time, relative to the seriousness of the AMD, or the lapse time before diagnosis, plus education, cultural or subcultural background, general health, socio-economic status etc. Making a standard checklist programme would simplify matters, to check overall progress gained, undertaken with no short-cuts.
- 20) Details of emotional behaviour must be gone into; this is why diaries, carer observation, firm but fair management, and bases for comparison are important. The manufactured opportunities for emotional self-dosing by 'normals' must be viewed with caution by the AMD; unregulated heightening of emotion is a danger, adrenalin should be seen as a potential toxin for susceptible AMDs.  
Surges or swings have to be countered by applying objective criteria; the emotional discomfort has to be either tolerated and overcome, eg, by avoidance methods, or by recourse to short term medication, or both. Potential cycles must be broken or controlled at an early stage. Emotion must be viewed with caution, rather than something to self-indulge or wallow in.  
To learn to be a cautious emotional outsider is a necessary part of AMD rehab. Carers and attending professional must be exemplars in this respect, and emotionally indulgent or exploitative persons avoided at any stage. **Remember, the AMD may be as emotionally vulnerable as a child**, and must learn to overcome this. Rehabilitation should produce an educated and self-informed, and well-rounded individual, who can cope with crises, love affairs, and con-artists, basically.
- 21) When 'normals' are seen in perspective, their behaviour will not always seem worthy of emulation, it would be wise to cultivate objectiveness in making comparisons with normal behaviour. There will always be a difference between AMDs and the rest, and vigilance must be maintained so as not to forget this fact. The AMD must always be careful not to be larger than life, in other words, 'normals' may get away with this, but the AMD will always attract a harsher judgement after the event! Group (and mob) psychology, and the dangers of substance abuse must be well understood by the rehabilitating AMD as potentially the greatest hazards to be faced, followed by ill-advised personal involvements and relationships.

#### **Avoiding problems with interpersonal relationships:**

- 1) Cultivate emotional detachment at all times, especially when meeting people. Avoid effusiveness, or other excessive reactions, especially with those newly met; keep the interest or dislike factors well in check. The worst danger is for those who have become isolated, or who have dealt with AMD by living alone. Beware the changes when a more intense or busy world is encountered, and the emotionally busy 'normals' who inhabit it. The emotionally exploitative normals will unerringly perceive this sign of emotional vulnerability, and act accordingly.
- 2) Avoid over-gratitude for assumed understanding when dealing with those who know of the AMD illness, employers especially, because this may invoke patronising or mere toleration, thus altering the relationship too much one-way, so that the other party is then putting themselves out, etc., on your behalf. Be a quiet, self-assured advocate for yourself and all AMDs.

- 3) Always be aware that heightened emotion brings vulnerability, either to outside influences, or to personal mental processes and decision-making. If it feels good, it may not necessarily be good, and so be skeptical about the activity. **When 'normals' turn on, perhaps the AMD should think of turning OFF.**
- 4) Monitor personal mental, **and** physiological states, like heart-rate, breathing, BP, irritability, hypersensitivity, tiredness, blood sugar, concentration, lethargy, anticlimax, sudden incongruities of thought, feeling or emotion, etc. These may not only show mood-change is imminent, or has begun, but most importantly, that objective reality may be threatened. If control or adjustment cannot be effected, withdrawal should be an option; politeness, or related considerations should not be issues, the stakes are too high to worry about that sort of incidental.
- 5) Avoid moral or other controversial issues that cause tension, conflict of interest, or appeals to goodwill or conscience, or any situation where exploitation of 'better' feelings is a threat.
- 6) Emotion can work as a blocker of mental awareness and thus of external reality. This is why the AMD must begin all over again, **as per Piaget**, to complete and graduate through, all emotional developmental stages, and to progress beyond childlike vulnerability, to being more well-rounded as an adult. Even if total detachment is not possible, then awareness and common-sense techniques will strengthen the AMD.

**7) Also, a base-line personality must be re-established that is not just subject to the extremes of AMD.** A reappraisal of lifestyle may eradicate old habits that may have been due to compensating for AMD, or were otherwise mistaken for the AMD's true and hidden personality. New scope for intellectual activity and concentration may also emerge, as the intellect is freed from old AMD-induced constraints, and not cluttered with compensatory behaviour, ill-advised relationships and other inhibiting influences. Discern the balance between internal and external reality at all times.

### **Tips For Cycle-Breaking**

- 1) Stress and recovery times should be equal if possible, in day-to-day life. Stress-relief techniques are as for 'normals', but with greater care, and **consistency**, though do exercise care with escapism....
- 2) While active, intellectually or physically, take regular breaks, **especially from those activities with a high motivational level. Beware of that poison, adrenalin.**
- 3) Adopt the policy in company that the more that 'normals' turn on, the more the AMD should turn off; back off, dissemble, even walk away if necessary.
- 4) Be coolly analytical, even critical in emotionally-charged situations, though avoid being unsocial, of course, without good reason.
- 5) Consciously work to minimise mental or physiological symptoms or changes that could get out of hand. **THIS IS MOST IMPORTANT.** This is a fundamental self-test, and vigilance in this respect can never lapse.
- 6) Be prepared to use AMD medication in on-going or unavoidable situations, though as a control, not as a crutch, and with due regard for the usual dosage regime required of the medication. Take care with going onto, or coming off medication; this should be well-learnt during rehabilitation anyway.
- 7) **The best way to break cycles is to avoid them ever developing**, especially highs, so live life always on a commonsense level, with ongoing self-vigilance and care; there is much at stake. Retain and maintain stability.
- 8) For those newly diagnosed, do not see this as a life sentence, and the medication as confirmation of this. The diagnosis is a **benchmark**, from which treatment and rehabilitation will commence, and progress will be measured from this point. From thence, cycles will be controlled or broken, and the over-all self-defeating cycle of the undiagnosed AMD will be broken, the baseline personality will emerge, and a better quality of life will ensue. Public and professional education about AMD will see more acceptance of the 'label' as just an early benchmark, and a more positive view of AMD, and the prospects of rehabilitation.
- 9) Maintain the firm-but-fair approach, and LEARN about the illness, eg, cycles, remissions, variations, statistics, right-brain effects, health care, medication, self-analysis, etc., **AND KEEP IN TOUCH** with medical progress, and other AMDs.

- 10) Overcome the effects of the 'Time Conundrum', do not let it be an obsession, worrying about lost time, time passing slowly, wasting time. etc. This will have adverse effects on application, diligence, ambitions, goals, and long-term planning that are all part of the objective decision-making process. Frustrations from worrying about time, or not allowing time to help the rehabilitation process, will affect overall progress towards finding stability, and the baseline personality that must be re-established. Long-term thinking can be hard to cope with for AMDs, especially those with untreated pain, distress, euphoria etc., but rehabilitation must change this as a fundamental step to a better, more planned and constructive existence.

**Lithium Holidays:** A controversial subject that need not be so, and also because patients themselves are not consulted, when so much can be learnt about individual management of the AMD by use of this key therapeutic tool. **Just medicating and dismissing patients, without holidays and the enlightened management that will follow what is learnt, is to condemn AMD patients to unreality and suspended rehabilitation, as well as health risks from years of unnecessary medication as a result of this neglect, because this is what it really is.**

Only the most severe cases may not benefit from holidays as a sound therapeutic tool, but every case has to be judged on its merits, and the technique should be tried to know, for sure, what the result will be for each patient. Lithium stabilises, then the (properly supervised) holidays help identify early signs of episode onsets, especially mania. Stabilisation, acceptance, reassessment, and improved management techniques, before holidays are then taken, should be the due process, with ongoing support, scrutiny, records, and feedback.

**The illness is always just below the surface, and the severity of any episodes is related to concurrent life events, thus 'trigger' is not really the correct way to describe the initiation of AMD episodes, although trigger is valid when describing stress that will feed increasing severity of an episode.**

With the lithium holidays, patients gain the necessary perspectives needed to manage the illness, **especially identifying the difference between the internal and external realities**. With awareness and practice, this important aspect can be better managed. Also, the learning derived from the holidays means less reliance on medication, easier on kidneys, thyroid or whatever else could be affected by that particular medication cannon. Optimum maintenance medication is balanced by insights that assist in managing daily living.

Lithium holidays, or holidays from other medications and combinations to treat AMD, if taken after stabilisation, acceptance, and progressive use of proper management techniques is a key therapeutic tool for effective AMD management and rehabilitation.

Re the film, **A Beautiful Mind:** although recounting schizophrenic experience, the story is relevant in context of medication management, and definitely worth mentioning. The film was well made, notably for enactment of Nash fiddling with his medication while figuring out the difference between his own external and internal realities. Laudable, and he was very smart, but hazardous to others if not properly explained and monitored, and if the treatment regime is not tailored to individual patient needs.

Balancing internal versus external reality, and lag times before this balance is achieved, is very important, needing carer support, and determined patient perseverance, to be reliable and ongoing. Medication manipulation can help with education about mood and mind changes, but this must be carefully carried out, and there should always be recourse once more to medication if the balancing of realities is becoming patently less successful.

## **Towards a Working Definition of Mental Illness/Cognitive Dysfunction:**

The term, and various states and stages of, 'mental illness' may be so easily trivialised or oversimplified by the various self-appointed messiahs of nifty pop psychology (or other spurious philosophies), who attempt to elevate themselves and supposedly educate society by originating omniscient decrees, in this case concerning the more defenceless and so-easily labelled unfortunates of our society. Even established cultures perpetuate myths, prejudices and misunderstandings about mental illness/cognitive dysfunction, so there is ample precedent for this sort of expediency.

There is nothing quite so heady for many humans than Revealed Truth, whatever the provenance, and with the advent of RT, the usually difficult path of intellectual striving is suddenly transformed into a four lane highway to Enlightenment; triteness, oversimplification, and misapprehensions notwithstanding. The mentally ill are especially vulnerable in not being able to defend against this sort of pseudo-intellectual predation that seeks easy and expedient 'proof' of its own validity and *raison d'être* by highlighting and stage-managing this vulnerable section of society.

Obviously, the 'rosy glow' approach to mental illness is dangerous for those with a genuine problem, by reinforcing a social culture of denial, and this is not comprehended by the Unfeeling and Unknowing, not having themselves suffered mental illness. This is, of course, a minor detail for the pseudo-intellectual predator given to bullying and 'control', thus there is no inhibiting the popular and confident opinions so common to such seers of the dangerously superficial.

Fiddling with definitions of society, or rhetorical sermonising on what, (or who), is 'normal' is further insult to those who continue to suffer while their illness is deemed to be a matter of poor definition, semantic confusion, incorrect self-attitude, or whatever. In truth, such self-righteous sophistries belittle the sufferers of mental illness, and are just another form of social and personal denial of the existence of real mental illness. Research and resources allocation are affected, as well as public and political understanding of the problem, especially involving the more serious forms.

'Psychological' is being confused with 'psychiatric', and the distinction blurred between psychological disorders and psychiatric illness. Thus, current attention paid to mental problems of 'normal' people tends to trivialise psychotic illness by blurring the distinctions, or by advocating pop cures or positive thinking-style remedies, and warm-fuzzy token approaches to public education and understanding. Mind-over-matter judgements are fostered that feed community prejudice, social welfare scapegoating, and Duty of Care of the mentally ill is consequently downgraded and/or neglected.

Mental illness is attracting a politically correct type of cant which ignores the scope of these disorders or illnesses. This does not, and will not, solve the problem of treating major psychiatric/cognitively dysfunctional illness. However, for the purposes of the **working definition** of mental illness, it is productive and practicable to see mental illness on a scale between two poles, as a matter of degree of function, of well-being, of productive life-style, etc., where normal is somewhere nearer the pole of 'sane', and increasingly abnormal or aberrant as nearer the 'insane' pole.

This may be the case for serious mental illness, or for transient or even one-off events, whether the cause be a major psychosis, cognitive dysfunction caused by physical condition or illness, or something less tangible, such as 'modern-day stress'. Loss of purposive mental function, for whatever reason, is always distressing to the individual, and is a prime symptom of mental disorder that should be investigated whenever identified.

**A 'normal' person day-dreaming over an astrology reading or undrawn lottery ticket shows all the signs of psychosis, (as in delusions, and hallucinations, both aural and visual!), but they manifest no distressing loss of coherent mental function, nor do they manifest any obvious problems with 'reality', or, potential social dependency, and are likewise not regarded as 'psychotic' in the medical sense.**

Which is doubtless why 'lack of reason' or 'weakness of character' in the cognitively dysfunctional patient attracts less sympathy than would be sensibly expected from the wider community. Fixations, obsessions, or distress at, and marked reactions to, external stimuli are unsympathetically regarded for similar reasons. A sense of empathy with the sufferer is not easily felt, and may be blocked or even shunned within themselves by normal onlookers, even those with medical experience or those supposedly charged with Duty of Care.

In all possible cases, observable behaviour, or other study of mental function, must be carefully undertaken, noted, analysed, and appropriate treatment devised for the individual problem. **BUT, the type and duration of the illness needs careful diagnosis, especially where major psychoses may be present, to facilitate correct treatment and rehabilitation. There are also common metabolic and/or physiological illnesses that cause cognitive dysfunction that may temporarily incapacitate patients, when outside intervention and help will be needed.**

When describing mood disorder in mental illness such as AMD, it is most important to understand that for AMDs, this means being in a mental **and** emotional state much more severe than those 'moods' that the non-AMD is subject to. A mood-state for a normal person is never usually as prolonged, nor does it disrupt ordinary cognition to any serious degree, or even more than momentarily, such as in momentary rage, and, may even be a mental state that is actively sought by self-regulating moods, such as a sad or horror movie, or just thrill-seeking.

However, a mood change for an AMD, fuelled by disrupted brain chemistry, and by interaction with a world usually oblivious to this sort of personal distress, is much more serious, extreme, and prolonged, especially if a mood clinical depression ensues as part of mood swing, or cycles, and the deep state of which may presage suicidal thoughts, and even attempts. The AMD must always be wary of external stimuli or activities that will interact adversely with personal mental states, 'feeding' the tendency of the illness to precipitate extremes or pronounced cycles that will probably need a re-stabilising regime of rest and medication, and even an existing medical regime will not induce immunity from the effects of events that may only affect 'normal' people on a short-term basis.

Unfortunately, describing such deep-seated clinical changes as occur with AMD in everyday terms, carrying much milder meanings and connotations, does no justice to the distress of the real sufferer, and further promotes their alienation from help or even some empathy. But, what terms should be used to convey the difference between the normal mood swing, and that of an AMD, or even schizophrenic or severe neurotic in mood distress? 'Mood' or 'emotion' really do not do this, so the use of such terms as mental state or mental illness, or, cognitive dysfunction, have to be invoked to convey the difference between the mild and the morbid.

Manic and mania for obvious reasons have always been difficult terms for the normal population to relate to without prejudice and confusion. 'Highs' and 'lows' have 'normal' connotations as well. Justly descriptive language suitable for understanding any mental illness, by all who genuinely desire this, definitely needs more thought. 'Clinical distress', or, 'changing degrees of clinical distress' could be used more often, perhaps? The obvious clinical distress of an acute schizophrenic state is so much more easily noted than the clinical extremes of AMD, unless the highs are really bizarre, or the patient has actually successfully suicided, by which time at least, diagnosing and treating the depressive state they were in is no longer needed even if relevant, and even treating such an extreme high will not be easy either.

This is also why properly trained Mental Health Interface Staff should deal with the mentally-ill in welfare agencies, and also be on hand to help identify those who may be in need of help, as manifested by ongoing behaviour or records taken over time, (e.g., see **Profile of a Possible AMD**, p. 10), but so far have never had the necessary scrutiny that could identify the cause of distress or dependency. Not an easy job, but someone must do it, and they must be intelligent, well-trained, and utterly professional, and have a balanced world view as well.

Lumping in the mentally-ill with everyone else in a welfare interface environment exposes them to mis-judgement, and poor or inappropriate treatment of their personal history and lack of proper recognition of their very real needs. Calling in a Goon, or Canceling a Benefit are quick, convenient, and no doubt very personally satisfying fixes for welfare interviewers, but not really the desired intelligent solutions to this sort of problem, that now becomes social as well as personal for the unfortunate mental health sufferer, and as well, a matter of increasing social responsibility?

**Duty of Care** must mean just that, and must never be left at the discretion of mediocre functionaries with no relevant training, and no interest in identifying personal problem outside their own cosy reality? Less than ideal DOC carers mean that institutionalisation soon eventuates, and the institution is, by default, run more for the convenience of overseers, and out-of-sight-out-of-society's-mind, rather than optimising management and rehabilitation of those under their 'care'. Apathy and stagnation soon overtake both carers and patients within increasingly entrenched institutionalisation, and this means social and political attitudes as well as actual physical edifices. Typically, the mental illness sufferer will again be denied real recognition and voice because of inappropriate and ill-informed 'normal' intervention and supervision, especially by those just following a default occupation, rather than having a strong sense of carer vocation?

Indeed, mental illness should really have a wider scope of definition than at present, not least because of attitudes fostered by terms like major psychosis on the one hand, and the quick-fix mind-over-matter expedience fostered by supposedly valid talking cures on the other, as well as often merely token management. The seriousness of any form of cognitive dysfunction caused by physiological or other medical problems must never be downplayed, so attitude to causes are important if these will affect diagnosis, focus of treatment, and ongoing research. AMD and schizophrenia are 'the major psychoses', yet both obviously and definitely have physiological origins, genetic links, and in the case of AMD, metabolic links.

Therefore, the focus of treatment should be likewise oriented towards **relevant, purposive** physical medicine, supported by common sense management and rehabilitation, because anything else will not solve the problem, or favour the care and future well-being of the patient. There may or may not be complete or even permanent cures, and only remissions of distress, but there should at least be stabilisation of the condition, and optimal normalisation of the patient's life, to the extent of being a functioning and re-integrated member of society and community.

The usual definitions of 'normal', or 'normality', usually run to terms like an average level of achievement, or being within certain limits, or conforming to accepted standards, and certainly being within certain limits of intelligence and ability, etc., in relation to other members of society.

However, when considering 'mentally ill' in relation to 'normal', regardless of the immediate cause, there should **also** be consideration of concepts like retention of stable and coherent personality and individuality, as well as being able to function efficiently **within acceptable limits** in work or social and personal relationships, with reasonable and realistic plans, ambitions, and levels of achievement.

The presence of self-defeating, bizarre, and/or self-destructive behaviour, with poor or even nonsensical logic or thought processes, poor personal care or hygiene, displays of tangential or imaginary reality, abdication of self-responsibility, etc., would further indicate a lack of coherent, functionally effective personal reality, with mental processes becoming less and less effective as the insanity pole of that hypothetical scale is more closely approached.

In all cultures and societies, the withdrawal from society, and the sad decline and disintegration of personality and intellectual capacities, plus lack of purposive mental functions, especially of the long-term or chronically mentally ill, are universally recognised, and unmistakable in manifestation, even if not always well understood, sensibly regarded, or properly diagnosed and treated. Remission, especially if episodic, is too often seen as a proof of underlying valetudinarianism and lack of moral fibre when cruel and misinformed judgements are made.

Historically, there have been various attempts to explain and treat mental illness, from shamanistic practices and exorcism to asylums to tranquilizers to redefining of society. A specific branch of medicine, psychiatry, has been developed in modern times to deal collectively with these illnesses, and the fact that psychiatry is still an evolving discipline, whose practitioners are only as good as their education and training, or that psychiatry has at times been misused by vested interests, should not detract from the relevance of the properly practised discipline.

This is especially true for diagnosis, and the very real need to succour and protect those people who are unfortunate enough to be identified as mentally ill. Although now, as a result of newer research, the medical emphasis for such illnesses is moving more to physiology, physical medicine, genetics, and more enlightened treatment regimes. **These psychiatry must acknowledge, and any other so-called 'psychological' treatment should never be applied unsupervised, or without direct reference to the physical dimensions and origins of any specified problem.**

To stress the point again, mental problems such as stress related illness or neuroses, as suffered by otherwise inherently normal people, have focused attention on what could be called everyday mental disorders. **But 'psychoses' and other major cognitive dysfunctions are a distinctly different set of mental illnesses, requiring specialised diagnosis treatment that differs in nature and degree to those measures employed in treating other less debilitating forms.**

However useful this attention to modern mental well-being may be, the distinctions must therefore not be blurred between these and more serious problems. Otherwise this blurring will inevitably lead to popular misconceptions of what really is a serious mental illness or cognitive dysfunction, even by the well-meaning and well-intentioned, and to more dangerous reliance on a more superficial approach to diagnosis and treatment **which could delay gaining proper treatment for those who really need this.**

To analyse and assess the status of an individual's mental processes, wherever they may be on this scale, be done by **differential diagnosis**, however long it takes, and this is what psychiatrists are trained to provide, in conjunction with other physicians, and what philosophers, lay-people, quacks, fringe medicine and positive-thinking pop-psychologists are definitely **not** trained to undertake. The heady sensation of empowerment by revelatory understanding, or enlightenment by personal agenda paradigms, when practised by the self-important subjective 'thinkers' of society, are positively dangerous anywhere near suspected mental illness, **especially** for the seriously mentally ill! **How many lives must be miserably lived or heedlessly, needlessly lost before all this is finally understood?**

It is best for such people to restrict these grand armchair theories to where they will cause least harm, or, better still, to change their own worlds by self-change, rather than trying to prove spurious points by abolishing mental illness by semantical revision or whatever.

Those foolish enough to attempt these Grand Design 'Diagnoses' to explain away what are very real problems for the mentally ill and those who diagnose and treat them, those who think a properly addressed health issue may

mean a future budget lost, those who make money from popular theories, texts and cures for mental illness, and those who think that the occasional tax-payer funded token publicity campaign *Does Society's Duty*, **all obstruct the the advances that should be taking place to properly diagnose, treat, and rehabilitate sufferers of 'psychoses' and other serious mental illnesses.**

Lack of public and political awareness and education, therefore, simply exacerbates the serious of the plight of most of the mentally ill in our so-called enlightened society. Renewed research into genetics, neurophysiology, and evolution with a more mechanistic rather than a philosophical approach to understanding, will aid demystification, and better social awareness of, mental illness. The religious and cultural bias against investigating evolutionary research, that has implications for all our species, is slowly being overcome, and along with this, the denial that accompanies this sort of intellectually stultifying close-mindedness. This intellectual ground must not be lost again!

The cultivation of objectivity concerning exactly what humans are in relation to the rest of evolution is by no means a universal intellectual standard, and until this standard is universally met, many of the mentally ill will continue to live in less than optimum, and even life-threatening, circumstances, because new research will be inhibited. Quibbling over the nature and even the **fact** of mental illness, as shamefully still continues, is inexcusable, and condemns homo sapiens sapiens as being somewhat less than sapient in this respect....

**Finally, an emerging genetic group of AMD illnesses, or an AMD 'genetic suite'**, also occurring in distinct patterns of inheritance, that occurs as a result of permutations of some negative gene combinations, has great significance for definition of what exactly is psychotic, whether the term should now be seen to have wider implications, and thus to be redefined. The implication that would cause the most consternation is that the currently trendy emphasis on certain mental illnesses may prove to be an embarrassment, if these illnesses, it transpired, were related to manic depressive psychosis. AMD would perhaps not then be trivialised so readily.

'Depression' in a general sense is one good example. What if OCD, certain neuroses, tendencies to substance-abuse, ADHD/HDD, Aspergers, and panic attacks, to name a few possibilities, were all classed as being genetically related to AMD? The recent trend has been to popularise less extreme forms of mental illness, and render them more socially acceptable. This has done much for confronting relevant related diagnosis and management for lesser mental problems, **but when major pschoses and/or cognitive dysfunctions are included in this umbrella terminology, by implication, they become trivialised in the public mind. Screening and early diagnosed are easily inhibited by this trivialisation. If AMD is not properly understood, both in origin and process, then how can treatment and management be successful? Kraepelin's Curse invoked!!!**

'Psychological' so often a mis-applied label which obscures the application and specific meaning of 'psychosis' or other cognitive dysfunction, and serious mental illness is then lost sight of in the mists of positive thinking, blanket medication, and the warm and fuzzy rush to de-institutionalise. A widening of the AMD 'family' could incur renewed denial of mental illness, and a return to evasive or euphemistic diagnosis. Or else, more sensibly, and hopefully, initiate a concerted attempt to understand AMD epidemiology, and then properly diagnose and manage the full range of these health problems, without obfuscation, discrimination or profiteering quackery.

However, if such an overall genetic link is proven, perhaps latent suicide will be also recognised as a species-wide phenomenon, and there will then need to be attention focused on this to understand and forestall fatalities. Perhaps such acceptance of the universal nature of suicide within our species will prepare the medical professions and the general population for the implications of an even larger AMD genetic collective, (or suite of genes), and promote universal common-sense and fair play in dealing with all forms of mental illness in society, genetically derived or otherwise.

There is a theory that the potential for human evolution is now being limited because the exigencies of earlier species survival by natural selection have been overcome by lessening of mortality rates before breeding age, and the survival and increase of previously adverse genetic material as health care increases. This depends on how one defines evolution, but presumably, the inference is that the capacity to survive and adapt, to continue survival, may be impaired.

AMD and suicide will probably be confirmed as being as old as our species, suicide more obviously so, and their survival in the human genome has thus far been well maintained, although not necessarily related except by cause and effect, with AMD, at least, being an example of a suicide **stressor? There may well be a common genetic link as yet unidentified. Certainly, some suicides seem to follow a syndrome pattern, even among those with no AMD history, when sufficient stress is applied, so suicide is certainly a mental illness or cognitive dysfunction that neds special investigation, surely?**

However, the implications of an increase in AMD-type illnesses because the illness may does not usually incapacitate breeding potential, will mean that although more brain-power will be available from classic manic depressives, (perhaps this most specific term should be revived for purposes of AMD type differentiation), the potential for suicide, disrupted lives, emotional traumas and substance abuse **will also increase as all AMD types increase as a proportion of human society.**

Perhaps the proportion is greater in more advanced societies due to overall survival rates? There is no small irony in that! But, these problems are serious, and more so because they have not yet begun to be properly confronted as popular attitudes still concentrate on effects, and rushing to judgement, rather than investigating causes.

Although genetics will now enhance screening, any possible positive genetic engineering lies in the future, but enlightened care, management, and rehabilitation can, and **must**, be utilised in the present. Public and professional education must increase in scope to enhance social perspective for future decisionmaking.

## **Analysis of Denial of Mental Illness by Individuals and Society:**

One of the main problems for the individual and the society in relation to acceptance of mental illness is that of the different manifestations of denial. These are inter-related, and feed on and profit by credulity and prejudice at all levels. In real terms, they all in turn feed on the primitive instinct for discrimination.

This impedes diagnosis, rehabilitation, carer perception, social acceptance and support, and the recognition of priorities of funding, research, publicity, etc., in short, disunity of Mental Health administration and vulnerability of individuals results.

Denial manifests in the following forms, each of which extrapolates to serve the intentional or unintentional purpose of individual or group. The PNARQ factor may flourish, also. (Philosophers, New Age, Religion, Quacks.)

### **1) The illness—does it exist at all?**

- if it does, then has it been correctly defined?
- can a proper cause, and thus classification, be defined?
- do conflicting 'experts' argue at the cost of the the actual individual as well as common sense?

IE, is the problem psychotic, neurotic, 'other', or just imaginary? This is the 'disagreement' principle, and in effect implies that if there is disagreement over the illness, then perhaps the illness does not actually exist. The patient and/or carer network, fearing stigma, may want to believe this and society certainly, but more as a means of scapegoating or avoiding responsibility.

### **2) If there is an illness**

- is there a cure?
- is there a treatment?
- is there a recurrence control or prophylactic?

### **3) If 2), then, what is the nature of the cure, treatment, etc.?**

- orthodox?
- 'alternative'?
- 'therapies'? Eg, psychological
- rehabilitation..?

In the case of 2), the approach is hopefully commonsense, but in 3), the denial stems from the 'partial disagreement' principle applied to possibilities of treatment, in which the nature of the illness is subject to dissembling, as for 1).

In general, any such dissembling implies that the illness is not serious after all, which again relates to avoidance of stigma or responsibility. Thus, there is potential for exploitation and lack of regulation. The PNARQ factor applies here, especially as regards to making profit, abrogating funding and resources, or cultivating power and/or dependence, as hope is exploited.

Denial influences may be selectively or collectively based on any of the above points. The individual who cannot cope with the fact of an orthodox diagnosis will readily listen to theories that will have them believe that they are not very ill, or temporarily ill, or not ill at all, or the most heady argument of all, that they are special and unique, but are described as ill because society does not 'understand' them to the extent that they become victims of 'injustice'.

Further confusion follows with AMD, when the nature of cycles or remissions are not properly understood, and may be misguidedly mistaken for cures; hope is then vulnerable to exploitation. Thus, 'dysfunction' and other labels and syndromes get a lot of mileage, and in turn, when there is perhaps no recourse to help or referral, a crisis may occur at a later stage.

Orthodox medicine can also show the influence of denial in its various forms by trivializing symptoms, reliance on drugs, and with no constructive referral. The patient may become more and more isolated in their immediate community, or else placed in the care of 'specialized' medicine and institutions, so that the 'out of sight and out of mind' principle then applies. Orthodox doctors may also relocate in PNARQ ranks. Do not be afraid to shop around for the best quality orthodox care.

**Re De-Institutionalisation:** Note that the rush to de-institutionalize patients into a newly warm and caring society results in the 'what more do they want, they've got their medication and pensions' principle applying. When de-institutionalising is not successful, the NIMBY principle is invoked, especially in suburbs with the 'better' type of public park. Rash promises by 'liberal' politicians, and public servants willing to show eager compliance means that

such decisions are misinformed, vital resources are misapplied, and even lost to PNDARQ-type agencies who thrive on governmental dereliction of duty. Park benches, and suicide statistics do bear witness to expedient decision-making out of touch with the realities of poor mental health...

PNDARQ theorists can, and do, write off patients with serious conditions as 'not trying', and believe utterly in what they say. Orthodox medicine is to them so suspect that they may ignore it altogether as a source of wisdom. The PNDARQs also seek the notoriety of their own self-perceived 'enlightenment', and this may also include professionals who have forgotten the principles they have learned in the rush to be famous/notorious.

**In all the above scenarios, rehabilitation may be improper, inadequate, or nonexistent.** Just being grateful for a pension is not rehabilitative, either. Rehabilitation must be to **optimal potential** to bear the description. Consistent and continually successful rehabilitation creates its own rewards and incentives, but unfulfilled or unrealistic and insupportable expectations can destroy optimism and self-respect, and worsen self-neglect and decline.

The most obvious examples of the PNDARQ-style notoriety which may breed among academics or professionals are Szaz, Foucault, Porter, and Breggin (author of 'Toxic Psychology' etc.) Owing much to armchair philosophy, laziness, poverty of ideas, and seized on by an unthinking media, these ideas trivialise the issues of mental illness, and as a result present the mass of society with the erroneous impression that the problems of mental illness, including psychoses, are not all that serious. Thus, 'radical' analysis and trendy popularisation results in trivialisation, which then results in further degradation in attitudes to the real issues and the needs of patients, and, by influence on decision-makers, more loss of resource share for mental health.

Thus, newly-diagnosed patient, confronted with the possibility of a demeaning life label, will naturally tend to hear what they want to hear to avoid a definitive medical diagnosis and resulting social stigma of such a label. The consequences of of this misplaced hope are all too real in a society still in denial of the reality mental illness, and the the importance of early diagnosis, and care, and ongoing social acceptance and support. Those doctors who perpetuate unrealistic optimism in the patient by not referring when necessary, could be said to practise '**denial psychiatry**'. The rest, PNDARQs et al, '**denial therapy**'. This results in any existing patient '**denial syndrome**' being reinforced.

**Thus, to the patient with denial syndrome:**

- If there is confusion over nature of illness, then I am not ill
- If the society is at fault, then I am not ill
- If the drugs are not 'right' then I am not ill
- If I am only 'dysfunctional' then definitely I am not ill
- If society does not 'understand me', then I am not ill
- If those who say what I want to hear are right, then I am also not ill
- If all the above are correct, then not only am I not ill, but obviously very mysterious, special, and well on the way to Enlightenment.....however...if none of the above were efficacious in my treatment, then it is all my fault, I know, **because I did not 'try' hard enough!**

Remissions do make cures either, so, beware of those who do not understand the true nature of the illness, or its tendency for remission. These are the dissembler, the positive thinker, the new waver, the untrained, even the substandard conventional doctor. Especially, beware of those therapeutic pretenders who do not subscribe to a definite set of ethics, or who are not bound to observe personal and professional duties of care and responsibility, they all have a vested interest in profiting by manifestations of the ancient and universal human fear of the different or unusual, and the desperation this engenders in vulnerable sufferers of chronic illness.

It is also important to note that the patient who becomes a 'professional' mental case, flamboyant, 'eccentric', and even defiant or aggressive in behaviour, 'in order to feel good about themselves', does no good for the image of Mental Health either. This is, in reality, another form of denial, (masquerading as a drop-out?), which precludes further individual progress, and entrenches a negative personal identity and self-image, and also a negative public image that may disadvantage others with the same illness in relation to public tolerance and recognition.

Their actions may thus result in lack of empathy and support, and promote the impression of anti-social behaviour in relation to mental illness, especially if high profile. There exists a sad irony when the reliability and good reputation of other more rehabilitated individuals may suffer as a result, or mental illness sufferers as a whole.

This is a very important factor in the public profile of mental health, because the onus of proof of rehabilitation is so heavily on the individual. In turn, the image of any organisation that actively promotes rehabilitation and possible return to the work-force **must** involve much more than tea, sympathy, and role-playing about 'difference'.

Rehabilitation must be concerted, constructive, and consistent with common-sense and directed towards future social acceptance and integration.

**Aspiring to be a good example is an important means of overcoming denial. This principle can operate with good effect in any area of Mental Health, and the rehabilitated and fully functional individual is the most important example of all.**

There is still much to be done on cause and cure of mental illness. Integrated and dedicated research must be funded, and real social tolerance and interest in these matters must be promoted. But the individual who faces up to their illness, **including their own and others' capacity for denial**, and goes on with life from there, has made the most important step towards optimal rehabilitation.

In turn, this should result in the illness becoming more accepted, better understood and supported, and more incidental to the mainstream of everyday life, which should be the ultimate priority for both patient and society.

**AMDs are thrice damned if the genetic origin and physiology of the illness are not understood, coupled with being told that it is all 'in their mind', with consequent useless 'cognitive therapy' and/or inappropriate medication being foisted on them. Also, as yet there is no coherent universal management system in place, because that comprehensive management and rehabilitation manual still needs to be written!**

## **Can you help with creating the following much needed world-first publication?**

### **'A Manual for Understanding, Treatment, Management and Rehabilitation of Affective Mental Disorders'**

As a guide to the appropriate candidate(s) in setting up the project, the following initial interdisciplinary networking is suggested:

Neurophysiology  
 Epidemiology  
 Genetics Statistics (including compiling and processing necessary survey material)  
 General Practice and Nursing  
 Physiology (including stress, diet, physical health maintenance)  
 Pharmacology  
 Psychiatry and Psychology as minor fields only  
 Media and Publicity (incl. target advertising and sales)

The readership targets are GPs, educated paramedics, other professionals, and intelligent lay people for optimum impact and public and social education.

### **Suggestions as to how the Manual could be written, and by whom:**

Two formats could be appropriate:

- 1) A single PhD student undertakes to produce the Manual as a PhD thesis subject, which will include research, surveys, interdisciplinary networks, interviews, clinical and field observation, etc.
- 2) As an anthology, with contributions from PhDs in networked departments, happy to have an opportunity to publication opportunities, and overseen by an Editorial Board  
 University and/or Government or funding should be forthcoming in either case, as such a comprehensive Manual would be a world first, have good sales and publicity potential for the University, and lead to successive editions as more research and feedback is incorporated. The project would have an indefinite lifetime, and presumably begin to be self-funding. Care would have to be taken to ensure that some financial returns were reserved for future research, surveys, editions, spin-off publications and sales, and not hived off by economic rationalists beyond reasonable expenses for university administration and publication costs...

Preferred options of the PhD student thesis would most likely involve either Medical Research, such as Neurophysiology, (or related medical field), or Nursing, and the criteria for participation would then be a suitable supervisor and student **with a particular interest in Affective Mental Disorders.**

**There must be a move away from the symptoms and drugs approach of psychiatry,** and the talking cures of psychology, if truly fruitful research into mental illness is to take place. Together, they represent an era of mental health that is now seen as flawed and moribund. As a consequence, a renewed interest in research will help to promote a new approach to AMD studies, and this should be emphasised when networking for relevant data. All parties contributing must be prepared to be objective, non-aligned and non-self-agendered, mental health issues more than ever needing this approach.

Two years would seem an optimal time to produce the first edition, firstly because there will be successive updated editions, but most importantly, because such a publication is so urgently needed to overcome moribundity of current AMD management. Many AMDs at present are un- or haphazardly diagnosed, and prone to preventable suicide, or lead less than ideal lives because of this moribundity problem. This sad fact imbues the project with some urgency. No other comprehensive, systematic or purpose researched management publication exists for AMDs, apart from subjective and limited lay publications of the buzz self-help kind. More more needs to be done.

If necessary, a project advertisement should be devised to 'test the waters', to see what sort of interest and candidates eventuate. The ad should stress that new research is being carried out on AMD which will bring a renewed appraisal of AMDs, their treatment, and potential to be managed more effectively, with more optimism for their future in society, and for the benefit of AMDs and society.

**The real innovation would be to poll AMDs themselves, en masse,** to gain their opinions as to management of their condition. Too often mental patients are considered incapable of insights into, and constructive feedback on, their own condition, even when recovery is well under way. A suitable questionnaire cum opinion poll will need to be devised for this purpose.

**Prospective Manual Format:** suggested chapters or sections:

- 1) **General overview of AMD**, comprising history, knowledge, and status quo of AMD treatment and management, including aetiology, epidemiology, diagnostic criteria, pharmacology, etc.
  - 2) **Neurophysiology of AMD**, including an update on latest research findings and trends, which would also include genetics, and studies on function and creative potential of the AMD brain.
  - 3) **Optimum requirements** for AMD treatment and management in an outline form:
    - a. social education relating to AMD, and appropriate screening measures, and with diagnostic tools
    - b. treatment regimes, including pharmacology
    - c. post-treatment, including self-management
    - d. differentiate between short and long-term AMD, uni-polar and cyclical and intermittent forms, with analysis and explanation
    - e. suggest that where crisis management is necessary, segregation is desirable to lessen trauma, and aids stabilisation
    - f. emphasise that public awareness, screening, and early diagnosis will reduce crisis management, personal trauma, and social cost.
    - g. judgemental social comment should be avoided in this section, but convey the message firmly and frankly; much PR depends on this.
  - 4) **Common obstacles** to effective AMD management include:
    - a. lack of public and professional education
    - b. lack of patient and carer education
    - c. lack of self-management techniques and training
    - d. too much reliance on drug and psycho-therapy
    - e. lack of awareness of scope of socio-economic effects for many AMDs
    - f. need to overcome denial and resistance to diagnosis, and not just the individual AMD, but carers, doctors, etc. are also culpable
    - g. confusion of symptoms with other mental or physical conditions, this being especially a problem for early onset AMDs, importance of analysis of the 'iceberg' analogy v. the relevance of 'triggers'
    - h. lack of community tolerance and understanding, and tendency to favour 'buzz' disabilities, and consequent continual re-prioritisation of lower-profile AMD needs.
    - i. lack of a coherent profile of AMD
    - j. lack of awareness of need for re-employment ASAP as a therapeutic as well as socio-economic necessity in all cases.
    - k. lack of extensive surveying of current AMD opinion to help shape improved management policy.
- The social and personal problems outlined in the Plight of the Phoenix are real potentially and/or consequentially for all AMDs, regardless of personal history, and this must be emphasised, as firmly and frankly as possible.**
- 5) **Detailed treatment, management principles and techniques:** Including crisis management, pharmacology, self-management, medication holidays as a therapeutic tool, lifestyle re-appraisal, prognosis, burnout, differences in types and duration of AMD, genetic implications etc. **(Major management section)**
  - 6) **Survey material from AMD personal experience**, objectively analysed and presented, which could include;
    - a. lapse of time or difficulty in getting diagnosis
    - b. early v. late diagnosis

- c. long v. short term AMD
- d. coping problems
- e. social and acceptance problems
- f. status quo treatment and management
- g. opinions and suggestions re improvements
- h. feedback for successive Manual editions

Such personal survey material would provide material for the first Manual, and a basis for comparison of conditions for AMDs as successive editions are produced. Similar surveys from doctors, social workers, carers, crisis management or support centres could be devised to highlight matters like identifying AMDs, assisting with getting diagnosis and treatment, and for AMD personal contact experience and management.

- 7) **Suicide section:** discussion as to incidence in the wider population, possible cause or causes, and special reference to AMD suicide patterns and prevention. Note that suicide is an important social topic, and that in-depth treatment in the Manual will add value and general interest to the project.
- 8) **'Recommended' checklist** list of facilities and procedures as a general guide for implementing and improving AMD treatment and management.
- 9) **As part of the project guidelines, emphasise:**
  - a. AMD is an illness of intelligent people, because irrespective of their enhanced brainpower during high(er) episodes, AMDs have a high average intelligence.
  - b. Mitigation and management of the adverse effects of AMD in society optimises the use of this intelligence potential, and at low cost compared to other disabilities.
  - c. AMDs have unlimited potential for treatment and management. Therefore, readership target for the Manual should include GPs and educated professionals and other lay people to ensure optimum impact and education about AMD.
  - d. AMDs need common-sense, low-tech help, targeted research, and only optimum funding; returns on this investment will far exceed economic outlay on their behalf for improved management.
  - e. The profile of AMD is disadvantaged by appearing merely as larger than life in relation to 'normals' in society, and in contrast to that other more obvious psychosis, schizophrenia, and is also being trivialised by trendy attention to less serious mental illnesses such as 'stress'. Psychosis and psychology are currently confused in the public's mind by the media. Depression, especially, is being trivialised in modern society as being easily 'curable'. See h.) below

**f. The Manual must stress the genetic origins of the illness and the implications to individuals and society. (Q. Is AMD incidence increasing?. Are there genetically related AMD illnesses? Is reclassification required?)**

- g. The importance of symptoms, however much they resemble extremes of normal behaviour, must be stressed as an indication of a major psychosis that requires specialised treatment and management, **but** with favourable prognosis for all properly managed AMDs. **Infinite** potential for management of the illness.
- h. Stress the need to counter superficial and ill-informed extant social attitudes and publicity that dog proper AMD recognition in society. Spurious theories, philosophies, talking cures and their perpetrators must be effectively rebutted, directly or indirectly, in the Manual.
- i. Stress that the Manual is not a substitute for medication use, but complementary to, and minimising of, this use.
- j. **AMD research and disease profile must never again become moribund. Management considerations should now include:**
  - 1) Separate facilities and trained staff required during acute and early rehabilitative stages
  - 2) Lithium holidays as an advanced therapeutic learning tool

- 3) Screening processes, including genetic when available
- 4) Identifying suicide as a stress-related condition, AMD as being the major stressor and pre-cursor.
- 5) Useful employment ASAP, post-stabilisation, for rehabilitating AMDs.
- 6) Cycle-breaking: Stop highs to stop lows, and thus break the cycle
- 7) Genetic implications: negative genetically, but not self-eliminating, so AMDs may increase as a population percentage? **Is there a wider genetic collective? Are ADHD/ADD, OCD, Dyslexia, are possibly others also part of a genetic suite hitherto not discovered? If so, the Manual must incorporate management techniques for these related conditions.**

**10) Comprehensive Index, References and Bibliography, and Networking Sections** to complement a publication suitable for a GP's surgery, and for all educated people to consult. The reference sections should cater for all specialist or research needs, and actually be an additional selling point. A more comprehensive scientific companion publication could be produced in due course that builds on the Manual. A critical analysis of existing AMD-related formal literature for assaying the quality of existing diagnostic criteria would also be advisable, as there are variations, grey areas, and even conflicting definitions extant that must be dealt with in a benchmark publication such as this Project intends to become.

### **Postscript:**

**How different would the situation be, now, if Kraepelin had the knowledge and insight, then, to have identified AMD/MDP as just another physiological and/or metabolic disorder, with both cognitive and physical consequences, rather than 'the other major psychosis'. The whole history of research, treatment, patient history, public perception, etc., all would have been so different. But this did not happen, and so, even now in modern times, the misunderstanding, misdiagnosis, mismanagement, crude medications, labeling plus lack of research and thus postponement of more enlightened treatment, still all regrettably subsist. If YOU want to be the one to write this thesis, bear in mind the terrible consequences and history of Kraepelin's (unwitting) Curse, and how important it is for all those with the illness, now and in the future, to ensure that this 'curse' is at least eased. If only this awful illness could finally be removed from the human genome, that is the last and best resort! Until then, there is only good management and rehabilitation to make the real difference between optimal lives, (and freedom from talking cures and other spurious ideas), or still more misery and ever-preventable deaths.**

**AMDs are, therefore, thrice-damned if the genetic origin and physiology of the illness are not understood, coupled with being told that it is all 'in their mind', with consequent useless 'cognitive therapy' and/or inappropriate medication being foisted on them. Also, as yet there is no coherent universal management system in place, because that comprehensive management and rehabilitation manual still needs to be written!**

**With the advent of such a dedicated Manual, and after such a long wait for proper recognition, at last the adverse experiences of so many AMDs, past, present, will have relevance. Most importantly of all, those experiences will not have been entirely wasted, and the future will also be so much better for those newly diagnosed. Hopefully, the Dedication from 'The Plight Of The Phoenix' is also acceptable for use by future Manual authors, appropriately re-edited:**

**'Dedicated to those who, in hindsight, should have survived. More importantly, this Manual is dedicated to those in the present and future, who, with improved foresight and common-sense help, will so easily survive as never before, and prosper.'**

**Notes:**