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

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
Media and Publicity (incl. target advertising and sales)

The readership targets are GPs, educated paramedics, other professionals, and intelligent laypeople 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 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 goverment 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 uni 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 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 prepared to be objective, non-aligned and non-self-agendered, because mental health issues more than ever need 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. Much 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. To 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. Analysis and explanation

e. recommend 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 the 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**:
Include 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) <u>Survey material from AMD personal experience</u>, 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 many 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 major 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 socoiety 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. **There is 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 staffif required during acute and early rehabilitative stages

2) Lithium, or other, holidays as an advanced therapeutic learning tool

3) Screening processes, including genetic when available

4) Identifying suicide as a stress-related condition, AMD as major stressor and/or 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 that AMDs may be increasing as a population percentage?

7) **Is there a wider genetic collective? Are ADD, OCD, Dyslexia,and 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 comprehernsive 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.

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 stimulii. Thus, 'cathartic therapies', role playing, and 'group therapies', are totally wrong, and even dangerous.

9) Stabilise, advise, 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.

Postcript:

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 AMD 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, trebly 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.

With the advent of such a dedicfated 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."

https://mentalhealth-uk.org/help-and-information/conditions/bipolar-disorder/types-of-bipolar-disorder/

https://scitechdaily.com/blood-test-developed-to-detect-depression-and-bipolar-disorder/

https://medicalxpress.com/news/2022-03-gene-brains-people-bipolar-disorder.html

https://medicalxpress.com/news/2022-03-scans-weakened-brains-adolescents-bipolar.html

https://medicalxpress.com/news/2022-04-chromatin-brains-patients-schizophrenia-bipolar.html

'The Brain That Changes Itself' https://www.youtube.com/watch?v=bFCOm1P_cQQ

https://www.futurity.org/bipolar-disorder-causes-1632792/

https://neurosciencenews.com/virus-genetics-mental-health-26151/

https://scitechdaily.com/groundbreaking-synaptic-imaging-reveals-biological-roots-of-autism-schizophrenia-and-more/

https://scitechdaily.com/scientists-discover-a-hidden-brain-clock-driving-bipolar-mood-swings/

https://www.sciencealert.com/several-psychiatric-disorders-share-the-same-root-cause-study-reveals?T

(https://en.wikipedia.org/wiki/Pleiotropy)

At last, a more organic view of causes, processes, and effects, of AMD, means that 'psychological', 'psychiatric', 'cognitive', and other related 'Talking Cure' terms, can now superceded by the much more relevant and useful term, 'Commonsense'...

Notes: