COMMON SENSE II

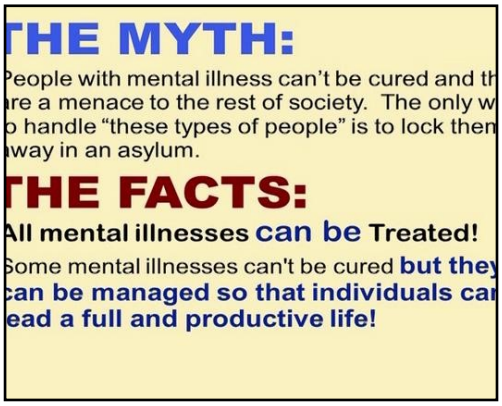
Capitalizing on the familiarity and influence of Thomas Paine's "Common Sense" pamphlets that provided American colonists with exposure to the conversation of great thinkers in the pre-Revolutionary period, this paper assumes the name COMMON SENSE II. Similarly, today's series of pamphlets strives to give a direct response to great political events and ideas of our time.

May 2019 Mental Health Issue Volume 14 Issue 5

Are We Making Progress?

By Valerie Conner

In days of yore people who were different, physically or mentally, were derided, ridiculed, and often tormented. Largely this reaction was from fear born of ignorance. We like to think we've come a long way since then, but have we? Not so long ago people with some mental illnesses were virtually warehoused in institutions where they were fed, clothed, sheltered, and medicated. Then people realized that at least some of those folks' rights were being violated, and they were released from the institution. Unfortunately there was no Plan B. Many of the newly released people had no place to go or real source of income. Many ended up on the streets and living under bridges, increasing the homelessness problem. Who among us hasn't tried to avoid noticing street people?



In some respects our attitudes and treatment of those with mental illnesses has become somewhat more enlightened. PSAs seek to lessen the stigma of seeking help, especially among veterans. Still, insurance companies tend to treat mental illnesses differently from physical illnesses. How many people with diabetes or heart disease are expected to be cured after 30 days of treatment?

Science is making great strides in understanding how the brain works both chemically and emotionally. With an estimated 20% of the population having some form of mental illness at some point in their lives, we as a society are trying to become more sensitive to the issue.

Language is a major factor in how we refer to and treat those with a mental illness. As Nancy points out in her article, we say you have the flu or you have a heart condition instead of you are the flu or you are a heart condition. Why, then, do we say you are bipolar or you are depressed? The National Alliance on Mental Illness (NAMI, www.nami.org) recommends we use "people first" language, saying "a person with schizophrenia" instead of "is schizophrenic," saying "people with mental illnesses" not "the mentally ill," saying "treatable or serious illness" instead of "life-long or chronic illness," saying "is experiencing" instead of "is suffering from." To recognize that each illness is different, say "mental illnesses" or "a mental illness." And of course, avoid saying "crazy," "psycho," "nuts," or "insane."

When I sent out the topic for this issue, I suggested some approaches to the subject:

- What is the effect of no longer "warehousing" people with a mental illness on homelessness?
- How can the layman (or professional, for that matter) determine if someone truly has a mental illness?
- If someone truly has a mental illness, does that mean anything should be done about it, or is he/she functioning well?
- Does the cause of a mental illness make a difference on how we treat the person? Should it?
- What is mental health? How can we promote it?
- What is the line between neurosis and psychosis?
- What is the line between bizarre behavior and true a mental illness?
- Where does Trump fit in here? How can people be convinced of that?
- What can and should the government (local, state, and/or federal) do about mental illnesses?
- What are some dangers of inappropriate diagnoses?
- What changes in insurance coverage should be made?

As you can see the topic is gigantic and the contributors wrote on even different aspects of this huge topic. Bringing the discussion to the personal level is an effective way to generate action on a policy scale.

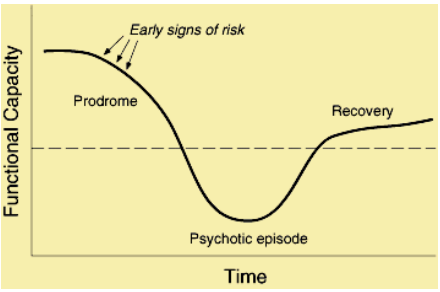
I don't know if mental illnesses are more prevalent today because of the pace and complexity of our society or if we just are more aware or science is defining more conditions as mental illness. In any case, we are trying to be more sensitive and to strive for effective treatment. That's where policy comes in. We as a society need to invest in research, treatment availability, and safety nets for those with mental illnesses as well as for caretakers and for the protection of the general public from the few who are dangerous to others as well as themselves. As with any remedy, that will take enlightened commitment and investment of money.

Living with Mental Illness

By Gregory Gamble

My younger son John experienced what was diagnosed as a "psychotic break" in 1996 when he was 16 years old. At the time he was living with his mother and step-father in Sumner, Washington. He was hospitalized in Tacoma for a couple of weeks and released with Risperdal prescribed as an anti-psychotic.

John's mother and I had divorced in 1986 but remained friends and took active roles in rearing John and his older brother. Our sons lived with me in Seattle. I remarried in 1994 and moved to Iowa in 1995. At that point John's mother and step-father made efforts to find a home for John with good schools nearby. John helped in choosing and ended up in Sumner which was about 35 miles away from our old home in Seattle. He had few friends in Seattle and developed none in his new home. I was told John had become increasingly depressed prior to the psychotic break.



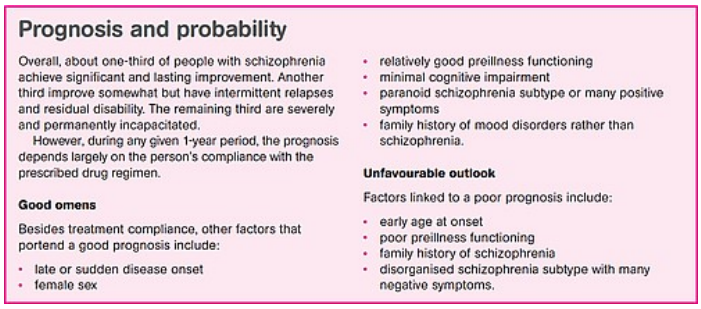
John had been enrolled in regular high school classes but after his break was unable to continue attending these classes. He was enrolled in special education classes in Sumner, but he was also unable to cope with these. John's mother and step-father could not deal with his illness and asked that I take over his care. John moved to Iowa in 1999 and has lived with me since.

Prior to leaving the Seattle area, John's mother had unsuccessfully attempted to get John qualified for Social Security Disability Insurance. After he moved to Iowa in 1999, I began paperwork to get John qualified for disability insurance. His application was initially rejected. We appealed, and after an interview with a psychiatrist, the application was approved. John was covered by SSI until about a year ago. He became eligible for Social Security Retirement, Survivors, and Disability payments from my and his mother's accounts. These payments were enough that he was no longer eligible for SSI. He became eligible for Medicare in 2012 through my Social Security account.

John has also been covered by Iowa Medicaid since shortly after he moved in 1999. This was good coverage for many years. Additionally, he received help through the Department of Social and Health Services in working at residential facilities for handicapped people. With the privatization of Medicaid in Iowa a couple of years ago, life has become more complicated for many disabled people. Residential work facilities have been closed, and many dental offices no longer accept patients covered by Medicaid. An onerous certification process now takes place every year. Regulations and requirements for state and federal assistance programs seem to change yearly. Parents or guardians should be forewarned about the hours and hours required every month to document and comply with assistance programs for the mentally ill and handicapped.

John has been fortunate to be under the care of a psychiatric nurse for most of the time he has lived in Iowa. She has monitored his behavior and adjusted medications to effect the best outcome for John. John has been hospitalized at least twice since 1999. Once was to adjust medication, and the other was for a catatonic-like episode after work. He was also seen at the University of Iowa Hospitals for evaluation.

John's condition has been diagnosed as schizoid affective disorder. He currently is prescribed five medications for anxiety, depression, blood pressure, and psychosis. He is able to work a few hours a week at a local senior center. He has done reasonably well over the years with medication, but he spends much of his waking hours listening to music with headphones. He was always a quiet person, and he has never discussed his feelings with me in any detail. I believe he has reported to his nurse that he hears voices. He helps a lot with housework and keeps his bedroom and bathroom clean. He prefers the solitary life at home but reluctantly goes out for required medical exams and tests, haircuts, and the occasional dining out. Interactions with strangers or even people outside our immediate family are very uncomfortable for him. He has difficulty with communication. People are obviously uncomfortable around him because of his lack of "normal" facial expressions during attempted conversations.



Prognosis and probability

Overall, about one-third of people with schizophrenia achieve significant and lasting improvement. Another third improve somewhat but have intermittent relapses and residual disability. The remaining third are severely and permanently incapacitated.

However, during any given 1-year period, the prognosis depends largely on the person's compliance with the prescribed drug regimen.

Good omens

Besides treatment compliance, other factors that portend a good prognosis include:

- late or sudden disease onset
- female sex
- relatively good preillness functioning
- minimal cognitive impairment
- paranoid schizophrenia subtype or many positive symptoms
- family history of mood disorders rather than schizophrenia.

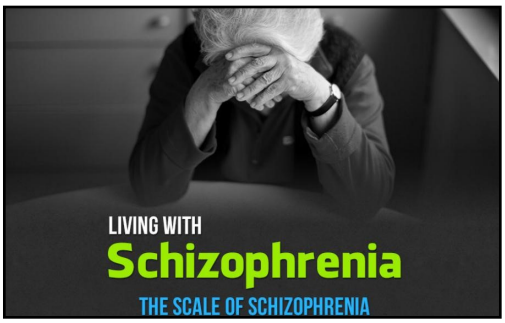
Unfavourable outlook

Factors linked to a poor prognosis include:

- early age at onset
- poor preillness functioning
- family history of schizophrenia
- disorganised schizophrenia subtype with many negative symptoms.

John's life since age 16 has been very tough for him and our family. For my part I often question whether or not my actions (leaving Seattle and him and his brother) led to his increased depression and psychotic break. Has his living with and reliance on me since 1999 handicapped him for the day when I am gone or can no longer care for him? Fortunately, John now has a good support team funded through state Medicaid that I believe could care for him absent my presence. He also has his mother and brother in Seattle who have long supported him and have assured me they would take care of him should I be gone.

In conclusion, I would like friends and family to know and understand what daily life is like for John and me and families that deal with similar medical issues. John has no friends, and his social interactions are limited to brief employment situations, family gatherings, and required interviews with medical and social services. What would his life have been like absent his illness? As his parent, I am plagued by anxiety, sadness, guilt, and worry for his future. This is despite being told often that I should not blame myself for his condition. Perhaps someday science will find a cure for schizophrenia.



Mental Illness 101

By Nancy Rudd

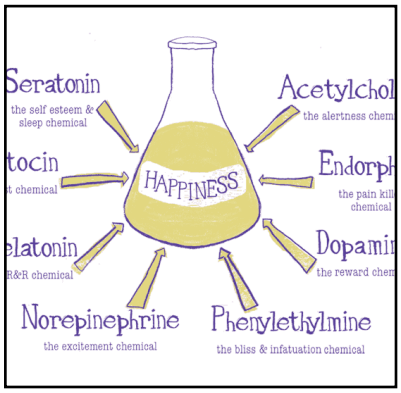
If you have ever had a situation that has felt as though it was too much to deal with, you might seek the care of a psychologist or a psychiatrist.

More than a quarter of American adults seek help for depression, anxiety, or another mental disorder. Others need help coping with chronic pain, a long term illness, relationships, and stress. Without the stigma of seeking help, many more adults might decide to see a professional to help them with the situation that has brought them to the precipice of their lives. Some never get the chance for help, and their life ends in suicide.

What causes the stigma of mental illness? If you have depression, chronic pain, or anxiety, society seems to say it's just a thing you have to deal with or buck up and get over it. When you go to a clinical physician, you are told that **you have the flu** or that **you have strep throat** or that **you have a broken arm.** When you go to a mental health professional and some clinical physicians, you are told that **you are depressed** or that **you are bipolar** or that **you are schizophrenic**. Changing the statement from **you are** to **you have** changes some of the concept of the mental health issue with which you are dealing. Your situation, whatever the mental issue, was not caused by you. It was caused by your brain and your body, just the same as illnesses for which you see you a clinical physician. Educating the public is another process to take away the stigma. Advertising and social media are valuable tools for this.

There are two main types of mental health professionals. A psychiatrist is a physician who specializes in the brain, its processes, and how they relate to mental healthcare, and can give prescription medication. A psychologist is a non-physician who has completed graduate studies in mental healthcare but can't dispense prescriptions. Whichever you choose, the counselor will help begin the process of working your way back from whatever your situation and give you hints to help with life and its stresses or give a medication that may help.

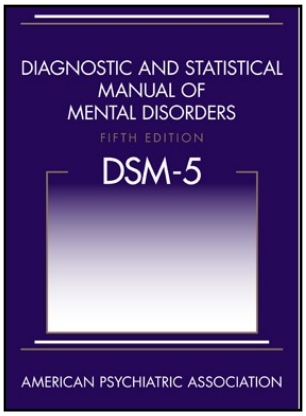
Since the brain is command central for the body, you would think that scientists would know more about how it affects our mental health. Scientists who study mental illnesses believe that an imbalance of chemicals in the brain contributes to many of these illnesses. Much more research needs to be done.



Brain chemicals tell us about certain mental illnesses, but depression and anxiety are the two that they point to most often. Some chemicals in the brain are

- Acetylcholine: Too much causes depression; too little will cause dementia.
- Dopamine: Too much causes schizophrenia; too little will cause dementia.
- Serotonin: Too little causes depression, some anxiety disorders, and especially obsessive compulsive disorder.
- GABA or Gamma-Amino-Butyric Acid: Too little causes anxiety and some anxiety disorders.
- Epinephrine: Too little causes depression.
- Norepinephrine: Too much will cause schizophrenia; too little causes depression.
- Adrenaline: Too much causes anxiety and anxiety disorders.

Do you think of addiction as a mental illness? Or is it just a matter of people who can't control their actions? Shouldn't they just use willpower?



The American Psychiatric Association uses the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) as the text they turn to in addressing all of the mental illnesses. It includes names, symptoms, and diagnostic features of each mental illness; the DSM-V includes addictions listed under "Substance Abuse Disorders." Substance abuse disorders are recognized for the following substances: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, cocaine, tobacco, and other unknown substances. Gambling is the first activity added to the list of addictions in the DSM-V.

Simplistically, there are three parts of the brain that deal with how we handle life. These parts of the brain and the chemicals involved tell us most about the mental illnesses of addiction.

The prefrontal cortex is located in the front of the brain behind the forehead. It is very underdeveloped in adolescents. This area is responsible for our decisions, organizing thought, controlling impulses, and emotions. When someone is addicted, glutamate is increased which disrupts the effect of dopamine. This turns down the impulse that would tell you to stop doing something and turns up the need to find the substance it needs.

The basal ganglia is located behind the prefrontal cortex. This part of the brain is the most active in addictions. This area is the place where you experience pleasure and rewards. This area is flooded with dopamine, making a person feel intense pleasure and euphoria (the high).

The amygdala is the part of the brain below the basal ganglia and just above the brain stem. This is responsible for stress, anxiety, and irritability. If you can't get the "fix" of the addictive substance, norepinephrine and another brain chemicals make you feel terrible.

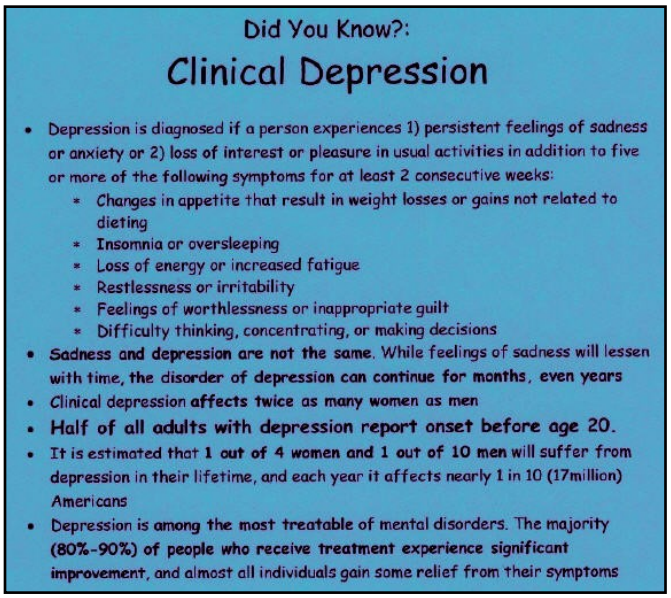
Obviously, having a mental health issue is not something we can just get over. Our brain and its chemicals play a major part. More study needs to be done to find out how other chemicals in our brain work to cause the other mental illnesses not covered here.

Surviving Clinical Depression

By Eric Grimsrud

According to the National Institute of Mental Health, an estimated 17 million adults in the United States had at least one major depressive episode in the year 2017. This number represented 7% of all adults in the U. S. In that year some 47,000 Americans committed suicide. Of these, about 90% had a diagnosable, curable psychiatric disorder at the time of their death.

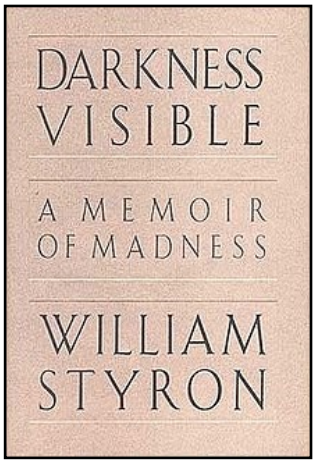
I have been visited a couple of times in my life by what's called clinical depression (CD). The term *clinical* is used to distinguish this very serious ailment from milder forms of depression which usually have some identifiable cause and, therefore, can be more directly addressed. The roots of CD in an individual are typically unknown however, and are



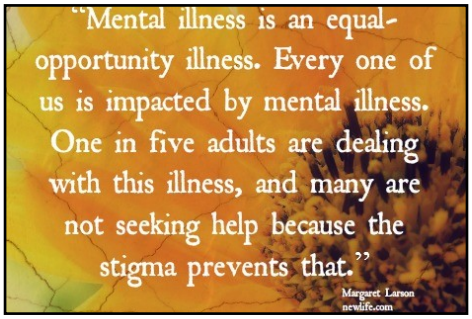
deeply embedded in far reaches of the victim's brain. Thus, the demons that constitute CD drive their victim toward a mental abyss while the victim doesn't understand what's happening. At the same time, however, it is well known that clinical depression can be treated so that the afflicted person can be returned to the mentally health sector of the human population. Most return to normal in this way, but too many do not—sometimes choosing the relief provided by suicide.

As a survivor of CD, I think I learned a few simple things that helped me overcome my own bout with the disease. During two periods of my life when I was in my 60s, the CD bug came upon me as a bad cold virus would—unexpected and strong—and each time persisted for nearly one year. In an attempt to defeat it, I increased my activities, both physical (running, walking, golf, tennis) and mental (reading, writing, speaking). Those efforts did not seem to help, however. My battles with dark thoughts and insomnia persisted. As many other victims of CD have said, I could no longer envision an escape from my mental state other than physical oblivion. My brain ached continuously, and I could not get sufficient sleep. When you get stuck in that hopeless state, you know that you have a full-blown case of clinical depression.

Not viewing suicide to be an acceptable solution, I kept trying to see my way through. Of the many things I did, the counseling provided by an excellent clinical psychologist helped a lot. Anti-depressant medications proved to be a mixed bag for me, often making me feel worse. In addition, I read a lot of literature about depression, and fortunately a friend sent me a short book, *Darkness Visible* by William Styron (author of *Sophie's Choice*), that was particularly helpful. In it, he describes his own battle with CD which included all of the stages I had experienced. The most important lesson I learned from his book was simply to believe that "I will be OK; I will make it," and that I should just try to "relax, be patient, and just let that happen," much like waiting for a bad case of the flu to leave your body. With flu you don't feel guilty for having contracted it and you also should not for contracting a case of CD. "Shit happens" and we have to roll with it even if we don't understand its origin. In my own case, the seeds of CD were possibly planted many years ago at age three when my mother died of breast cancer. I have been told that I had great difficulty in adjusting to the loss of her. But then, who knows what the real cause of my CD was, and furthermore that knowledge might not have even helped me heal myself.



Styron was an academic type like me and had been hit with the CD bug during his most active and most productive years—again, like me. Like me, he came to the conclusion that he had been randomly hit by the CD bug and that he had no control over that fact. Thoughts of this sort provided me with my first notions that I might eventually be OK. So I relaxed, waited for the bug to leave, and stopped tormenting myself with heroic efforts to "improve myself." Sure enough, the CD bug gradually left my brain. I didn't know why exactly but did not care; my escape from the demons of CD was sufficient reward.



About 10 years later, I am now very glad that I survived CD and look forward to undertaking the challenges offered by each day. In short, I think that I am now a mentally healthy person, with some 20 years possibly left in my already long life (75 years old). Equally important, my wife, four children, and six-going-on-seven grandchildren are also pleased that I once again am residing in the land of the living.

I hope this essay will be of some assistance to other victims of CD. Better still, I encourage such individuals to read William Styron's book and to know that there is, indeed, a light at the end of the tunnel even though you can't see it. Styron does, indeed, do a good job of making that darkness more visible.

America and Mental Health

By Bob Passi

One way to look at mental health is to think of the peacefulness of the mind. If there is some sustainable human core, then the mind is better able to make sense of the world and the environment in which it finds itself and allow it to recognize unhealthy trends in that environment. It also provides a solid center to nurture the resilience required to adjust and adapt to the everyday changes in that life.

Part of this description is about the environment in which the individual finds him/herself, and the other part is related to the internal resources available to deal with the realities of that environment as well as the changes that occur within that environment.

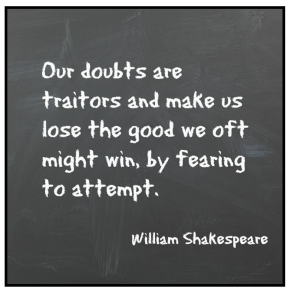
We all know about the environment in which most citizens find themselves in America today. It is an environment of great anxiety and insecurity. While we are told to fear external threats and terrorism, it is often the economic insecurities that are most pervasive and omnipresent. Whether those insecurities are about low wages, job insecurity, housing costs, educational costs, or retirement and health costs, they take a heavy toll on the individual through stress since we, as individual citizens, have little control over the factors that determine these issues. We are simply left to respond to whatever change is determined by those in the decision-making roles.

Not only that, we find ourselves living on a deteriorating planet with increasing degradation and pollution that show no signs of stopping.

It is understandable that many feel powerless about their lives, the lives of their loved ones, and their futures, as well as the future of the planet.

The context within which we find ourselves is an economic paradigm in which ordinary individuals are defined by roles as producers and consumers, to be used by that system in the most economically effective way to produce wealth for others.

What used to be the source of our resilience was a sense of internal worth as a human being, a spiritual heart and soul as a source of energy and hope. With so little emphasis and value being placed on those central elements of what makes human beings human, we are losing our way in a life that buffets us with changes that are about profit but no longer about people or life. We are reduced to economic units with little to no value except as the producers of commodities which can be monetized and turned into products and wealth.

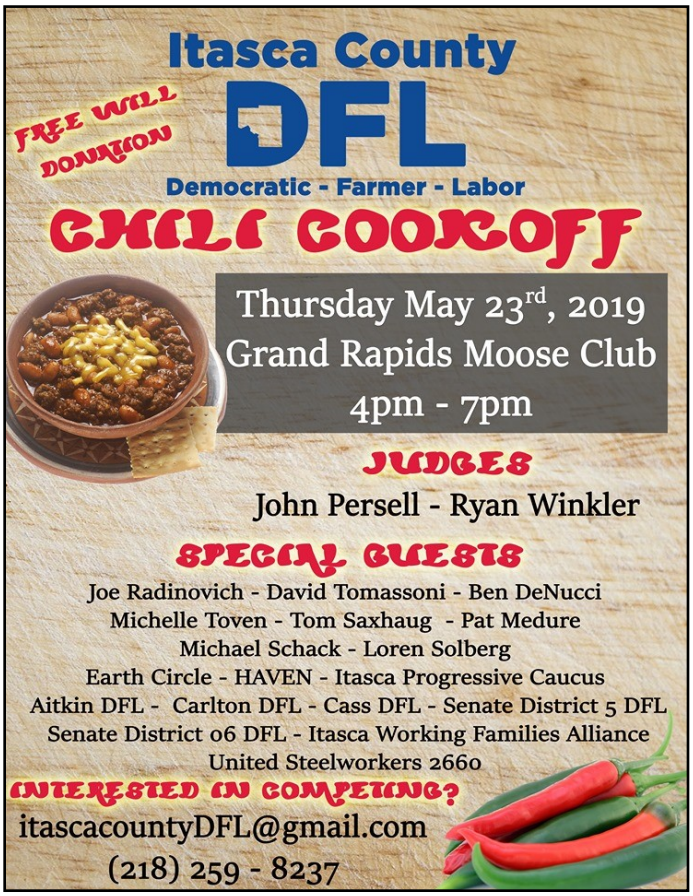


It is like taking the heart and soul out of life. Once you have removed that core, the heart and soul, the spiritual reality of life, you have hollowed out human life and stripped away the important basic resources which in the past provided a way to deal with such a heartless system. Add to that the continuing negative changes that are foisted not only upon the citizens of this nation but also upon the planet itself.

Ultimately the degenerating mental health of this nation—the craziness and even violence—is about the lack of value connected with the humanizing heart and soul of the people. If we define mental health as the necessity to find ways to accept the human degradation of this system, then mental health has been separated from human beings, and we become automatons to be programmed for whatever purpose is suitable to the prevailing system.

To try to adjust the human psyche to accept this kind of inhumane and soul-killing system is craziness itself. All the pills in the world will not make that adjustment anything but destructive to humanity, and it often simply represents an attempt to rewire human beings to fit the needs of the system.

This is an existential threat to the very defining characteristics of being human. We must rise and restore sanity before humanity is destroyed, or perhaps worse, changed into some unrecognizable form that serves the masters of wealth.



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Almost the Worst Call of Her Life

By Nancy Rudd

It was a Monday in June when she received the phone call. It was early in the morning. When she answered, it was her son. He was hundreds of miles away from home in a state university. He was bogged down in a summer session, taking more classes than he should have been. Why the adviser and counselors signed off on it she and her husband would never know. They had made their case against it.

She remembers answering brightly, "Hi, Honey. How are you doing?"

He answered, "Not really good, Mom. I have to tell you something. I spent last night across the hall with a friend. If I hadn't done that, I think I'd have killed myself."

She sucked in her breath then took a deep one. "Are you better now? Do you think that you're okay enough to drive home?"

She thought quickly about what he would have to do before coming home. She knew that he would be here for a while, maybe a long while. "Put enough clothes into a suitcase, give your perishable foods to your friends, lock up, and come home, but drive carefully. You're sure that you're okay to do that, Honey?"

He was quiet for a moment, and her heart pounded in her chest. He told her, "Yeah, I can do that, and Mom?"

"Yes, Honey?"

"Thanks and for not freaking out or anything."

"No problem. You know that I love you."

"Love you, too, Mom."

Four hours later, he pulled into the driveway. They met each other halfway, arms opened, enveloping each other in a long, tight hug. Tears were running down both of their faces as they rocked back and forth. Neither wanted to be the first to let go. Somehow, one of them did. With their arms around each other, they walked into the house, wiping the tears from their eyes. She brought two glasses of water to the sofa so that they could talk.

She began, "First, I'm SO happy that you didn't go through with suicide and that you were brave enough to tell me the truth. Second, you have to make a choice. I'll give you the names of two physicians that you know. You pick the one you'd feel more comfortable talking to about this, and we'll get you into to see him."

He responded, "I had to tell you. I know that you've had problems with the pain from your surgeries. You told me how hard it was to go ask for help, but you did. I knew that you would understand and know what to do."

The rest of the summer was filled with long talks with both his mom and dad. He was taking antidepressants. His mom was working with his adviser and his counselors about how to finish up his degree. The most important thing, he would tell his parents later, was that they didn't judge him. He graduated *Cum Laude* in the fall of the year and went on to get his masters in computer engineering. He graduated *Summa Cum Laude*, number one in his class from a private university. His parents couldn't be prouder!

This is a true story. Suicides among young adults is on the rise. In the United States among people ages 15-34, suicide is the second leading cause of death. It's not just a mental health issue; it's become a public health issue. Suicide is not just for the mentally ill, and it can happen to anyone struggling with serious problems.

In this case, there was an open dialog between the parents and their son. Remember that teens and young adults can see problems and issues as a bigger than life crisis. Don't judge our kids too much. A friend who seems to be a bad choice by his looks may be an okay person once you get to know him. Have rules, but be reasonable. Let your children know that they can talk to you about anything. Tell them that you can discuss things, and you won't lecture. Then keep that promise—no matter how frustrating it is. Each family and each situation is different.

CALENDAR OF EVENTS—GET INVOLVED AND GET IT DONE!

Event	Date /Time	Location
DFL Headquarters Open (326-6296)	Tues & Thurs 2-5 pm	DFL Headquarters
Itasca Progressive Caucus (259-4490)	3rd Monday 6:30 pm	DFL Headquarters
DFL Central Committee Meets	4th Monday 6:30 pm	DFL Headquarters
DFL Social Club & Lunch	1st Wednesday Noon	DFL Headquarters
DFL Pot Luck (Open to the Public)	3rd Wednesday 5:30 pm	DFL Headquarters
Earth Circle	3rd Saturday 2:00 pm	GR Public Library
Itasca Working families Alliance	2nd Monday 6:30 pm	Dutchroom
Itasca Indivisible	2nd Tuesday 7:00 pm	Dutchroom
GR Human Rights Commission	Last Wednesday 4:00 pm	GR City Hall
GR Healthcare for All	1st Thursday 5:00-6:00 m	DFL Headquarters
Circles of Support	Every Thursday 6:30 pm	811 NE 4th St.
Deadline for *Common Sense II*	June 7, 2019	conray@arvig.net