"Education" MDDA "Support"

The Thermometer Times

Published by The Manic Depressive and Depressive Association of Riverside, California

VOL. 10 NO. 11 | Out of darkness . . . | November 2000

Dates to Remember

****

RAP GROUPS

Clients and their guests are invited to come and participate. Professional care providers are always welcome.

Saturday, November 11

Saturdays 18, and 25
10am–12 noon
Riverside County Mental Health Administration Building
(see page 9 for address)

Thanksgiving Dinner
at JoAnn's
Noon, November 23

IT IS ESSENTIAL TO BE ON TIME in consideration for others in the group. In fact, please come early to socialize, sign in, or help set up the room.

Directions to Jo Ann Martin's Home

Exit 91 Frwy at Van Buren. Go south 4.2 miles on Van Buren to Whispering Spur. Turn left.

2nd driveway on right

16280 Whispering Spur,
Riverside, CA 909/780-3366

Parenting and Bipolar Children

Timothy McRae, M.D., spoke to the Tampa Bay Depressive and Manic Depressive Association on June 13, 2000. Dr. McRae is board certified in psychiatry and has a private practice in Tampa.

Approximately one person in a hundred will develop some form of bipolar illness, a genetically and environmentally determined, lifelong but treatable illness. The most dramatic form of this disorder is called Bipolar I. These people experience full blown manias with psychotic features (losing touch with reality) and the risk for this form is approximately 1/1,000 people. Bipolar II encompasses a range of bipolar disorders that usually manifest as cycles of depression and hypomania, that is, less severe manias that do not result in psychosis. Although the manias are less severe in Bipolar II, the depressions are very severe. In all forms of the illness, it is three times more likely to be present with an initial depression than with a manic episode. The time of life that these disorders tend to first be diagnosable is the late teens to the early 30's in both males and females.

The initial symptoms of bipolar illness may vary a great deal and children generally do not present the more typical patterns of adults. Children with early bipolar disorder usually present mixed states and rapid cycling, rarely with a clear manic or depressive episode. They are much more likely to have dysphoric hypomania, a mixture of depressive and manic symptoms simultaneously, such as being chronically unhappy but having a higher than normal energy level. Also, they often have monumental tempers and problems with aggression.

In all forms, bipolar illness is a life-long condition. Our genes, early life, coping mechanisms and major stressors all affect how the illness progresses, and medications are the primary method of keeping the illness under control. There is a tendency over time, for the illness to level out with fewer episodes. In predicting the course of the illness, the previous 2-3 years is usually indicative of the next 2-3 years,. assuming that there are no major stressors such as a death in the family, major relocation, or environmental catastrophe.

Deciding whether a child has bipolar illness or ADD (Attention Deficit Disorder) is. according to Dr. McRae, "the most vexing differential diagnosis in child psychiatry." The symptoms of both can be very similar and infrequently a child may have both. When a child's "center of the universe" mentality persists inappropriately and unreasonably past 4 to 5 years of age, and when that child is also hyperactive, aggressive, and has temper tantrums, the diagnosis may not be resolved for years. Dr. McRae states: "The most important diagnostic tool is the history." When information is conflicting and the full picture is not clear, re-examining across time is what eventually clarifies the picture.

The younger that a child develops symptoms of bipolar disorder, the worse the symptoms tend to be. Parents want to see their own children as "normal" and may unknowingly apply changing parameters of "normal" behavior in order to see their children as being well. Once these children start to spend more time in the community at around 3-4 years of age, they are observed by preschool teachers and daycare

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Parenting (continued from page 1)

staff who see the behaviors of these children compared to that of their peers. It is often this input from outside the family that eventually persuades the parents that there is need for evaluation.

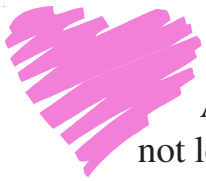
A typical presentation for early childhood bipolar illness is very similar to ADD or ADHD. Both disorders are often manifested by hyperactivity, temper, aggression, and problems in school. The initial visit to a psychiatrist's office is frequently because of disruptive behavior, learning problems, or lack of appropriate achievement despite being bright. Most clinicians would diagnose a child of four with ADD rather than bipolar disorder. Statistically, ADD is more likely to be correct to the relief of the parents. Eventually, the bipolar children will demonstrate greater severity of symptoms and less response to the medications used for ADHD, such as stimulants. Many are successfully medicated with stimulants and mood stabilizers. Although the stimulant medications (such as Ritilan) may result in a worsening of hyperactivity, more bipolar children do well on them than do poorly.

Bipolar children are immensely hyperactive and some require very littie sleep. Dr. McRae recalls one mother telling him about her 4 year old child who was up at night removing the locked kitchen cabinet doors.

Dr. McRae spoke of parenting issues for parents of bipolar children: "All of our struggles are much more similar to each other than they are different from each other. It is a matter of degree. Those of you with bipolar kids certainiy have a different situation in parenting your child than a neighbor whose child is not bipolar." It is essential that children learn to do as much for themselves as possible. For individuals to grow, function well, and be capable of living successfully, they must gain a sense independence and self-esteem. Parents need to not only provide for their children, but to allow and encourage children to do what they can do. Kids will not learn if the parents always intervene to make life "easier". Some of these children will need more help than others. Regardless of the severity of the illness, it is important to assume that they will grow up and become independent; they need to be given this chance.

According to Dr. McRae, "one of the things that begins to give a clear picture of whether the diagnosis is ADD or bipolar disorder is the issue of temper." There is a difference between a child becoming angry and one who "loses it." When a child loses a rational grip on what is happening, parents describe a glazed look on the child's face, or say that his face gets so red that it is purple, he doesn't hear us, or he is out of control. Children with bipolar

continued on page 3 (Parenting)



A thousand words will
not leave so deep an impression
as one deed.

–Henrik

The Thermometer Times

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Parenting

(continued from page 2)

disorder can tend towad t;his "extraordinary, sky-rocketing, literally dangrous temper". They don't hear their parents when in this state and they will not stop when told to do so. When verbal commands are not effective, shift to a non-verbal approach of containment. The child needs to be protected from hurting himself or others and to be removed to a time-out room. By setting clear limits, parents are letting the child know when he has gone too far and will be removed to a time-out area. One minute per year of age is an appropriate gauge for the amount of time.

A time-out room needs to be small and safe, if possible. The child's bedroom is not an effective area for time-outs because it is the room that has intentionally been made interesting for the child. Sending the child to his room does not result in isolation and discipline. Bathrooms are not good because of all the dangerous hard surfaces and chemicals. No one has a padded room in their house, but there needs to be some area that will suffice for containing a child that is out of control. It is important to find methods that work to maintain safety in the household. As children grow and become teens, states Dr. McRae, "older rage is hormone driven and worse." These unsafe situations need to be addressed and resolved early to prevent future more dangerous scenarios. Male bipolar patients that are grown and living at home and not taking responsibility for their illness and treatment are often a problem. When a person is a danger in a household, they must be removed. In-patient admission is an option for the short-term.

Regarding treatments for bipolar illness in children, Dr. McRae states: "Medicine is virtually always necessary " Mood stabilizers and antidepressants are used as well as several of the newer, atypical antipsychotic medications such as Risperdal and Zyprexa. Used as add-ons to other rnedications, they enhance mood stability and temper control.

Jane Trilling

Source: Tampa Bay Depressive and Manic-depressive Association Newsletter Oct./Nov. 2000

Coming of Age of the Bipolar Spectrum International Conference

Presented by

International Mood Center
University of California San Diego
Department of Psychiatry
School of Medicine

November 18-19, 2000
U.S. Grant Hotel
San Diego, CA

For further information:
Ms. Patricia Turpin
http://psychiatry.ucsd.edu
Phone: (858) 534-2541 - Fax: (858) 534-2541
UCSD Psychiatry/Bipolar Conference
9500 Gilman Drive
La Jolla, CA 92093-0603

Winning the Race Against Depression

by Robert Lipsyte

Excerpted from an article by Robert Lipsyte
***The New York Times,* May 21, 2000**

Down the black hole of Julie Krone's depression four years ago slipped her career, marriage, friends, even the thoroughbred racers she once drove with flicks of her powerful little hands.

"Horses felt my anxiety, they got weird, they reared up," she said last week in a torrent of memory. "I had been given a magical talent to positive-image a loser right into the winner's circle. I had been possessed; I could pick a horse up with my will and put it right down in front. And then suddenly it was all gone, and I was exhausted."

The magic eventually returned.– in April, Krone became the first woman rider elected to racing's Hall of Fame. She "takes the pioneer responsibility with pride," which is a reason, she said, for also becoming the first major athlete in any sport to speakso publicly and openly abut mental ilnness, psychotherapy, and antidepressants.

At the American Psychiatric Association's annual meeting in Chicago, Krone was the star of a provocative symposim on psychiatric drugs and athletes spaonsored by the International Society for Sport Psychiatry – Krone, happy in the limelight afain, vividly described the painful dilemma of elite athletes whose socialization makes them hesitant to seek help.

Typically, she resisted therapy even after anxiety attacks, migraines, sleep and

continued on page 4 (Winning)

IMPORTANT!
ALWAYS TELL YOUR DOCTORS ABOUT ANY CHANGES YOU THINK SHOULD BE MADE IN YOUR MEDICATION ROUTINE. DO NOT TAKE HERBS OR OVER-THE-COUNTER DRUGS WITHOUT YOUR DOCTOR'S KNOWLEDGE

Winning (continued from page 3

eating disorders had turned her into a recluse and a loser. She resisted medicine even longer.

"I'm a jock," she said. "I can do anything on my own. I thought it was humiliating to get help. Meanwhile, the only real relief I felt was planning my suicide. I saved sleeping pills, but I was going to drink alcohol, slit my wrists and maybe hang myself, too. I wanted to do one thing right."

Krone, 36, had won a lot of things right from the age of 15, when she first began a 19-year professional riding career that took her to the winner's circle 3,545 times until she retired last year.

She won $81 million, 16th on the career earnings list. She was the only female jockey to win a Triple Crown race, the Belmont Stakes in 1993 aboard Colonial Affair.

On January 13, 1996, she was tied for leading rider at Gulfstream Park when her horse broke down in the middle of a race and pitched her off. Rolling on the turf, she covered her head with her hands, which were broken.

"It fried me," she said. "I couldn't talk. The straw didn't break the camel's back, it gutted the sucker, left the camel dead. I was numb, couldn't think, I was afraid of horses, hated riding.

"My husband said: 'Get back in there, you're tough, that's what I love in you,' which is about the worst thing the closest person can say to someone who is depressed. And typical."

Six weeks later, she was back in there, but her mending hands were on fire and her brain was feverish with flashbacks and fears. Walking to the barns she imagined her execution. When she vomited before she rode, it was anxiety, not weight control. . .she heard voices telling her she was giong to fall off, die, mess up, which she often did, her nerve and authority gone.

It was an almost causual encounter with an old friend that summer, a racing fan with a psychiatric practice in Saratoga Springs, N.Y., that began her healing process. She shambling across the backstretch after another loss, her signature bopping bounce long gone, when Dr. Qualtere invited her to come talk to him.

She began seeing Dr. Qualtere four times a week, eventually driving from Belmont to Saratoga. But she rejected his suggestion that she try a psychiactric drug. Talking to a shrink, she felt then, was enough of an admission of weakness.

Krone's descrption of her early therapy includes – a remarkably bold willingness to use the term "mental illness," (a willingness) which is extremely rare among athletes. When she moved to central New Jersey two years ago and could no longer make the frequent trip to Saratoga, she picked a Red Bank, N.J. psychiarist Dr. Furey A. Lerro, off the Internet because his first name was the same as a horse she liked. It was Dr. Lerro who put her on antidepressants.

"I picked Zoloft," he said, "because some of the others take longer to clear from the body, not good if she had a reaction while racing, and the tendency to sedation, which is also not good for a jockey."

According to Krone, she felt manic the first three days on the drug, then suddenly felt "anchored, back to Julie Krone again. I'm not sorry I didn't start the medicine sooner–I needed to first get to a place in talk therapy."

She said: "You don't fully realize how wierd it was until you have yourself back. I'd been spending the minutes before a race using all my energy to defeat an anxiety attack, and now, well, listen to this. At the end of last year, in a 60-day period, my mother died, I got divorced and I moved to California. And I'm here, I'm O.K."

Source: Life in Balance
MDDA Detroit, October 2000

What Do These Famous People Have In Common?

Gioacchimo Rossini	Composer
Philip Roth	Writer
John Ruskin	Writer
King Saul	Biblical Figure
Charles Schulz	Cartoonist
Robert Schumann	Composer
Delmore Schwartz	Poet
Alexander Scriabin	Composer
Jean Seberg	Actress
Sabatini Sevi	Messiah figure
Anne Sexton	Poet
Mary Shelley	Author

All of them are believed to have suffered from depressive disorders. Yet they are known not for their illnesses, but for **their achievements!**

Ziggy **By Tom Wilson**

Who Are You?

Sandy would like to interview members for a brief personality profile that we can publish in *The Thermometer Times.* If you would enjoy participating in this, please call her at 688-0368.

Casting Shade: SAD

NAFDI News, Fall 1999

As the days grow shorter, many people encounter the "winter blues"–lethargy, gloom, craving sweet and/or starchy foods, difficulty getting up in the morning. People who suffer from Seasonal Affective Disorder (SAD), experience this acutely. For an estimated 10.8 million North Americans, the urge to "hibernate" makes it impossible to function normally.

They may increase their sleep by several hours, gain many pounds and feel sluggish and asocial. Women with SAD often suffer a worsening of premenstrual symptoms. However, all these troubles are relieved with the coming of longer days and more light–some even experience a hypomanic or manic summer state.

For treatment, Dr. Michael Terman of the Winter Depression Program at the New York Psychiatric Institute told us that "current evidence strongly favors exposure to bright light in the morning." This is known as Light Therapy–exposure to intense levels of light under controlled conditions.

Dr. Terman cautions that it is difficult to quantify success rates across studies that have used different intensities and durations of light, but estimates that "about 80% of people with simple winter depression show significant benefit from Light Therapy. . .almost 50% (of sufferers) experience complete remission."

The most common form of treatment is via a light fixture that gives off bright, diffused light. The individual sits in front of this light box, which contains broad-spectrum fluorescent lamps behind a diffusing screen, for a session of 15 minutes to one hour, once or twice a day. One need not look directly at the light, but read, write, eat or carry on other activities while facing the light fixture.

This treatment has few, if any, side effects, and those often abate on their own. Most common complaints are of mild nausea, headaches, eyestrain, irritability or overactivity. Adjusting the duration, intensity and/or time of day of treatment usually mitigates these symptoms. Light therapy has been in use since the mid-80s and there are no known side effects to long-term use.

There are several manufacturers who produce light boxes in various models. The price runs from $200 to $500. This may be reimbursed by insurance, with the proper diagnosis and prescription from a physician, although coverage is unpredictable. (Please note that tanning lights or "grow lights" should not be used as their ultraviolet levels can be harmful. Homemade light fixtures are also often dangerous.

Other strategies for managing SAD include use of antidepressants.

According to the Center for Environmental Therapeutics, Inc., these are measures you can start before winter, to help prevent these doldrums: get outdoors for at least 30 minutes during the day; increase the general light level indoors; eat complex carbohydrates (whole grains) instead of foods with simple sugars (sweets, refined grains); avoid dehydration–drink water; exercise, outdoors if possible; monitor your moods to be aware of patterns that may connect to the sea-

continued on page 6 (SAD)

I Know
by Kurt Sass

Source: *Moods*, Newsletter of the Mood Disorders Support Group, New York 2000, No. 3

I know my son, who is mentally retarded, lives in a group home not because of his disability, but because I couldn't handle him.

I know my wife's life would have been much better if she had married someone more stable than I.

I know I must be insane since I've needed over 20 shock treatments so far.

I know God has it in for me.

I know my entire life has been a waste.

I know I am the weakest person on the planet.

I know I have disappointed everyone close to me.

I know I am a pussy for not having the guts to kill myself.

I know I am a curse to myself and everyone around me.

I know my son is retarded because of something I did.

I know I deserve everything I get.

I know that murderers as well as people who abuse their children live happier, more contented, and more peaceful lives than I, and have less guilt.

I know I am being punished for something I did in a previous life.

I know it would be better for everyone if I had never been born.

But then. . . .just like that. . . . .

My latest major depressive episode starts to lift and

Reality returns,

Thank God.

Riverside Suicide Crisis Help Line
Call
(909) 686-HELP
[686-4357]

SAD *(continued from page 5)*

sons, medications, and/or changes in diet and be gracious to yourself.

These measures behoove anyone and may be sufficient to manage a mild case of SAD. However, if you seem seriously impaired in mood on a seasonal basis, seek treatment.

Source: The Rollercoaster Times September 2000

Physicians Urged to Screen Teens for Suicide

By Michelle Beaulieu
***Reuters Health*,**
Arch Pediatric Adolescent Med.,
Feb. 18, 2000

Fewer than one quarter of US pediatricians and family physicians who see adolescents regularly screen this population for risk factors associated with suicide–the third leading cause of death in this age group.

Yet 47% of physicians surveyed reported that one or more of their adolescent patients had attempted suicide in the past year, according to Dr. Diane L. Frankenfield, formerly of Johns Hopkins School of Public Health, in Baltimore, Maryland, and colleagues.

The investigators surveyed nearly 600 pediatricians and family physicians regarding adolescent suicidal behavior, risk factors and screening in their practices. Only 23% of the physicians reported that they routinely screen their adolescent patients for risk factors for suicide.

Physicians who did screen routinely were significantly more likely than others to counsel their patients about the safe storage of firearms and child passenger safety. The same group was more likely to believe that they were adequately trained and knew how to screen for suicide, that they had sufficient time to screen for mental health problems during routine clinical encounters, that physicians can play an effective role in teen suicide prevention. This group was also more likely to spend "more than 5 minutes in anticipatory guidance during the well visit," and to be women.

Many physicians said that they needed or would be interested in more training about teen suicide and screening for risk factors. "The most frequently mentioned topic would be referral options. . .(including) more training in how to identify problems and refer patients on to more specialized care," Dr. Frankenfield told Reuters Health, since pediatric and family physi-

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Alliance Library

1215 N. Buena Vista
Suite K
San Jacinto, CA

Open 1p.m. to 3 p.m.
Tues., Wed., Th., Fri.
654-7569
927-2546
658-5335
927-5642

The public is invited to check out books, videos, audio tapes and materials on emotional disorders, their causes and treatments. Education and knowledge are powerful tools to understanding and compassion.

From Florida Ave., go north on San Jacinto Ave. to Esplanade. Turn left. Turn right at Buena Vista. Continue to the end of the street, turn in to the driveway. Suite K.

Phone Phriends

If you need someone to talk with, you may call one of the following members at the corresponding times.

Leroy
6 a.m. to 9 p.m.
(909) 686-5047

Sandy
3 p.m. to 9 p.m.
(909) 688-0368

Josie
10 a.m. to 9 p.m.
(909) 822-1928

Donna
10 a.m. to 9 p.m.
(909) 736-9665

Georgia Ann
6 a.m. to 9 p.m.
(909) 352-1634

Marlene and George
Before 9:30 a.m. and from 8 p.m. to 12 midnight
(909) 685-6241

Family/Friends Support Group

Riverside Co. Dept of Mental Health

JOURNEY OF HOPE

Second Wednesday of
Each Month
2–4 p.m.
Hemet Mental Health Clinic
1005 N. State Street, Hemet

and

Third Wednesday of
Each Month
6:30–8:30 p.m.
Meadowview Clubhouse
41050 Avenida Verde,
Temecula

These support groups are for families and friends of people with severe and persistent mental illness. The County is also offering a 12-week series of educational meetings. There is **NO COST TO YOU.**

Please contact:
Camille Dirienzo-Callahan
(909) 791-3369 or
Mekkia deSanchez
(909) 600-5055

Teens *(continued from page 6)*

cians tended to view themselves as gatekeepers rather than primary providers of mental health services.

A major barrier to screening teens for suicide risk factors in the clinical setting is confidentiality, Dr. Frankenfield said. She advises physicians to "get across to these kids that 'whatever you tell me will be confidential'."

Another important barrier to screening is "competing demands," the study director said. Because physicians tend to have several topics they need to cover during routine clinical encounters with adolescents, screening for suicide may be passed over.

The use of an easily scored "screening form that the adolescent and/or parent would fill out while they're waiting to see (the physician)" could help relieve this burden, while easily identifying patients who may need to be probed further about suicide risk factors, she suggested. Alternatively, it may be possible to use ancillary healthcare personnel for screening rather than physicians themselves.

"We know that most kids do see physicians once a year," Dr. Frankenfield told Reuters Health. "We don't want that to be a missed opportunity."

Source:Moods Gazette
DMDA of Humboldt County
Summer 2000

from "Ask the Doctor"
with Dr. Ivan Goldberg

Q. I have treatment-resistant rapid-cycling biplar disorder. My doctors suggested I take Mexitil. What is it and why is my doctor suggesting it?

A. Mexitil (also known by the generic name mexiletine) has been available in the USA since 1985. It was used to treat people with distubances in the rhythm of the heart. Recently, however, Mexitil has been used successfully for treatment-resistant bipolar disorder. Patients with rapid cycling and mixed states seem to respond best. Side effects of Mexitil include nausea, lightheadedness, tremor, nervousness and coordination difficulties. About half the patients I've treated with Mexitil significantly improve. For further information about Mexitil, see: http://www.ncbi.nim.nih.gov/entrez/query.fcgi?cmd=Retrive&db=PubMed&list-uids=10708839&dopt=Abstract

Source:Moods, Newsletter of the Mood Disorders Support Group, New York, 2000, No. 3

Preventing the Holiday Blues

Adapted from an article by Belinda Terro Mooney, ACSW, LCSW
October/November 1998

Many of us experience feelings of sadness around the holidays. The holidays blues come in many different rhythms and degrees of sensitivity. Memories of past losses, alienation from one's family, uneasiness in certain social situations, physical fatigue and a variety of other factors combine to make the season stressful. The holiday blues don't necessarily lead to clinical depression, but they can throw us off balance and out of step. Here are some suggestions for coping.

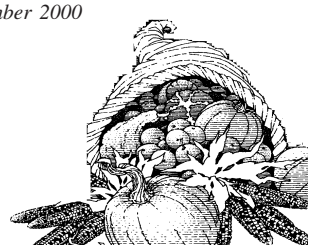
1. Before the holidays arrive, closely examine any feelings you may have about past losses or deprivations and do what you can to make peace within yourself. Plan ahead how you'll respond to these feelings should they arise in whatever seasonal situations you'll be facing.
2. Structure your time. Lack of planning can lead to lonliness, boredom and feelings of abandonment and rejection. Make holiday commitments after you decide what you'll do for yourself this season.
3. If you don't already keep a journal of your emotional life, this is a great time to begin. Keeping in touch with your feelings on a daily basis will help you embrace problematic moods of sadness or irritability before they can swell into depression.

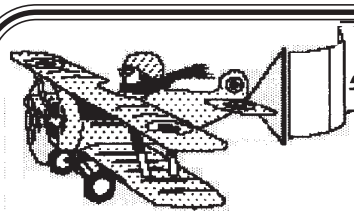
continued on page 8 (Blues)

Blues *(continued from page 7)*

4. Reduce the "ordinary" stressors you've been carrying all year. Take some time out to survey the overall causes of stress in your life, determine how these can reduced, and follow through.
5. Schedule regular times for exercise and relaxation. You'll gain energy and raise your ability to handle the season's increased activity and excitement.
6. Don't get involved in everything! Gather information about parties, gatherings and public events ahead of time and stay away from those likely to cause you stress, whenever possible. Dare to say "No," even for no other reason than feeling uncomfortable, ambivalent or uncertain about how you will fare in a given situation. If alcohol is an issue for you when accepting invitations, try learning the recipes for a few of the delicious non-alcoholic drinks available these days and offer your help to your host in providing them.
7. Ask ahead for the support of special friends in situations where you're vulnerable. Taking time to understand and accept your feelings will give you the confidence to call on your friends when you need them. Schedule time with trusted friends to balance out or compensate for those relationships or holiday rituals that carry a high level of emotional risk.
8. Pay attention to your inner signals, but don't overreact. If you're reading persistent signs of depression, take action. Attend more support groups; call a friend; consider seeing your therapist or psychiatrist if the situation calls for it. Anticipating the steps you can take at each level of emotional difficulty will help you avoid an anxious downward spiral.
9. Take heart! Beauty and mystery are all around us this time of year, although our moods may conceal them. Keep returning to the deeper meanings of the season, and you'll gain the perspective you need to deal gracefully with the disappointments.

Source: The Initiative, DMDA,Colorado Springs, October-December 2000





ANNOUNCEMENTS

THE UPLIFTERS
(Christian emphasis) meets at
Victoria Community Church
Contact Arlie (909) 780-0379

UPLAND DMDA
FONTANA DMDA
Meet Thursday evenings
Call David or Samantha Johns
(909) 947-1307 OR
e-Mail dmjbf@aol.com

UPS & DOWNS - Riverside
Call Family Services at
(909) 686-3706

HEMET SUPPORT GROUP
"Foundations" meets every
Monday and Tuesday 7–9 pm.
Trinity Lutheran Church
Please call (909) 929-1223

TEMECULA DMDA
Meets every Tuesday 11 am–1 pm.
41002 County Center Dr.
Contact Mark at (909) 696-7496
or (909) 507-1365

UPS & DOWNS - San Bernardino
Meets Saturdays at Noon–2 pm.
Call David Avila at (909) 862-1096

UPS & DOWNS/DMDA - Highland
Meets Wednesdays 7–9 pm.
St. Adelaide Church - Ministry Bldg.
27457 E. Baseline (at Palm), Highland
Call David Avila at (909) 862-1096

For Support People: AMI - Riverside Mental Health Administration Building, 4095 County Circle Dr. (off Hole Ave. near Magnolia) 7:30 pm, 1st & 3rd Monday each month (909) 737-5747 (call FIRST)

If winter comes,
can spring be far behind?
–Percy Bysshe Shelley

California Network of Mental Health Clients Annual Conference

December 2nd and 3rd
at the Marriot Mission Valley Hotel
For more info: 800/626-7447

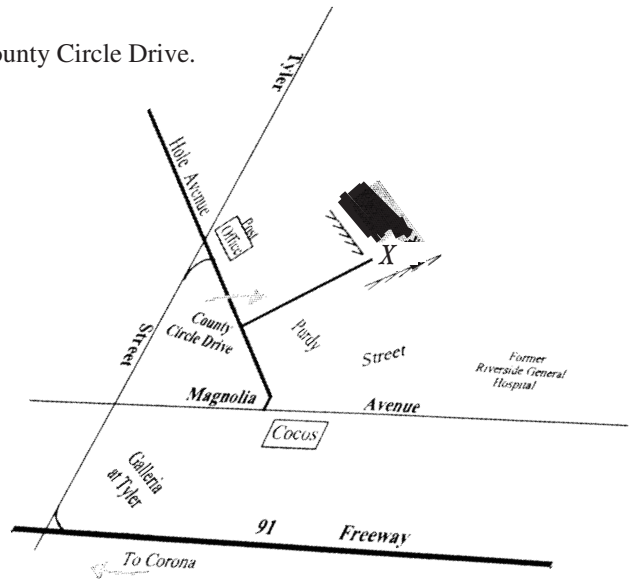
ORIGINAL MATERIAL WANTED

Do you have a story to tell,
or a poem or art work?
We welcome submissions
to our newsletter.
If you have something you think
we could use, please send it to:
EDITOR
MDDA P.O. Box 51597
Riverside, CA 92517-2597
FAX 909/780-5758

MDDA of Riverside
Map Legend

= Meeting Location
= Parking

Buses 1 and 13 stop on Hole near County Circle Drive.
Bus 12 stops at Tyler and Hole



ABOUT MDDA

MDDA Of Riverside is a support group for manic-depressives and depressives who have sought or are seeking treatment for their illness. MDDA is totally patient run, which means we need volunteers like you to help with mail-outs, telephoning and planning. A work time is held at the home of Jo Ann Martin on the Saturday afternoon following the last Rap Group Meeting of each month to assemble the newsletter for mailing. Directions are printed on the lower left corner of the front page of this newsletter. You may reach Jo Ann or Leroy at (909) 780-3366. Our Rap Group Meetings are on the second, third and fourth Saturdays of the month from 10:00 a.m. to 12:00 noon at the Riverside Mental Health Administration Building, 4095 County Circle Drive (off Hole Avenue near Marnolia), Room A.

MEMBERSHIP INFORMATION

Individual membership for the Manic-Depressive and Depressive Association of Riverside is $15.00 per year. This helps defray the cost of the monthly newsletter and helps pay for the cost of our meetings. Subscription to the newsletter is $8.00 per year. If you are unable to help financially, the newsletter may be sent upon request. Volunteers are always needed. If you would like to volunteer, indicate below.

Mail to MDDA of Riverside, 16280 Whispering Spur, Riverside, CA 92504

DATE _____ ✍ Please Print ❒ New ❒ Renewal

NAME _____PHONE _____

ADDRESS _____ZIP_____

Please check one of the following:
I am ❒Manic-Depressive ❒Depressive ❒Family Member ❒Professional

❒ Other Birth Date (Optional) : Month _____ Day _____ Year _____

Enclosed is my payment for MDDA Membership _____ $15.00 (includes newsletter).

Enclosed is my donation of $ _____ to help others receive the newsletter.

I would like a subscription to the newsletter only. ❒ $8.00 (12 issues per year).

I would like to volunteer my time and talent to help. ❒