"Education" MDDA "Support"

The Thermometer Times

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

VOL. 10 NO. 5 | Out of darkness . . . | MAY 2000

Dates to Remember

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RAP GROUPS

Saturdays May 13, 20, and 27
10am–12 noon
Riverside County Mental Health
Administration Building
(see page 9 for address)
10 am–12 noon
and Tuesday May 9 7 pm
at JoAnn's

NO EDUCATIONAL MEETING this month

Memorial Day Picnic at JoAnn's
1 pm May 27
Bring swim suit & towel
Food to share
Musical instrument (optional)

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

Pushing the Mood Swings

Social and psychological forces sway the course of manic depression

Manic depression, also known as bipolar disorder, has a well-deserved reputation as a biologically based condition. Wayward brain chemicals and genes gone bad seem to bully people back and forth between weeks of moderate-to-intense euphoria and comparable spells of soul-deadening depression. A few weeks of relative calm often separate these disparate moods.

Manic depression, however, may nurse a more sensitive side. Its intense mood swings increasingly appear to reflect a variety of social and psychological influences.

Research finding such relationships raises hopes that new forms of psychotherapy may improve the treatment of bipolar disorder. "This illness wreaks havoc with what makes us most human—our attitudes, our relationships, how we feel about ourselves, and our ability to trust our judgments about those closest to us," remarks Thomas A. Wehr, a psychiatrist at the National Institute of Mental Health in Bethesda, Maryland. "Even though it's tough to go through, psychotherapy makes sense as a way to understand this condition."

Until recently, treatment hopes largely rested on biological investigations. When tools for genetic analysis emerged around 15 years ago, making it possible to link signature pieces of DNA to specific illnesses, researchers quickly took aim at manic depression. Its tendency to run in families makes it a promising target. Although investigations have yet to identify genes that contribute to this mental condition, the search area has narrowed considerably.

Whatever its biological basis, manic depression shows remarkable tenacity. Only a small minority of bipolar patients who improve on psychiatric medications avoids a return of mania or depression in the ensuing 5 years. As many as one-fifth of the estimated 3 million people in the United States who develop bipolar disorder eventually find the emotional ride intolerable and kill themselves.

Treatment with lithium carbonate or any of several other drugs helps to even out the emotional peaks and valleys for about two-thirds of people with bipolar disorder. Ironically, the leavening of intense feelings causes up to one-half of these drug responders to stop taking medication at some point. None longs to plunge back into depression's cold waters. Yet many crave mania's intoxicating pleasures, such as heightened creativity and a sense of unbridled potential.

Repeated forays into both mania and depression, however, lay waste to marriages, friendships, and other social ties. Moreover, people with bipolar disorder frequently observe that the quality of their close relationships affects their moods. In many cases, whether or not medication helps, bipolar sufferers seek psychotherapy in hopes of gaining insight into their volatile lives.

"Lithium ... makes psychotherapy possible," says psychologist Kay Redfield Jamison of Johns Hopkins Medical Institutions in Baltimore in *An Unquiet Mind* (1995, Alfred A. Knopf). "But, ineffably, psychotherapy heals."

Pushing *(continued on page 4)*

A LITTLE NOTE FROM The Editor

May may be chill, may be mild,
May pour, may snow,
May be still, may be wild,
May lower, may glow,
May freeze, may burn,
May be gold, may be gray,
May do all these in turn—
May may. —*Justin Richardson*

Yes, May is a month of possibilities, potentials, and plans. Children finish their school projects and workbooks, eager to toss the books for idle hours watching the clouds. Families clean the crusty barbecue and shake out the dusty hammock. Brides-to-be enjoy the final fittings of their gowns. Previews of the summer movies appear between commercials for water parks and sundresses.

What's on your "self-improvement calendar" for the next few weeks? What are your own "Coming Attractions"?

As you prepare for changes to your routines, don't neglect to feed your mind. Dig out your library card, and borrow those classics you've always meant to read or the hot new novel everyone is talking about. Attend a free lecture or join a poetry group. Focus on positive and helpful reading matter and social activities.

Come to the MDDA Picnic on May 29. Invite friends for a day at the lake. Go mall walking (without shopping lists or money!) —it's free and air-conditioned. Certain meds, including lithium, don't mix well with hot sun, so protect yourself from those beams. Carry drinking water wherever you go.

Going to bed early may be harder now as the lengthening days and balmy evenings tempt you to stay out later. Make it a habit to get 10 hours of deep sleep in a dark, quiet place. (See this issue's lead article for good reasons.)

And—need we remind you?—Meet all your doctor's appointments and take your meds as prescribed: Who needs "episodes" interrupting the good stuff you've got going?

Attend your support group meetings. Plan to get together between meetings for a pleasant social outing.

Reach out to someone who needs a helping hand or a kind word of encouragement. Donate your unneeded clothes to the homeless. Volunteer at the humane society.

This list isn't meant to be preachy. In fact, I wrote it mostly for myself! But I hope it gives you a few ideas. May you enjoy this wonderful May! —*Yen Cress*

The Thermometer Times

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Begin planning now to attend the
11th Annual CDMDA Conference
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—in beautiful San Francisco!
October 27 & 28, 2000

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Since we have no full-time staff, leave a message and one of our volunteers will call you back. Due to budget constraints, we are unable to return long distance calls unless you give us permission to call you collect.

Thank you for renewing your memberships and newsletter subscriptions.

If you find errors on your mailing label, including the renewal date, please contact us at: 909/780-3366

The Rhythm of the Mind

Rodolfo Llinas, Columbian-born neuroscientist of New York University Medical School and highly respected researcher, has developed a new theory about how the brain is organized. His research was presented to the annual Society for Neuroscience meeting in October 1999.

Llinas believes that many seemingly unrelated psychiatric and neurological disorders result from the same brain defect described as a de-coupling of two brain regions, the thalamus and the cortex. According to this theory, the neurons in these regions are not firing in synchrony as they normally do. There are disruptions in the electrical rhythm or communication between these two areas.

Symptoms that result from this decreased synchrony include: the shaking and immobility of Parkinson's, the deep sadness and negative thoughts of severe depression, tinnitus (ringing in the ears), the hand washing of obsessive-compulsive disorder (OCD), the hallucinations of psychosis, and intractable pain.

Dr. Llinas believes that the defective mechanism is similar in these disorders, but at different locations within the thalamus. The de-coupling from the cortex naturally produces low-frequency oscillations, setting off high levels of activity in the surrounding areas, triggering symptoms. As the neurons in the cortex lose thalamic control, they oscillate out of control.

Dr. Llinas believes that in the future all of these disorders might be treated by implanting electrodes into the thalamus, like a pacemaker.

—Condensed from *Discover Special Issue* Jan 2000 and "New Ways of Looking at Diseases of the Brain" *NY Times,* 10/26/99
As seen in Tampa Bay DMDA *Newsletter* Spring 2000

Air Force Cuts Suicides 80

A program to curb suicide in the Air Force, while far from unique in concept, has been so successful that it will now be applied to civilians. Government reports say it cut the service's suicide rate 80 percent.

Self-inflicted wounds are the second-leading cause of deaths in the military, accounting for nearly a quarter of all fatalities. (They are #9 among civilians.) The Air Force's incidence of suicide rose from about 10 per 100,000 active duty personnel in 1990 to more than 16 per 100,000 in 1994—the highest rate in the military.

The trend led many bases to implement their own suicide-prevention programs. The chiefs of staff soon decided that a top-down effort was needed, too. Air Force colonel Dr. David Litts says the program involved a concerted, community-wide approach. Squad leaders, base commanders, and the highest officers emphasized the importance of seeking help for people with depression and suicidal thoughts. Personnel were queried about their emotional state when enrolling in the military health plan and offered referrals to mental health experts if necessary. And bases provided a framework within which psychological problems could be addressed.

One of the program's core messages is that seeking help for emotional distress won't affect prospects for promotion or assignment, Litts says. A suicide attempt or treatment for depression doesn't constitute grounds for discharge, says Litts, unless it occurs in the context of illegal or intolerable behavior. Indeed, he says, "If people get help early, it should help their careers."

The program was implemented in 1996, and by 1997 covered about 80 percent of the estimated 300,000 active-duty members of the Air Force. Since then, the suicide rate in that service has fallen to about 2 per 100,000 airmen—a drop of 80%.

Litts says the key to the program's success—and the reason it could work for other large groups—is that it de-emphasizes the health aspect of suicide and highlights its social quotient. "The principles we have followed—involving the whole community and leveraging the leaders to speak out on the issue—should be transferable to any population," says Litts, now helping the U.S. Surgeon General's office implement the program in the public sector.

— Adam Marcus, 11/29/99
HealthSCOUT<www.healthscout.com>
As seen in *Polars' Express*, MDDA Boston March, April, May 2000

THIS IS YOUR BRAIN *ON* STRESS

You're deep in debt, your marriage is a wreck, and you just got fired. Now you can't remember where you parked and you forgot a lunch date. You're not losing your mind. In trying times, the body cranks out a hormone that weakens short-term memory.

So says Washington University psychiatrist John Newcomer. For four days, he and his colleagues gave 31 people the hormone cortisol in doses that matched levels produced by mild or major stress; 20 others received a placebo. In tests of memory and attentiveness, the high-dose crowd fell short in one area: the ability to recall details of two paragraphs that were read to them. By day four, they retained 25 percent fewer facts than their counterparts.

A tough day at work or a fender-bender isn't enough to set off this mental glitch, says Newcomer. It would take something severe—losing a loved one, for example, or a painful divorce. The problem should vanish when the initial shock eases: Six days after the high-dose group stopped taking cortisol, memory returned.

—*Health,* September 1999
As seen in Tampa Bay DMDA *Newsletter*, April/May 2000

Pushing *(continued from page 1)*

Jamison speaks about manic depression from an insider's perspective. She has personally struggled with the condition since adolescence.

Investigators are now beginning to explore the impact of intimate relationships, social stress, individual styles of thinking, and psychotherapy on the course of bipolar disorder.

People who suffer from bipolar disorder have perhaps most frequently noted the sensitivity of their moods to social influences than have mental-health clinicians. Still, case reports published decades ago described how stressful events and disturbed relationships sometimes trigger episodes of mania and depression.

Over the past decade, several studies have found that bipolar patients released from psychiatric hospitals more often climb back on the emotional roller coaster if they encounter a lot of daily stress. Living with a hostile, critical family ranks high among such strains.

In contrast, social circumstances that contribute to healing have received scant attention from researchers. A new investigation finds that people treated for an episode of mania or depression recover within about 8 months if they have supportive families and friends, reports psychologist Sheri L. Johnson of the University of Miami in Coral Gables. Bipolar patients who lack these helping hands have a recovery time of more than a year.

However, the benefits of positive personal relationships fade in the face of the death of a loved one, job loss, or other major setbacks. These can extend recovery time to more than a year, Johnson and her colleagues reported in the November 1999 JOURNAL OF ABNORMAL PSYCHOLOGY.

The cruel slap of an unexpected loss or growing friction in a cherished relationship usually signaled the imminent return of depression, but not mania, according to the study.

Any of a variety of social, psychological, and biological mechanisms may provoke depression, the scientists theorize, but only a single brain network inspires mania. That network, involved in positive emotion and striving for rewards, responds to a narrow spectrum of external influences, they suggest.

Johnson's team studied 59 adults diagnosed with bipolar disorder, most of whom entered the study during an episode of either mania or depression. Of that total, 36 took lithium or other prescribed medications, as they had before the trial. The findings held regardless of whether participants received drug treatment.

A related investigation, published in the same journal issue, indicates that some people with manic depression prove more psychologically vulnerable to stressful events than others do.

Psychologist Noreen A. Reilly-Harrington of Harvard Medical School in Boston and her coworkers used questionnaires to probe the thinking styles of 49 people who had previously been diagnosed with bipolar disorder, 97 individuals who had suffered from major depression (which recurs without periods of mania), and 23 who had never been diagnosed with a psychiatric condition.

What Do These Famous People Have In Common?

Burgess Meredith	Actor
Edward Meunch	Artist
Conrad Meyer	Writer
Michelangelo	Artist
John Stuart Mill	Writer
Edna St. Vincent Millay	Poet
Kate Millet	Writer/Feminist
Spike Milligan	Humorist
John Milton	Poet
Charles Mingus	Composer
Carmen Miranda	Singer
Mavor Moore	Producer

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

Most participants in these three groups weren't receiving any mental health treatment.

Over a 4-month period, depression increased only among those individuals with either bipolar disorder or major depression who displayed negative thinking styles and reported a death in the family, divorce, or other stressful experience. Negative thinkers blame themselves for personal misfortunes and consider themselves incompetent.

Such a mix of negative thinking and stressful events also heralded rises in manic symptoms for volunteers with bipolar disorder, the researchers say.

It's possible that in bipolar disorder, manic episodes serve as a psychological defense or counterpunch against a relentless propensity for sinking into depression, Reilly-Harrington and her colleagues propose. Psychoanalytically inclined clinicians have long articulated this position.

Reilly-Harrington's group suggests that along with negative thinking and personal misfortunes, disruptions of a person's daily routines or sleep-wake pattern appear to promote mania.

This view is supported by a 1998 study directed by psychologist Susan Malkoff-Schwartz of the University of Pittsburgh School of Medicine. Her group found that bipolar patients tended to become manic within about 2 months of having their daily routines rearranged, even temporarily. These alterations included air travel across several time zones and losing a full-time job without immediately starting another.

In fact, evidence is building that efforts to initiate a steady pulse of daily activities and sleep can tame manic depression. Using a treatment dubbed interpersonal-and-social-rhythm therapy, psychologist Ellen Frank of the University of Pittsburgh School of Medicine and her coworkers are trying to dampen bipolar extremes by stabilizing social routines.

Pushing *(continued on page 5)*

Pushing *(continued from page 4)*

In this approach, psychotherapists help bipolar patients recognize the interplay between their moods and the inevitable ups and downs of everyday existence. Counseling sessions also focus on how emotional turmoil in relationships can disrupt a person's daily routines and bring on a bout of mania or depression.

Bipolar patients then learn to plan and hold to a daily routine, adhere to prescribed medication doses, and work on relationship problems as they arise.

At the halfway point of a 2-year study, Frank's team has observed that this form of psychotherapy helps prevent recurrences of bipolar-disorder symptoms. Unexpectedly, though, they found that patients benefited most from staying in the same treatment program throughout the first year of the program, even if it wasn't interpersonal-and-social-rhythm therapy.

The researchers randomly assigned 82 people diagnosed with bipolar disorder to regular sessions of either interperson-al-and-social-rhythm therapy or clinical management (consisting of advice and support from a concerned therapist) or to a 1-month period with one of those therapies followed by a switch to the other method for the remainder of the year. Participants who changed therapies retained the same therapist.

Most patients who stayed in either type of therapy for 1 year managed to avoid return episodes of mania and depression, Frank's group reported in the Novernber 1999 JOURNAL OF ABNORMAL PSYCHOLOGY. Those who switched from one therapy to another fared considerably worse.

The ongoing study may eventually reveal specific benefits attributed to the social-rhythm treatment, Frank predicts. Still, even modest changes in the nature of psychotherapy appear to throw bipolar patients seriously off-kilter, she says.

For example, a person who improves with clinical management and then changes to interpersonal-and-social-rhythm therapy abruptly confronts instructions to explore sensitive areas of conflict with loved ones. This may undercut the sense of stability achieved in support-oriented discussions that didn't probe emotional sore spots.

Moreover, Frank notes, 25 bipolar volunteers who changed therapists but not treatments during the study—due to a clinician's maternity leave or departure from the clinic—maintained their initial improvement after the switch.

"It appears that the consistency of routines, including the routine of the patient's psychosocial treatment, is a protective factor in the course of [bipolar] disorder," remark David J. Miklowitz of the University of Colorado at Boulder and Lauren B. Alloy of Temple University in Philadelphia. The two psychologists wrote a comment on Frank's, Johnson's, and Reilly-Harrington's studies in the same issue of the JOURNAL OF ABNORMAL PSYCHOLOGY.

A dose of stability—in the form of extended nightly bed rest and sleep—may help prevent mania as well as a particularly severe form of bipolar illness, according to Wehr.

He and his colleagues prescribed 10 hours of nightly bed rest in the dark for a 51-year-old man diagnosed with bipolar disorder. The man had begun to shift from full-blown depression to relatively severe mania every 6 to 8 weeks, with no calm period in between. Psychiatrists refer to this speedy mood turnaround as rapid cycling. Lithium and other medications had provided no relief.

The man's condition dramatically improved after several weeks of enforced night rest. During nearly 4 years of adhering to this routine, his sleeping pattern and mood largely stabilized, Wehr's team reported 2 years ago.

Staying up late night after night under the glare of artificial lights, an unheard-of activity until quite recently (SN: 9/25/99, p. 205), may worsen some forms of bipolar illness, Wehr theorizes. Under these circumstances, the timing of the body's sleep-wake cycle appears to come unhinged from the outside world's daily cycle of light and darkness, he suggests.

Swiss researchers led by Anna Wirz-Justice of the Psychiatric University Clinic in Basel had similar success in treating a 70-year-old bipolar woman with 10 hours of nightly bed rest for several months. An extremely rapid cycler, going from severe depression to mania within 1 week, the woman had been hospitalized on and off for 24 years.

Along with prescribing the lengthy night rest, the scientists administered 30 minutes of bright light to the woman each morning after she awoke. Wirz-Justice's case report appeared in the April 1999 BIOLOGICAL PSYCHIATRY.

Although Wehr suspects that sleep critically influences bipolar disorder, other features of his intervention may help corral wild moods. Increased activity during the day and consistent timing of behaviors, as well as the quiet, isolation, and darkness at night, represent possible agents of improvement.

Whether or not larger studies carve out a place for sleep therapy, people with bipolar disorder will continue to clamor for psychotherapy, Wehr and others hold.

"If nothing else, psychotherapy has an important role in helping people to accept that they have this illness and need ongoing treatment," Frank says.

—Bruce Bower
Science News, Vol. 157, April 8, 2000

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

The Los Angeles County Jail, with an estimated 3500 detainees with mental illness, has become the largest de facto mental hospital in the United States.

—D.K. Phillips III, Ph.D.
The Mental Health American
Spring 2000

Communication Tips

for Supporting a Depressed Loved One

by Laura Epstein Rosen, Ph.D., co-author, *When Someone You Love is Depressed*

1. Never talk behind a depressed person's back. Using a third party as an intermediary can quickly lead to misunderstandings.
2. Avoid name-calling. Labeling someone as "lazy," "selfish," or a "couch potato" doesn't help.
3. Don't resort to "kitchen sink" tactics in which every last grievance is thrown into an argument—including money problems, neglected chores, or issues with the in-laws.
4. Avoid sweeping, accusatory generalizations like, "You never like to go out any more." A more effective thing to say is, "I'm concerned because you haven't wanted to go out for the past week."
5. Even when frustrated, it is important to keep calm—shouting only impedes understanding.
6. Watch nonverbal behavior, too. Averting your eyes or fidgeting is likely to lead a depressed person to believe he or she has nothing interesting to say.
7. When listening to a depressed person, try to acknowledge what has been said while showing empathy. Let the person know you understand and can imagine what it must be like to be in his or her shoes.
8. Take responsibility for the role you have played if a communication breakdown occurs. But also help the depressed person think about his or her contribution to the trouble.
9. Humor can help defuse tension in a relationship; be able to laugh at yourself and point out absurdities or humor in a stressful situation.

—Condensed from *Spectrum*, DMDA Chicago Jan/Feb 2000
As seen in *MoodPoints*, Houston & Harris County DMDA, Spring 2000

Help Others With Mental Illness

Your Success Story Could Make A Difference For Someone Else

Are you currently taking Seroquel, Zyprexa, Risperdal and/or Paxil, Zoloft, Prozac, Celexa?

If so, are you:

- living independently
- currently employed
- having new life experiences

? ? ?

We are interested in hearing your success story...

(Story will be shared only with your permission)

To share your story, please call or write:
Liz Helms
Perry Communications Group, Inc.
925 L Street, Suite 600
Sacramento, CA 95814
Tel: (916) 658-0144
E-mail: LHelms@ThePerryGroup.com

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

MDDA of Riverside NEEDS

YOU!

We need responsible people to volunteer to organize and help with fundraising events such as craft or bake sales. You could fill a need and have a lot of fun helping MDDA! Please call

(909) 780-3366

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:

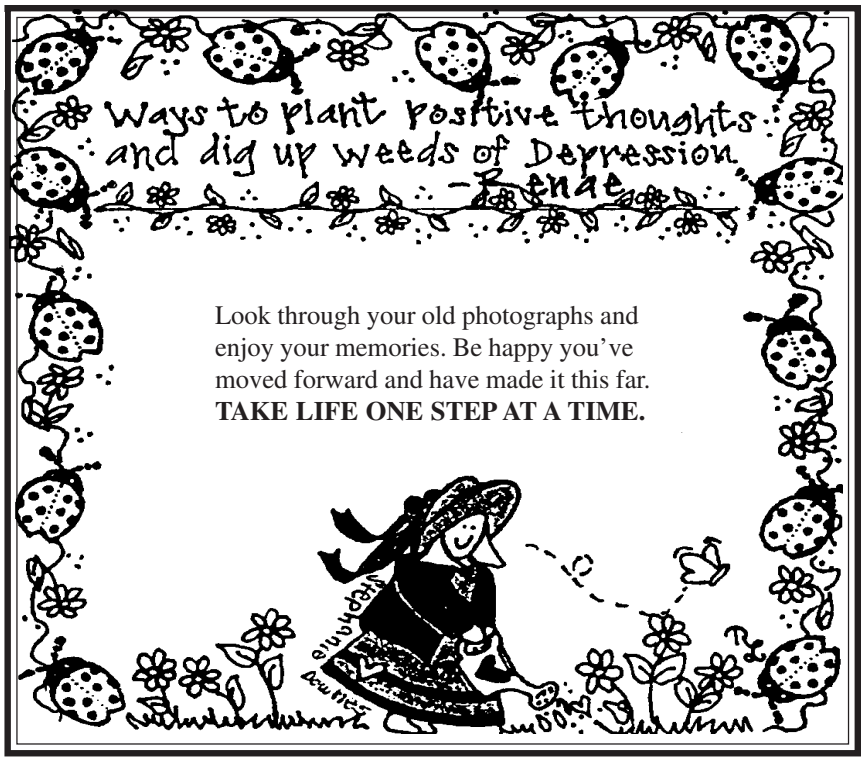
Camille Dirienzo-Callahan

(909) 791-3369 or

Mekkia deSanchez

)909) 600-5055

Renae's Thoughts



Antidepressants & *Weight Gain*

—A Common Complaint Newly Addressed

When Prozac was first introduced, an appealing side effect appeared—it caused weight loss. This soon became a powerful selling point for using it even in the absence of depression. However, the flip side has now turned up: While some initially lose weight, more patients gain steadily during long-term use of SSRIs [as well as mood stabilizers (particularly lithium and valproic acid) and certain other psychotropic drugs] and have difficulty losing the unwanted pounds. Following withdrawal, weight loss may be slower if the drug is one that is excreted slowly (as Prozac is).

In its April, 2000, issue, *Currents in Affective Illness: Literature Review and Commentary* published an extensive interview with Norman Sussman, M.D., Clinical Professor of Psychiatry at New York University School of Medicine, on the effects of psychotropic drugs on body weight. Citing several recent research projects, Sussman commented that earlier research failed to emphasize the weight effects, and that clinicians often observe a disparity in practice from what has been reported in clinical trials.

Now researchers believe that SSRIs may reset the appetite and/or the metabolic thermostat or by some other mechanism alter the way weight is controlled. The only antidepressant that has been approved that causes more weight loss than weight gain is bupropion (Wellbutrin), which, unfortunately, is not effective for social anxiety disorder, panic disorder, or obsessive-compulsive disorder.

Another contributing factor may be the lethargy and apathy that some patients experience after several weeks or months of SSRI use. This understandably reduces the activity level of the patient, resulting in fewer calories burned, and thus more weight retained. Some doctors prescribe the addition of a psychostimulant to counteract the apathy.

—Yen Cress

Think & Smile . . .

When I hear somebody sigh that "life is hard," I am always tempted to ask, "Compared to what?"

—Sidney J. Harris

☺

Love never dies of starvation, but often of indigestion.

—French proverb

☺

Depend on the rabbit's foot if you will, but remember it didn't work for the rabbit.

—R.E. Shay

☺

I never been in no situation where havin' money made it any worse.

—Clinton Jones

☺

If it weren't for the optimist, the pessimist wouldn't know how happy he isn't.

☺

After thousands of years, we have advanced to the point where we bolt our doors and windows and turn on our electronic burglar alarms—while the jungtle natives sleep in huts without doors.

—Clinton Jones

☺

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
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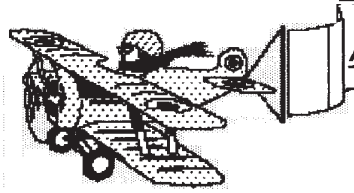
FAX 909/780-5758



ANNOUNCEMENTS

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

INLAND VALLEY DMDA
EAST (Fontana)
Call Phil (909) 796-0615

UPLAND DMDA
FONTANA DMDA
Meet Thursday evenings
Call David or Samantha Johns
(909) 947-4081 OR
e-Mail dmjbf@aol.com

HEMET SUPPORT GROUP
"Foundations" meets every 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 - Riverside
Call Family Services at
(909) 686-3706

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)

What Is Recovery?

What does the word "recovery"mean in relation to serious mood disorders? Does it imply a return to total wellness and stability independent of drug or "talk" therapy? Or is a more moderate view possible—maybe the acceptance of some fluctuation of mood, with extremes controlled or prevented by the intervention of psychiatry or medication, and a restoration of normal activity? Or does it imply even the slightest improvement? Without understanding what is meant by the term, communication on the subject is impaired between patients, families, and professional care providers. After all, if "recovery" is seen as a final goal, when does one achieve it?

It may be more sensible to see "recovery" as a process, an evolution, a journey rather than a destination, especially since mental disorders are frequently not "all-or-nothing" states, but are frequently a pattern of episodes separated by stable intervals. With this perspective, "recovery" becomes a more realistic expectation. As the episodes become less severe, the intervals between longer, the disruption of life reduced, and productivity restored, the process of recovery can be assumed.

People who perceive recovery as an absolute, an end point, without honoring the steps to getting there, may never be free to claim it. But everyone who takes steps toward wellness is already recovering.

—Yen Cress

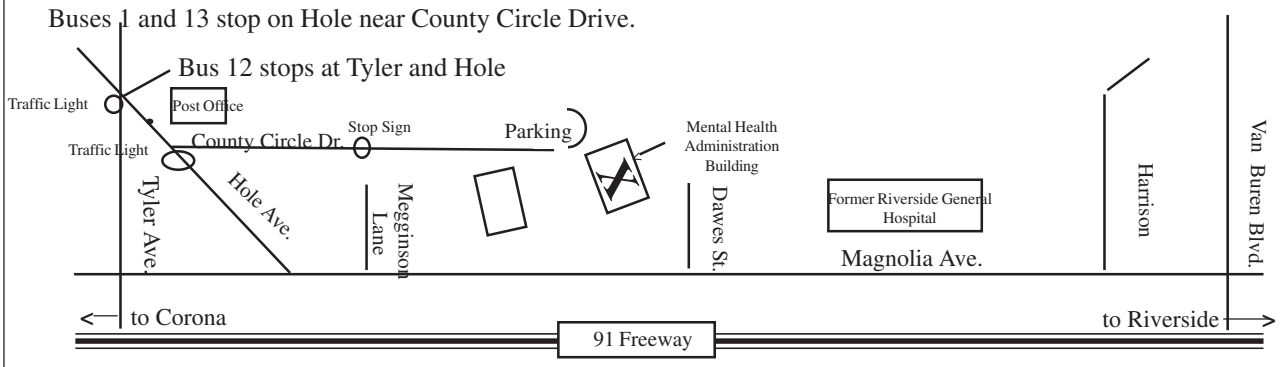
Nestle Responds to MH Voices of Reason, Stops the Insanity

The giant Nestle food company has announced that the offensive Tangy Taffy flavor names "Loony Jerry," "Weird Wally," and "Psycho Sam" are being discontinued, with all packaging and marketing plans updated. Mental health consumer advocates recently protested the stigmatizing names, and some called for a boycott unless changes occurred.

—Yen Cress

WHAT MDDA IS ALL ABOUT

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. Please call for directions. 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 Dr. (off Hole Ave. near Magnolia), 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 _____
Street City State

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. ❒