"Education" MDDA "Support"

The Thermometer Times

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

VOL. 14 NO. 3 | Out of darkness . . . | March 2002

Dates to Remember

****

CARE & SHARE GROUPS

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

Saturdays, March 2, 9, 16, 23, & 30

10am–12 noon

at

Riverside County Mental Health Administration Building
(see page 9 for address)

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

COGNITIVE DIFFICULTIES

IN MOOD DISORDERS

Many people with mood disorders have cognitive problems. In fact, cognitive difficulties are actually one of the symptoms of depression. Memory difficulties, attention and concentration problems are all common. A. large number of people also have difficulties making decisions and may become overly indecisive. Problem solving skills and rapid decision making may also be difficult. This may be a particular problem at work, for example. You may be able to ask for deadline extensions to allow you the extra time necessary to complete a project.

Cognitive problems may increase feelings of inadequacy in depression sufferers. They can create a frustrating feedback loop. For example, an inability to remember household tasks or details of a recent discussion with a friend can leave someone feeling as if they are unable to hold up their end. Most depression sufferers battle low self-esteem. Feeling that you are not a good friend or spouse only increases stress.

People suffering from manic-depression are also not immune to cognitive difficulties. When entering a manic phase, they may be particularly susceptible to the effects. A manic person may not recognize the decreased cognitive ability and therefore increase the potential for problems.

Studies are being conducted to determine if these difficulties affect response to treatments such as cognitive therapy. Comparisons to antidepressants in clinical trials should provide useful data in the near future to assist those suffering from cognitive impairment due to a mood disorder.

Cognitive difficulties may parallel the severity of a particular episode. However, these impairments are temporary and usually lift when the depression is successfully treated. Discuss any cognitive impairment with your doctor. Some medications produce grogginess. ECT sometimes causes cognitive impairment. If the difficulty is caused by your treatment, your doctor may be able to help.

Cognitive problems can affect a person's ability to carry out day-to-day activities. It is important for loved ones to recognize this as part of the suite of symptoms of the mood disorder. It is not an intentional act or a lack of effort on the depressed person's part. Those suffering from the illness must also realize that this is a symptom and forgive themselves when they cannot remember their best friend's phone number.

Source: NAFDI News, Spring 1999 via Life In Balance, MDDA Detroit 3/01
& The Polar Star, MDDA, Los Angeles, Winter 2002

Depression and the Shrinking Brain

The Tampa Tribune, October 2, 2001

WASHINGTON – Major depression makes an important part of the brain actually shrink. Stress seems to be a suspect, but no one knows how to stop the atrophy.

Now a new study of primates' brains says a European antidepressant seems to counter the shrinkage – raising calls for more research to see if other medications might help people, too.

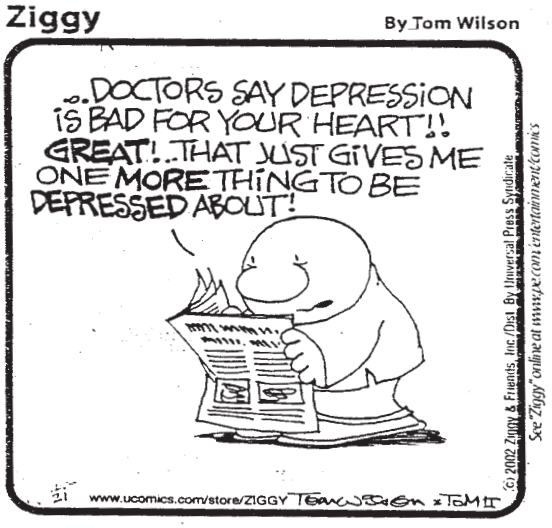
"These are impressive and important findings," said Robert Sapolsky of Stanford University, who reviewed the new research, published in the Proceedings of the National Academy of Sciences.

But, "this is one antidepressant and this is a fairly atypical one" compared to the antidepressants most Americans use, Sapolsky cautioned.

German researchers tested a new antidepressant sold only in Europe called tianeptine. The antidepressants most popular in the United States – Prozac and similar medications – work by blocking the dissipation of a neurotransmitter called Serotonin that's important for mood. Tianeptine does exactly the opposite, enhancing serotonin uptake.

Major, long-term depression can cause a brain region called the hippocampus to shrink, in some cases nearly 20%. The hippocampus is important for learning and memory, so that probably explains why memory loss often accompanies depression. And the region doesn't seem to bounce back after the depression is cured.

Source: Tampa Bay DMDA Newsletter, Feb.-Mar., 2002



We are now officially on the web.
Check it out at:

http://www.geocities.com/mddariv/

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You may now contact us via e-mail at:
MDDAOFRIV@AOL.COM

Eli Lily Loses Patent for Prozac in Court

After fighting for six years to maintain its patent on Prozac, Eli Lilly and Co. reached the end of the legal road Monday when the U.S. *Supreme* Court refused to consider reinstating the drug maker's rights to the popular antidepressant. Company officials said they were disappointed but not surprised.

ASSOCIATED PRESS

Source: The Press Enterprise, Riverside, CA
January 29, 2002

The Trouble with Men

William Styron, Mike Wallace, Art Buchwald, cultural luminaries with one trait in common: All are prominent men who have publicly revealed that they suffer from depression. Perhaps distinction or age, or both, afforded them safety in disclosure.

That, however, is protection that most men lack. For them, depression carries so much of a burden of shame that it is hidden — sometimes so well it fools those who gave it. It often masquerades as drinking and lashing out at others, and subverts relationships.

As a result, depression is vastly under diagnosed in men, insists Harvard psychologist William Pollack, Ph.D. When the true body count is taken, depression may be as common among men as it is among women, although current dogma holds that depression favors women two to one.

Dr. Pollack and others contend that the culture goes to work early on boys to suppress their real rate of emotional suffering. "Boys are trained in ways that make it likely they get depression later.

If it doesn't destroy their relationships sooner, it shows up by midlife. Midlife crisis is a euphemism for male-based depression."

The problem is males and females express depression differently, although no matter what triggers the disorder, in both genders it eventually shows up in biological changes in the brain.

Even today, many boys are still brought up by a code that says, "Don't cry." "Stand on your own two feet." "When you're most in need of help, don't show it because you should do it on your own." "Don't show your need to be held." "Avoid anything 'feminine', which especially involves the expression and discussion of feelings, feelings of vulnerability in particular."

'We still do this, subtly and unconsciously," says Dr. Pollack. The only feelings deemed acceptable for boys to display are anger and frustration. What the boys code forbids them to do is to show signs of depression that women do — weepiness and helplessness—at least in front of others.

Unfortunately, the diagnostic criteria for depression are almost exclusively based on women's experience of the disorder—because they've been the ones willing to present themselves as patients.

There are many men who experience the "classic" signs of depression, too. But there is a difference in them, observes family therapist Terence Real, MSW. They hide it. Their shame at having feelings inconsistent with the male role silences them. They suffer a compound depression—on top of their now hidden depression, they are depressed about being depressed.

Even more men exhibit what he calls covert depression. 'They don't see the depression itself but the defensive maneuvers men use to evade or assuage it," says Real. Signs include:

- Self -medication
- Risk - taking
- Radical isolation.
- Lashing out.

'Women internalize depression and tend to blame themselves," says Real. "Men tend to externalize distress and blame others." a move into action —and distraction.

Such defenses may protect them from *feeling* depressed but not from being depressed. The intoxicant defenses and lashing-out defenses, Real finds, represent men's attempts to ward off the anguish of shame by inflating their own value. As he sees it, the inclination to bravado takes permanent hold at adolescence. Indeed, until then, boys and girls exhibit the same rates of depression.

The mental health establishment recognizes that grief and other forms of emotional pain in males may be expressed in acts as well as words throughout childhood. Drinking, substance abuse, and antisocial substance abuse, and antisocial behavior are all cited in the DMS IV as signs of depression among teens, but not among men.

"Somehow, when a boy turns 18 we split depression off from the behaviors that make it up," says Real. 'We stop seeing the acting out as due to an underlying depression and instead call it a character disorder. That's not science, it's morality.

Prohibiting males from expressing grief, sadness, and loss makes their depression look different, but only at a superficial level. 'Where there's anger, irritability, rejection followed by self-medication, or compulsive behaviors." says Sam V. Cochran, Ph.D., "there's usually a mood disorder going on."

Edited from an article in the "Blues Buster'
The Newsletter About Depression Dec. 01/ Jan. 02
and DMDA, Humboldt County
newsletter, winter 2002

"Thank you for calling the Self-Esteem Center. You are wonderful no matter how long we keep you on hold."

Late-onset Bipolar Disorder

C. Umpathy, M.D., Robert Mann, M.D., N.J. Jacob, M.D.

Jues Rosen, M.D., Benoit Mulsant, M.D., & C. F. Reynolds, M.D.

Although manic-depressive illness ("bipolar disorder") usually begins before old age, we believe that approximately 10 percent of patients with bipolar disorder become ill for the first time after age 50.

Patients with late-onset bipolar disorder usually have been found to have a lower rate of mood disorders among their family members. Sometimes mania first appearing in late life is caused by another underlying physical disorder, particularly head trauma, stroke, delirium, or other neurological illnesses, or prescribed or non-prescribed drugs (particularly alcohol, corticosteroids, L-dopa, and thyroid medications). Also, it is often the case that patients with late onset bipolar disorder have been reported to have a history of major depression and a first manic episode associated with antidepressant medication treatment.

Unfortunately, there are no controlled studies on the treatment of bipolar disorder in old age. The limited data available does support the usefulness of lithium in the acute and preventive treatment of mania in older patients. Older patients are typically treated with lower doses and levels of lithium. When we examined the case registry of the University of Pittsburgh's Stanley Center for the Innovative Treatment of Bipolar Disorder, we found that close to two thirds of the patients older than 65 were still receiving lithium and that just below one third were receiving anticonvulsants.

Anticonvulsants (such as Depakote) are increasingly being used as a safe and effective alternative to lithium. One of their main advantages, especially in the elderly is that the side effects are tolerable. Furthermore, there may be a subgroup of bipolar patients with frequent mood swings (rapid cycling between low and high moods) who may respond better to anticonvulsants than to lithium.

To the best of our knowledge, no studies have focused ui the treatment of depression in older patients with bipolar disorder. For younger patients, the best practice is first to prescribe a mood stabilizer like lithium or Depakote and to reserve use of an antidepressant for those who do not respond. There is some information that older tricyclic antidepressants are more likely than Wellbutrin or serotonin anti- depressants (Paxil, Celexa, or Zoloft) to induce a switch from depression to mania.

Because of the great need for scientific evidence to guide the treatment planning in late life bipolar mood disorders, our Intervention Research Center has opened a treatment program for patients aged 60 and above with a diagnosis of bipolar disorder. We are working with other doctors at the University of Pennsylvania and at Cornell to plan a multi-site study of treatments for bipolar disorder in old age. Despite improvements in their diagnosis and treatment, older patients with bipolar disorder remain at high risk for excessive illness and early death. We need to know more about safe and effective treatments for bipolar illnesses in this age group. We ask that family members of older bipolar patients work with us to improve the treatment of their loved ones. We are also developing educational and support services for family members who may feel exhausted or overwhelmed by this devastating illness in a family member. For more information, please call us at 412-624-1886

Source: Bipolar Disorder in Old Age: Need for More Treatment Research, Aging Upbeat, Winter 2001, Vol 2, No. 3

Prisons Within A Prison

Huddled in the dark
all day long
exchanged one prison
for anoth
afraid to go outside
for what might happen
I stay locked within
a mind of fear
and loneliness,
For it is what I have known
most of my life
Prisons within a prison
with no key
to set me free.
Shelly Bell

National DMDA Conference 2002

Start planning for the National Depressive and Manic-Depressive Association's Annual Conference this year in Orlanndo, Florida.
The date is August 9 through 11th.

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

An Interview with Sandy

Sandy Waples talks with Shelly Bell

Sandy: Before your diagnosis, what made you suspect that you might need one?

Shelly: I was aware enough to know that I was ill, paranoid, and grandious with delusions brought on by 4 week's use of cocaine and other illicit drugs.

Sandy: Was your diagnosis ever changed?

Shelly: Yes to schzoid affective disorder.

Sandy: How did you feel about having to take medication?

Shelly: I did like it then but don't like taking medication now.

Sandy: How did you think your friends might react if they were to hear your diagnosis?

Shelly: I felt that they wouldn't like me and would be ashamed of me.

Sandy: If you told your family of your diagnosis,what was their reaction?

Shelly: They have never understood, except for my brother, who is 11 months younger than I andhis wife. They were the onnly ones to visit me in 20 years of hospitalizations.

Sandy: Did you stay on your medications, or go on and off'?

Shelly: I went on and off.

Sandy: During your illness, did you try to work or volunteer even if just part time? If so how did that go ?

Shelly I was able to work awhile until I got too sick to work. Once I tried to volunteer but ended up in the hospital.

Sandy: Do you have some skill or hobby that you enjoy?

Shelly: :Yes, writing poetry.

Sandy: How, if at all, has the MDDA helped you in your feeling about life in general?

Shelly:I feel less alone and more optimistic.

Sandy: In your view, what does the future hold?

Shelly: I hope it holds a career for me.

Sandy: What is your view of yourself?

Shelly: I am a survivor of a dual diagnosis of Bipolar disorder with psychotic features and addiction. It took 20 years to diagnose and find effective medications.

Sandy: What are your feelings about going after what you want ?

Shelly: I feel that time, patience, discipline, fortitude, and hard work are all important to achieve goals.

Sandy: Do you have a personal faith that encourages you? Describe it briefly.

Shelly: I believe in thinking positively and that God is all around us and alwa;ys there.

Sandy: Have your friends or family members become more understanding & supportive?

Shelly: Lately, they seem to be more supportive now that I'm out of the hospital and recovered.

Sandy: If you were to give a fellow sufferer some words of encouragement, what two statements would you make?

Shelly: 1. Maintain a close relationship with your doctor, being very specific about your symptoms. 2. Don't give up hope of finding the right medications for you. Keep a journal for your doctor containing all your symptoms and medications.

Sandy Waples, MDDA Interview Correspondent

Phone in to Lucinda Bassett every Saturday at 6 PM on KLAC 570 AM, Los Angeles. She will help you cope with everything from personal relationships, emotional challenges, career, difficult situations and people, anger, depressiion or anxiety, parenting and anything else.
Call in Lines: 1 800/977-5522 Switchboard 213/385-0101
www.570klac.com

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 909/688-0368.

Alliance Library

1215 N. Buena Vista
Suite K
San Jacinto, CA

Open 1 p.m. to 3 p.m.
Tuesday, Wednesday,
Thursday, and Friday.

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 develop 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, and turn into the driveway. Suite K.

Riverside Suicide Crisis Help Line
Call
(909) 686-HELP
[(909) 686-4357]
24 hr. Hotline
7 Days a Week

GOT E-Mail?

If so, join **NAMI Stigma Busters** E-mail network. Help flood stigma-builders when they do or say offensive things that create stigma.
Go to NAMI website:
http:/www.nami.org
click on **Campaign Page** then **Stigma**. Leave your name and address.
Done!

Pfizer to offer huge discounts to needy elderly

by Janelle Carter
The Associated Press

Beginning March 1, Pfizer will offer senior citizens **Lupitor** – a cholesterol lowering drug, **Norvasc** – used for high blood pressure and angina, **Neurontin** – ro acute epilepsy and depression, **Zoloft** – for depression at $ 15 each a month. To qualify, seniors must be enrolled in Medicare only, having a gross income below $18,000 or less than $24,000 for couples This is a temporary program until the drug prescription benefit is passed.Card applications available at: 800 717-6005 or on the Web at http://www.pfizerforliving.com.

Emotional Health Anonymous
Saturday Riverside Meeting
Emotional Problems?

Do you suffer from DEPRESSION, ANXIETY, or other EMOTIONAL PROBLEMS not related to substance abuse?

We are not professionals. We are a group of men and women who share their experience, strength, & hope with each other that they may recover from their emotional illness and help others who still suffer from emotional problems to find a new way of life.

When: **EVERY SATURDAY**
Time: 4:00pm - 5:00pm
AT KNOLLWOOD PSYCHIATRIC CENTER
at 5900 Brockton Ave., Room 2

For more info: 626/287-6260, San Gabriel Valley Intergroup of Emotional Health Anonymous, P.O. Box 2081, San Gabriel, CA 91778 www.flash.net/sgveha

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

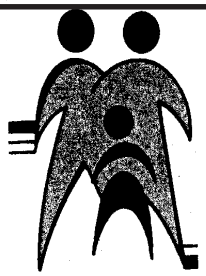
Arnold
(909) 685-1663

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

Georgia
12 noon to 6 p.m.
(909) 354-8727

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

Dawn
12 noon to 9 p.m.
909/688-1803



Family/Friends Support Groups

Riverside County Dept. of Mental Health
Offers support groups for families and friends
of people with severe
and persistent mental illness.
These support groups are offered
throughout the County of Riverside.

The County also offers the

NAMI Family-to-Family Education Program
This program is a 12-week series of
educational meetings for
family members.
There is NO COST TO YOU.

For information on dates, times and location,
Please contact:

Riverside Co. Dept. of Mental Health
The Family Advocate Program
(909) 358-4987/1-800-330-4522

Possible Blood Test?

Reelin is a protein that is reduced in brains of those with bipolar, depression, schizophrenia, and autism. A University of Minnesota study* found "180 kDa Reelin" blood values dropped significantly in bipolar and depressed patients, suggesting that blood Reelin levels may be used as potential peripheral markers to diagnose psychiatric disorders.

• Division of Neuroscience Research, Department of Psychiatry and Community University Health Care Clinic, University of Minnesota Medical School, Box 392, Mayo Building, 420 Delaware Street SE, Mmflea polis, MN 55455

McMan's Depression and Bipolar Weekly, November28, 2001, Vol.3, No.46
Source: DMDA of Colorado Springs "The Innitiative" Winter 2001

Natural antidepressant has its limitations

For over 2,000 years, people have been taking St. John's wort to escape bouts of anxiety and depression. But this plant with small yellow flowers isn't for everybody, according to a new study.

St. John's wort, now popular as an ingredient in herbal remedies, doesn't help people with moderate or severe forms of depression, concludes the team of psychiatrists that conducted the study. Since the risks of inadequate treatment for major depression are so high, the scientists conclude that people with serious depression "should not be treated with St. John's wort."

Many people with depression have preferred St. John's wort over conventional drugs because of its lower cost and fewer side effects, says study leader Richard C. Shelton of Vanderbilt University in Nashville. Many studies on St. John's wort have bolstered anecdotal evidence that the natural antidepressant is more effective at relieving depression than a placebo is (SN: 10/30/99, p. 280). Several experiments even found that St. John's wort worked as well as some standard antidepressant drugs. However, Shelton says there are flaws in that research.

The previous work, for example didn't distinguish patients with milder forms of depression from those with more severe depression, he says. So, he and his colleagues focused their research on moderately to severely depressed people—the population that would be harmed most if treatment failed. Discouraged by unrelenting symptoms, these people can become suicidal, says Shelton.

The researchers recruited 200 adults diagnosed with moderate to severe depression. All the patients had been depressed for at least 4 weeks before the study and had not taken St. John's wort.

Half the patients were treated with three 300-milligram tablets of St. John's wort extract per day. If a patient didn't show improvement after the fourth week of treatment, the researchers increased the dose to four tablets a day. The other half of the patients received a similar treatment regimen, but with a placebo in place of the herb.

After 8 weeks, the researchers found no significant difference in depression between the two groups. Shelton and his colleagues report their findings in the April 18 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

James E. Simon, a medicinal plant biologist at Rutgers University in New Brunswick, N.J., notes that the new work confirms a "long-held belief" that people who have moderate or severe depression shouldn't rely on St. John's wort.

"There's a window of opportunity where [St. John's wort] looks like it's effective," and that's only for people with mild depression, says Simon.

Shelton notes that his team's findings have no bearing on the herb's effectiveness in people with mild depression and says that on that matter, "the jury's still out." *—L. Wang*

Source: Science News, Vol 159, April 21, 2001

Depression in the Physically Ill

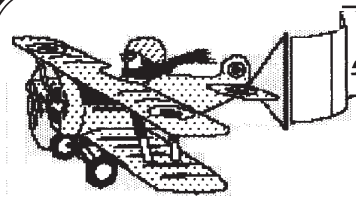
New studies have shown that depression in medical patients can make their conditions worse. Psychiatrists are now calling for a special effort by physicians to identify and treat depressions. That is difficult, the psychiatrists say, because many of the symptoms of depression, like loss of appetite and lethargy, can be mistaken for signs of other diseases, and most physicians are not well trained in diagnosing depression.

When medical patients are depressed, they cannot tell if it is part of the physical illness or something else. Very often their doctors don't know either. But studies show that for many severe and chronic diseases, like diabetes, treating a patient's depression also tends to speed recovery from medical symptoms or to lessen disability caused by the disease. Treating the psychological state has benefits medically. Of course, anyone who gets a serious illness is vulnerable to depression, and a disease like cancer can itself trigger depression. Psychiatrists say, however, that only some medical patients become depressed, and that these patients do less well than patients who have similar medical problems but are not depressed. Depressed patients are less able to do whatever it is they need to do to help themselves get better. If one is depressed on top of a serious medical problem, one does not have the energy, the interest, or the sense of purpose and hope.

The problem of depression's going unnoticed and untreated also seems to be prevalent in patients who do not have severe illness. Disease is a stressor that can trigger depression. Many widely used medications, like steroids, also sometimes lead to a depression. If one treats a patient's depression, one will see improvements over and above any changes in the underlying medical condition.

By Debra Weinberg
NAFDI News, Fall 1996

Source: MDDA newsletter of Detroit, MI, January 2002



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

HEMET SUPPORT GROUP
"Foundations" meets every
Tuesday 7–9 pm.
Please call 909 / 658-0181

TEMECULA DMDA
Contact Mark 909 / 926-8393

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)

☺

Calling all interested consumers.

We are looking for consumers who are interested in sharing their personal recovery story. Living With Schizophrenia and Other Mental Illnesses *(LWSIOMI)* is a recovery-education program given by trained consumer presenters for other consumers, family members, friends, professional, and lay audiences.

Individuals need not be active in mental health advocacy at this time, but they:

- *"have been there"*
- *are in recovery*
- *believe in treatment, with medication as the cornerstone for recovery*
- *must be able to present professionally*
- *have the time to be trained, and periodically present at 1 1/2 to 2 hour workshops, often during working hrs.*

Stipends will be paid for presentations.

NAMI - - Living With Schizophrenia and Other MentaI Illnesses

Please call for more information: Lisa Partaker, Program Coordinator
(909) 686-5484 or email: llpartaker@excite.com

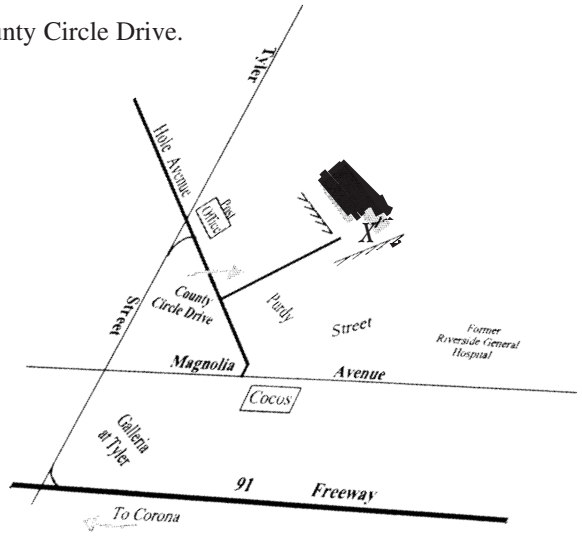
A collaborative effort brought to you by:
Riv. County MH Dept. — NAMI, Western Riverside County —
Jefferson Transitional Programs

☺

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 first,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 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 _____CITY_____STATE ____
ZIP _____

Please check one of the following:
I have: ❒ Manic-Depression ❒ Depression I am a: ❒ Family Member ❒ Professional

❒ None of the above 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. ❒