The Thermometer Times

Published by The Depression and Bipolar Support Alliance of Riverside, California

VOL. 18 NO. 3 Out of darkness . . . March, 2006

Dates to Remember

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CARE & SHARE GROUPS

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

Riverside County Mental Health Administration Building
(see page 13 for address)

Every Saturday,
10 am–12 noon
This month, March 4
11, 18 & 25

Tom Wooten, "The Bipolar Advantage"
Saturday, March 18
at Jo Ann's, Lunch after the meeting

Meetings start promptly at 10 am. Do yourself a good turn: Be on time to visit with friends before the meeting starts. If you come late, please enter quietly. Announcements will be made at the close of the meeting.

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 the right

16280 Whispering Spur
Riverside,CA 92504 951 / 780-3366

New Developments In Psychiatry

by Mark Hinsch

Have you been wondering what new developments are occurring in the field of psychiatry? To find out, we invited psychiatrist Dr. Syed Ali to our educational meeting on September 27, 2005. Dr. Ali is a director of DuPage Mental Health Services Ltd., and the Clinical Assistant Professor of Psychiatry at the Loyola University Stritch School of Medicine. He was joined by one of his colleagues, Ann Megna, Doctor of Psychology, and Tom Carmichael, Senior VNS Therapeutic Consultant from Cyberonics, Inc.

One of the main developments discussed by the speakers is called Vagus Nerve Stimulation (VNS). This type of therapy was developed by Cyberonics, Inc. You are probably wondering, what is it, how does it work, and who is it for?

The vagus nerve is one of the primary communication pathways from the major organs of the body to the brain. VNS Therapy is delivered by a pulse generator (like a pacemaker) and thin, flexible wires that send mild pulses to the vagus nerve in the left side of the neck. The vagus nerve delivers these pulses to the areas of the brain involved in the regulation of mood. A surgical procedure is needed to implant the device and to connect the wires to the vagus nerve in the neck.

VNS Therapy is indicated for use as an adjunctive (add—on) long-term treatment of chronic, recurrent, treatment—resistant depression for patients over the age of 18 who are experiencing a major depressive episode and have not had an adequate response to four or more adequate antidepressant treatments. Some patients using VNS Therapy experience a remission of their symptoms. Others wait a year or more before noticing an improvement, while still others receive no benefit from the treatment.

Dr. Ali also discussed several new medications used for the treatment of sleep problem. Among those discussed were 3 that cause sleeping (Lunesta, Ambien CR, and Rozerem) and one that causes wakefulness (Provigil). It was mentioned that Lunesta is approved for long—term use. Ambien CR is indicated for sleep maintenance, and Rozerem helps regulate the parts of the brain responsible for the wake—sleep cycle. Provigil is indicated to treat excessive sleepiness associated with certain sleep disorders.

Non—medication strategies for the treatment of insomnia are also available. These may include avoiding caffeine, sugar, stressful stimuli, and exercise before bed; using cognitive behavioral therapy (CBT) and deep breathing exercises to relax; and maintaining a calm, quiet sleep environment. Keeping a sleep diary can also be useful.

Ann Megna, Psy.D., contributed to the evening by discussing cognitive behavioral therapy (CBT), biofeedback, hypnotherapy, and self-care strategies (such as getting enough sleep and exercise and eating healthy foods). CBT involves regulating your thoughts which in turn helps to regulate your feelings. Biofeedback involves learning how to monitor and regulate your body's physical state such as your heart rate. And hypnotherapy involves entering a relaxed state during which suggestions are made by a trained therapist that help to create positive changes. She also demonstrated several different computer programs that aid in these strategies.

Source: DBSA, Fox Valley Speaker Meeting, Sept. 27, 2005

a note from the Editor

Thank you for your response to this column and your submission of articles and poetry.

We invite you to continue to submit similar material for review and possible publication in the newsletter. These kinds of articles allow us to get to know one another in greater depth and to learn of the many talents, interests and assets of our members.

We again want to solicit articles and poetry from you, for publication in *The Thermometer Times*.

Articles, poetry and/or drawings can be on anything pertaining to:

*Uplifting affirmations or positive experiences you have to share regarding overcoming.

* Depression and/or Bipolar Disorder: what it is to live/cope with it; how you learned of it, what helps, what doesn't, etc., etc., etc..

* Any other mental health issue or problem that you are passionate about.

*Tell us about yourself and how you spend your time and what's important to you.

*A report on a mental health event you attended or a mental health book you have read.

Drawings should be black and white, line or half-tone.

Your work may be submitted to JoAnn, Leroy or Lynne at DBSA Riverside meetings.

It may be mailed to:
JoAnn Martin
16280 Whispering Spur
Riverside, CA 92504

E-mail it to: JoAnnMartin1@aol.com

FAX to: 909/780-5758 (if you have a problem with that FAX call JoAnn at 909/841-4774 and she will turn on another FAX machine.)

Materials submitted may or may not be published, at the discretion of the editors, and may be edited for length.

Get your creative juices flowing and share your knowledge and experience with your DBSA friends through *The Thermometer Times.*

Thank you.

Lynne Stewart, Senior Editor

"One of the advantages of being disorderly is one is constantly making exciting discoveries."

-A.A. Milne
Writer

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Riverside Suicide Crisis Help Line

Call **(909) 686-HELP [686-4357]** if you need to talk to someone. It is available 24 hours - 7 days a week.

National Suicide Prevention Hotline

Call **1-800-273-TALK (8255)** if you need to talk to someone in any of 109 crisis centers in 42 states. The National Suicide Prevention Lifeline has just been launched by SAMHSA (Substance Abuse and Mental Health Services Administration) as part of the National Suicide Prevention Initiative (NSPI). In addition, a new Web-site has been established at **www.suicidepreventionlifeline.org.**

George Frederic Handel

Handel's general look was somewhat heavy and sour, but when he did smile, it was his sire the sun, bursting out of a black cloud. There was a flash of intelligence, wit, and good humour, beaming in his countenance, which I hardly ever saw in any other.

-Charles Burney, 1785

George Frederic Handel, born in Halle in 1685 but naturalized an Englishman, in many ways quite unlike the other four composers whose lives and works are being presented in today's concert. Schumann, Wolf, Berlioz, and Mahler, all born in the 19th century, were unusually introspective men who wrote extensively and well about what they thought, felt, and experienced. Handel, cut from a different bolt in a different era, left little written record of his psychological and emotional world. Christopher Hogwood's recent biography makes the point that, "As a public figure Handel is well documented, as an individual he remains hidden: his private life is rarely exposed, his letters are few and unrevealing..:" Still, certain aspects of Handel's character and temperament are portrayed by his contemporaries with consistency and conviction. He was perceived as energetic, persevering, generous with his wealth, adventurous in his financial enterprises, explosive ("his temper was legendary"), flexible, and with a "natural propensity to wit and humour:" Burney wrote, in 1785, that Handel was:

..full of fire and dignity... He was impetuous, rough, and peremptory in his manners and conversation, but totally devoid of ill nature or malevolence.

A tribute written the year after his death described the composer:

Such was Handel, in whose character whatever there was wrong there was nothing mean; though he was proud his pride was uniform; he was not by turns a tyrant and a slave: a censor in one place and a sycophant in another; he maintained his liberty in a state in which others would have been vain of dependence: he was liberal even when he was poor, and remembered his former friends when he was rich.

Handel's mood disorder, a cyclothymia, or milder form of manic-depressive illness, was characterized by long periods of sustained high energy and singular productivity, broken by episodes of depression. It is not clear whether any of these depressive episodes were of psychotic severity, but they interfered seriously with his professional functioning. Major depressive episodes occurred during 1737, 1743, 1745 (described as a "nervous breakdown") and probably in 1729, 1734, and 1741 as well. Little is known about Handel's mental health after 1745, and much of his dejection in later years was attributed to his progressive loss of sight. Handel's depressions were characterized by sleeplessness, pessimism, despondency, greatly reduced productivity, and less appetite for food and drink (symptomatic of many depressed individuals, the latter was particularly striking in Handel, who "required a great supply of sustenance to support so huge a mass, and... was rather epicurean in the choice of *it").* At various times Handel was described as deeply melancholic, behaving with "oddity," mentally deranged, and as having experienced a "physical and mental collapse:' In 1745 Lord Shaftesbury wrote:

Poor Handel looks something better. I hope he will entirely recover in due time, although he has been a good deal disordered in the head.

Handel's librettist, Charles Jennens, described the composer as having a head "more full of maggots than ever:" According to Handel biographer Percy Young, " The maggots came from mental derangement on the one hand and flooding inspiration on the other:' Although Handel's episodic difficulties were seen initially as signs of a "paralytic disorder," the nature of his symptoms, and the patterns of onset and recovery, make this unlikely. Neuropsychiatrists Slater and Meyer have pointed out that his ostensible stroke in 1737 was strangely gradual in onset, and very rapid in recovery; that there were no signs of progressive damage or of intellectual impairment; and that there was no indication of a speech defect, difficulty in walking, facial asymmetry, or changes in handwriting. Handel's temporary inability to use his right arm was almost certainly due to muscular rheumatism or depression.

Continued on page 4 (Handel)

Handel *(continued from page 3)*

Recent biological and psychiatric research emphasizes the importance of seasonal and other rhythmic patterns in mood disorders. Many of Handel's depressed phases occurred during the late spring and early summer months, with bursts of extraordinary productivity in late summer and early autumn. It is possible that some of Handel's seasonal productivity patterns were due to the professional demands on his time during the rest of the year. However, they are also consistent with what is known about peak seasons for mania (July through September); compositional patterns in many other composers; and results from a recent study of mood disorders and seasonal productivity patterns in outstanding British writers and artists. Certainly Handel's compositional rate was remarkable. In the summer and fall months of the decade 1738-48, his compositions included:[1]

1738	**23 July-15 August**	Saul (Draft)
	9 Sept.-20 Sept.	Imeneo (Draft)
	1 Oct. 1- Nov.	**Israel in Egypt**
1739	**15 Sept.-24 Sept.**	**Ode for St. Cecilia's_Day**
	29 Sept.-30 Oct.	**Concerti Grossi, Op. 6**
1741	**22 August-14 Sept.**	**Messiah**
1744	**19 July-17 August**	**Hercules**
	23 August-23 Oct.	**Belshazzar**
1746	**8 or 9 July-11 August**	**Judas Maccabaeus**
1747	**1 June-4 July**	**Alexander Balus**
	19 July-19 August	**Joshua**
1748	**5 May-13 June**	**Solomon**
	11 July-24 August	**Susanna**

The lack of detailed descriptions of Handel's moods, and the absence of information about any family history of mood disorders, make retrospective diagnosis more difficult than in very severe and well-documented instances of manic-depressive illness (for example, Schumann, Wolf, and Berlioz). However, the consensus of modern psychiatric opinion is that Handel had an unusually pronounced cyclothymic temperament, a variant of manic-depressive illness.

Undoubtedly the most meaningful perspectives on Handel remain those expressed by an anonymous contemporary:

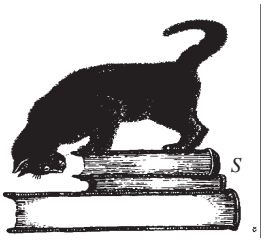
Whose Compositions.
surpassed the Power of Words
In expressing the various Passions
Of the Human Heart.

and by Beethoven:

Handel was the greatest composer that ever lived.

Source: Excerpted from a program from a concert by the Los Angeles Philharmonic . May 19, 1983

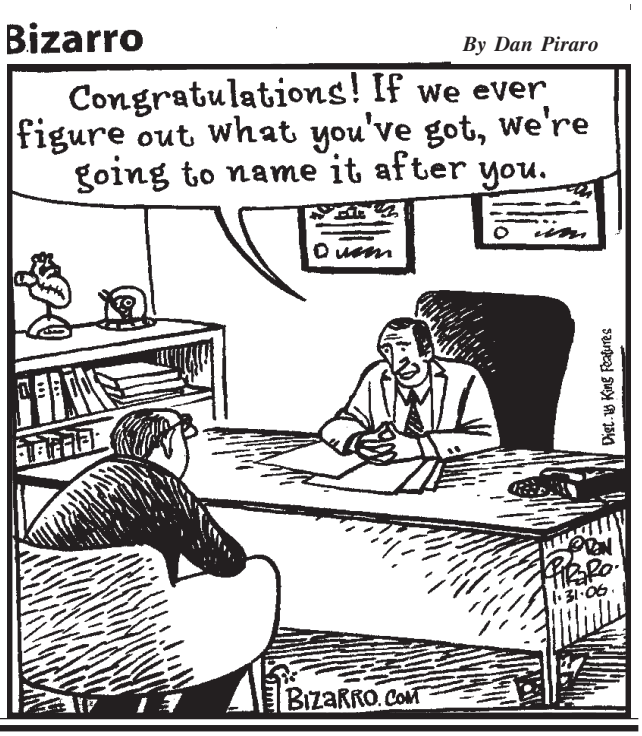
BOOK REVIEW



LOST IN AMERICA:
A Journey With My Father
by Sherwin B. Nuland. (Vintage, $12.)

This memoir by a distinguished surgeon and writer is both an old-fashioned success story of a second-generation immigrant who grew up poor in a Yiddish-speaking Bronx family dominated by a volcanic father**,** and a harrowing account of his own mid-life crisis, a prolonged episode of depression that required hospitalization and 20 electroshock treatments. Nuland 'brilliantly conveys the inner experience of depression as an effect of the emotional dynamics of family life," Morris Dickstein said here last year. His "may well be a great book, full of feelings and memories that ring true."

Source: New York Times Book Review
Sunday, February 15, 2004



Meds Alone Couldn't Bring Robert Back

Experts like to debate the effectiveness of new drugs, but they overlook a key element of recovery.

BY JAY NEUGEBOREN

When my brother Robert arrived at Bronx Psychiatric Center in 1998, Dr. Alvin Pam, chief of psychology, told me it was the consensus of the staff that Robert would never be able to live without supervision, and if discharged, was destined to be repeatedly re-hospitalized. By this point in time, my brother had been a patient in the New York state mental-health system for nearly 40 years, and had been given nearly every antipsychotic medication known to humankind.

But he had not yet been given any of the new medications—the so-called atypical antipsychotics, a National Institute of Mental Health study recently found were not significantly better than the old ones, a discovery that has caused intense debate in the mental-health community. Robert's reaction to the drug was seemingly dramatic. Several months after Robert started taking it, Dr. Panmcalled to say his recovery was nothing short of miraculous—he was clear thinking, free of delusions, and the hospital was planning his discharge.

A few weeks after that, Robert telephoned. *"Alan's leaving—Alan's leaving!"* he kept screaming. Alan was my brother's social worker—a man to whom he was very attached and whom he had known for many years, from his long-term stay at another hospital. I called and discovered that, without warning, Alan had been transferred to another state hospital.

Robert began having tantrums, hallucinations, bodily tremors, irrational fears, panic attacks, and he became both dangerously manic and depressed. It would be more than a year before the hospital would again prepare him for discharge. The question, then: why did the medication that worked so well—so miraculously—on Monday stop working on Tuesday? The answer: because Robert was deprived of a relationship that had been a crucial element in his recovery.

At about this time I was interviewing hundreds of former mental patients for a book I was writing. They were people who had been institutionalized, often for periods of 10 or more years, and who had recovered into full lives: doctors, lawyers, teachers, custodians, social workers. What had made the difference?

Some pointed to new medications, some to old; some said they had found God; some attributed their transformation to a particular program, but no matter what else they named, they all—every last one - said that a key element was a relationship with a human being. Most of the time, this human being was a professional—a social worker, a nurse, a doctor. Sometimes it was a clergyman or family member. In every instance, though, it was the presence in their lives of an individual who said, in effect, "I believe in your ability to recover, and I am going to stay with you until you do" that brought them back. So it was with my brother, who, through his daily collaboration with Alan and the dedication of Dr. Pam (who refused to go along with the staff consensus that Robert would never live on his own) has not had a single recurrence for more than six years, the longest stretch in his adult life.

At Robert's new home at Project Renewal in Hell's Kitchen, the staff is equally dedicated to the 60 or so residents. Re-hospitalization rates are below 3 percent each year, and director Jim Mutton says, "Most individuals remain compliant with their medications for years at a time."

Like Jim, I too have witnessed hundreds of formerly homeless, mentally ill adults renew their lives not only through access to a wide range of medications, but through access to individuals like Jim and Dr. Pam, who believe that pills, while useful, are only a small part of the story, and that the more we emphasize medications as key to recovery, the more we overlook what is at least as important: People working with people, on a sustained long—term basis.

In New York state, there are more than 60,000 individuals living with psychiatric disabilities. What (does it matter if one medication is superior to another if 34,500 of these people have no safe place to live, and therefore no opportunity to work, no choice of treatments and no access to dedicated individuals who are being paid decent wages to work with them?

Let's provide a range of medications, and let's study their effectiveness, but let's remember that the pill is the ultimate downsizing. Let's find resources to give people afflicted with mental illness what all of us need: fellow human beings upon whom we can depend to help us through the dark times and, once through, to merge into gloriously imperfect lives.

NEUGEHOREN lives in New York City.

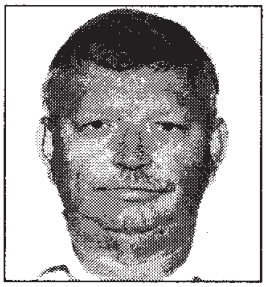
Source: Newsweek, February 6, 2006

GRIEVING ELEPHANTS

Elephants keep vigil over the dead and appear to experience grief, says Joyce Poole, scientific director of the Amboseli Elephant Research Project in Kenya. They have even been known to collect the scattered bones of dead elephants

Source: Psychology Today, April, 2006

IN LOVING MEMORY OF



GEORGE E. TURNER
12/04/1935 - 02/09/2004
Loving Father, Grandfather and Husband

We all miss you and love you. I miss you most of all, because when you went to be with the Lord, part of me went with you.

Your Wife, Marlene

Should I Drop My Antidepressant?

THE CONVENTIONAL WISDOM: Expectant mothers should avoid all nonessential drugs, whether prescription or over-the-counter.

Our current understanding is as follows:
First, antidepressants do not appear to cause major birth defects (with the exception of Paxil—the FDA recently linked it to heart malformations in babies). Second, there's not enough data to determine if antidepressants harm the fetal brain. Third, a mother's depression can definitely harm fetuses and newborns.

Depression during pregnancy is both common and potentially serious, occurring in at least 1 in 10 expectant women. It has been linked to miscarriage, premature birth, low birth weight, fetal growth problems, excessive crying and other signs of infant distress as well as preeclampsia, a type of hypertension which can be fatal to both mother and child.

Furthermore, it's known that women who are depressed before giving birth often experience postpartum depression. And among women who stop antidepressants before conception or in early pregnancy, some 75 percent will relapse into depression, according to a recent study in the *Archives of Women's Mental Health.*

To Gideon Koren, professor of pediatrics and pharmacology at the University of Toronto, the risks of untreated depression outweigh what he sees as largely speculative risks associated with drugs. One study by his group, published in the *American Journal of Psychiatry,* compared children of women who took antidepressants while pregnant to those whose mothers were not depressed. It found no differences in behavior, temperament or IQ associated with medication in children up to 6 years old.

Long periods of maternal depression after the birth, however, are linked with lower IQs in children. A mother's depression may also affect speech development in her kids. Young children whose mothers suffer repeated bouts of depression tend to score lower on language tests. The evidence suggests that better treatment for depression benefits both mother and child.

Other researchers are much less sanguine. Sandy Zeskind, a professor of pediatrics at the University of North Carolina, points to the fact that serotonin— a neurotransmitter affected by these drugs—plays a critical role in brain development, acting as a growth factor, not just a chemical messenger. It helps wire a baby's brain, telling neurons where to go.

At birth, up to 30 percent of infants born to women who take antidepressants suffer withdrawal or toxicity syndrome, in which they may be jittery, suffer breathing problems or even have seizures. The symptoms sound horrific, but research finds that they aren't long-lasting and have never produced a fatal outcome. Testing for the level of medication in the infant can determine whether symptoms are associated with withdrawal (low levels) or toxicity (high levels), and thus whether tapering doses should be given.

Studies have also found differences in motor skills and in pain sensitivity in babies exposed to antidepressants in the womb.

The Bottom Line

Is there another way? Because the third trimester is the most critical period for serotonin exposure, some physicians rec-ommend that women taper off medication during the second trimester and restart it afterbirth if needed. Such an approach might best balance risks and benefits— especially since breast-feeding does not appear to expose most babies to high drug levels. Using the lowest effective dose—not the lowest possible dose—is another way to reduce risk.

MAIA SZALAVITZ is a senior fellow at media watchdog group stats.org.

Source: Psychology Today, March/April 2006

Ask The Doctor?

How can I maintain a healthy weight when my meds make me gain weight? This is different than normal weight gain because it happens so quickly,. I gained 50 pounds in three months. That alone makes me depressed. Which mood stabilizers and antidepressants generally do not make people gain weight?

Kim

Dear Kim:

Weight gain in our society in general and particularly in people who need to take various medications, is a very serious problem for the individual and for our country, in terms of a public health problem. Not only is weight gain associated with a low self-esteem, but there are significant health risks associated with weight gain. Though you did not inquire about weight gain induced by the atypical antipsychotic drugs, these medications for the most part have been associated with weight gain, as well as high cholesterol, high triglycerides, and high blood sugars. Diabetes mellitus can also be induced without weight gain. Atypical antipsychotics, listed in descending order from the chance of most weight gain to those less likely to affect weight gain are: clozapine (Clozaril), olanzapine (Zyprexa), aripiprazole (Abilify), and ziprasidone (Geodon). (The propensity for weight gain is only one of many factors the physician considers when an atypical antipsychotic is selected to help the patient).

The weight gain caused by these medications seems to be due to an increased appetite. Though metabolism may slow down, most researchers and clinicians feel that the weight gain is a consequence of increased food consumption. Also, if certain medications decrease the patient's physical activity level, the patient may expend fewer calories because of less activity, and therefore, gains weight. Prior to going on these medications, a patient should get counseling from the physician, and/or dietician to develop a healthy diet and exercise plan. Ideally, the patient should begin a good diet prior to initiation of these medications, and also, plan to increase the amount of exercise, under the supervision of the doctor. Also, baseline weight, waist size, and certain laboratory tests should be done before starting the atypical anti-psychotics.

Virtually all the medications used to treat mood disorders can induce weight gain. All of the SSRI's (Selective Serotonin reuptake Inhibitors) can induce weight gain. With many of the SSRI's there may be a decreased appetite for the first three to six months, but then an increased appetite follows. The SSRI's include sertraline (Zoloft), Fluoxetine (Prozac), paroxetine

Continued on Page 7 (Weight Gain)

Weight Gain *(Continued from Page 6)*

(Paxil), fluvoxamine (Luvox), citalopram (Celexa), and L-Citalopram (Lexapro).

Buproprion (Wellbutrin) may indeed be weight neutral or associated with a very modest weight loss. Other antidepressants can cause modest increases in weight loss. Other antidepressants can cause increase in weight, e.g., venlafaxine (Effexor), Mirtazapine (Remeron), is also associated with weight gain. However, the choice of the antidepressant should be discussed with your doctor so that the propensity for weight gain will be considered, as well as the other side effects associated with each particular medication.

Generally, the mood stabilizers, can induce weight gain. This includes lithium and divalproex (Depakote), Carbamazepine (Tegretol), and oxcarbazepine (Trileptal) may be associated with a modest weight gain. Lamotrigine (Lamictal) is not associated with weight gain, and is also considered to be weight neutral. Topiramate (Topamax) may be associated with weight loss. However , Topamax has its own side effects which include perhaps mental dulling and kidney stones.

Weight gain is a very serious problem and though physicians are very much concerned about the potential for weight gain because of the psychological and physical consequences, careful monitoring of diet and exercise are critical so the patient can remain on the medication safely. Besides stimulants (including phentermine—-Aripex or lonamin) which can reduce appetite, other medications sometimes used for weight loss include orlistat (Xenical) and sibutramine (Meridia). However, all these medications can have serious side effects, and most clinicians are therefore reluctant to prescribe them.

In summary, the mood stabilizer which seems to be weight neutral is lamotrigine and the antidepressant which may not induce weight gain is buproprion. However, these medications, because of the other side effects and other clinical considerations, may not be in the patient's best interest. The decisions about which medications to use for a particular patient are complex, and involve careful discussion between patient and the physician. Further questions should be explored with your doctor.

Thank you very much for bringing up this very important side effect which occurs with many of the medications used to treat mood disorders. I hope this information is of some help to you. Hopefully, you will be able to reverse the weight gain with the help of your doctor and a dietician. On a more positive note, often weight gain tapers off after several months.

I want to thank Dr. Richard Berchou for reviewing this response and for his suggestions.

Sincerely, Alvin B. Michaels, M.D.

Source: DBSA-Metro Detroit,Sept/Oct 2005 and NAMI of Tulare County, newsletter, Jan. 2006

Reprinted due to many inquiries concerning weight gain and medications.

Help For Cutters

In a few weeks, I will be giving a presentation to educators on students who self-mutilate. Some people call them "cutters," the students who use knives or razor blades to cut parts of their bodies. One of the questions I will surely be asked,"Is this behavior normal? "

Even though the sheer number of students who are cutting is skyrocketing, the answer is, "No, this is not a normal or typical adolescent behavior."

Young people who self injure are not going through a phase. The reasons they do it vary. For some, it is a means to communicate. They are telling others by these behaviors that their emotional pain is so intense, so unmanageable, they want others to know the amount of discomfort they are experiencing. These students lack confidence in their ability to communicate and do not feel they will be understood.

Another reason often cited by self-injurers is, " It relieves my pain." Students who cut themselves will say, "When I cut I feel more in control. It's the only way I can relieve the tension that builds inside of me." It is their way of controlling the uncontrollable.

Some come from broken homes, some do not. Some have experienced sexual, emotional or physical abuse, and others have fairly benign childhoods.

Many parents react to the news their child is cutting themselves with horror or disgust. They'll say things like, "Get away from me!" or "Stop this right now!" Neither of these reactions is helpful, although they are understandable.

Parents who have a child who chooses to self-injure should put their own anger aside and try to understand what could motivate a child to act so angrily toward him-or herself.

These adolescents need professional help to assist them in sorting through what may seem like insurmountable problems. Typically these young people believe they are victims of external problems and have no choice but to act out physically.

No therapist, no doctor is going to "fix" these young people, but rather the professional will join forces with them to build up their confidence in communicating in less destructive ways and help them understand they do not need to be punished or pay penance.

The process is individual, but this condition is certainly treatable. Most cutters do not need to be hospitalized, and only a few of them are suicidal (many cutters will say they self-injure so they won't kill themselves).

But it is not a transient or insignificant behavior. I will encourage all educators to resist the temptation to build an alliance by keeping a student's self-injury a secret and to understand it must be told to parents so the parents can get their child the help they need.

Mitchell Rosen, M.A., is a licensed marriage and family therapist with practices in Corona and Temecula. Contact him at family@pe.com

Source: The Press Enterprise,Riverside, CA, 1-08-06

BIPOLAR DISORDER AND RELATIONSHIPS

Bipolar disorder is tremendously destructive to relationships. The divorce rate among marriages in which a spouse is manic-depressive is very high. It is demoralizing for a husband or wife to endure a day-to-day relationship with someone from whom they can't get a positive response, and can't help. Manic episodes can be as daunting for a partner to endure as can be depressive ones. People like to believe they can contribute to their partner's getting better. "Count your blessings,'a spouse will tell his mate. But while the intention is to cheer and show support, such reassurances don't work for a person with bipolar disorder. A partner cannot alter the course of the illness, and the well-meaning spouse ends up feeling rejected and frustrated. People blame themselves for not being able to turn their partner's illness around.

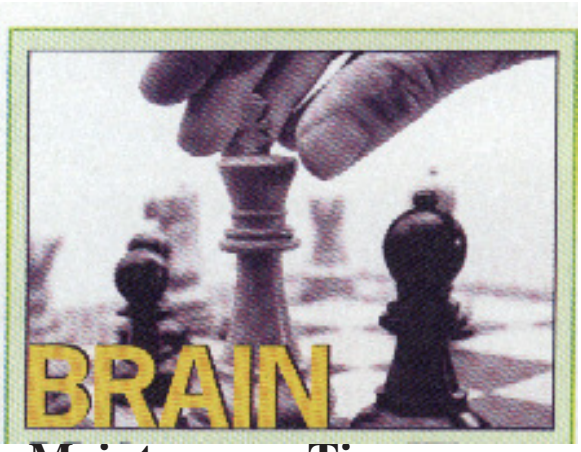
When a person with bipolar disorder becomes intense, the very elevation of his or her mood can frequently create problems with interpersonal relationships. Intensity can fuel manifestations of ebullience, overconfidence, and volatility. These episodes may fluctuate dramatically and be interspersed with periods of irritability and rage. "We, the afflicted, become transported into a world of unlimited ideas and possibilities. The sky's the limit," said Nancy.*

"While we're soaring, other people frequently are put off by such apparent grandiosity. We may seem too talkative, uninhibited, pompous, manipulative, or intrusive: our ideas may sound outlandish; or we may exhibit other irresponsible or inappropriate behavior. Such characteristics are manifested during periods of mania, or hypomania (less extreme), and our seemingly inexhaustible supply of energy and self-confidence can erode, and even torpedo, relationships.

"You're not hearing me," I've been told on numerous occasions,"one patient said. "Although I might have heard every word, at that moment, I may not have been in a position to control my garrulousness. When my bipolar condition kicks in, oftentimes it's accompanied by irrational behavior. I feel distraught."

In a troubled marriage, the ill person usually gets the blame immediately and receives no support from his or her partner. But any relationship can quickly deteriorate, and even the strongest ones can be extinguished over time. Women, more often than men, are the more traditional caretakers. As a result, more women than men will stay around to nurture and support the relationship when illness strikes a loved one.

Source: Excerpted from "New Hope for People with Bipolar Disorder", by Jan Fawcett, M.D., Bernard Golden, Ph.D., & Nancy Rosenfeld, Three Rivers Press*

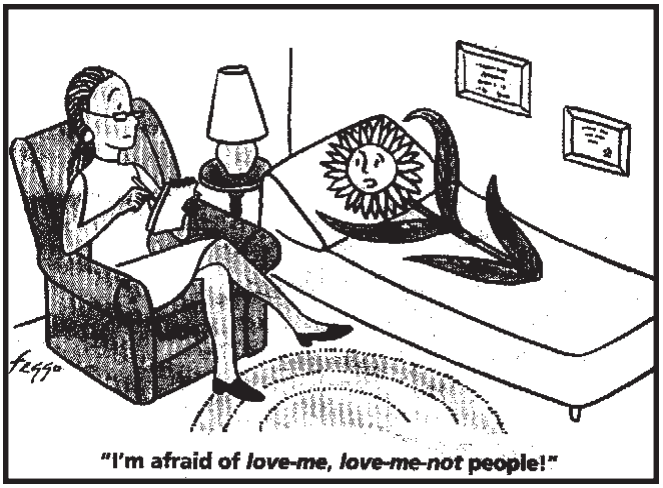


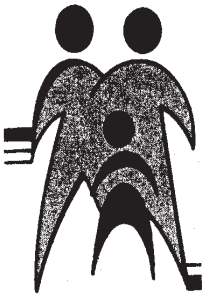
Maintenance Tips

Follow these tips to keep your nerve cells and your brain working at top speed:

- Exercise your mind by reading, playing challenging games, and following current affairs
- Exercise your body to help keep your heart and blood vessels healthy and increase blood flow to the brain
- Eat a healthy diet to provide your brain with plenty of fuel
- Get a goodnight's sleep to help you retain information
- Stay socially active and learn new hobbies to engage your imagination

Source; Psychology Today, February 2006





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

The Starting Point **SUPPORT GROUP FOR DEPRESSIVES AND BIPOLARS**
Mesa Clinic, 850 Foothill Blvd., Rialto
Mondays from 10:30 to 12:10
For more info: *82 (909) 864-4404

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
DBSA P.O. Box 51597 Riverside, CA 92517-2597
FAX 951/780-5758

Join us for the
Holidays
Picnics or dinners
at noon at Jo Ann's

Swimming, badminton, spa, food and more...
during summer months.
Friendly sharing during the winter.

Bring a salad, main dish,
or dessert.
If you can't bring a dish, come anyway.
Meat & beverage will be furnished.

Holidays include: Memorial Day,
4th of July, Labor Day,
Thanksgiving, and Christmas.

See page 1, lower left column of this
newsletter for directions.

Check us out on the web!

Website for DBSA Riverside:
http://www.geocities.com/mddariv
E-mail addresses: *DBSA, Riverside: dbsaofriv1@aol.com.*
DBSA,California: *dbsaofca1@aol.com.*

Do you have a Medic Alert Bracelet?

Do you wear it? All the time?
In an emergency, would others know what
medication you are taking and why?
Always wear your
Medic Alert bracelet.
It could save your life.
If you don't have one,
ORDER ONE TODAY!
(Available through most pharmacies)

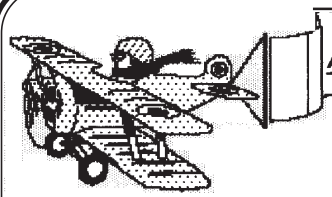
Phone Phriends

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

Leroy
6 a.m. to 9 p.m.
951/686-5047

Yen
951/315-7315

Kevin
kevin2004n@aol.com



TEMECULA DMDA
Mark Monroe
951/926-8393

HEMET SUPPORT GROUP
Hemet Support group meets at
Trinity Lutheran Church
Tuesdays, 7 to 9 pm. Fridays,
1:30 to 3:30 pm
Please call 951/658-0181 (Lyla)

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

THE UPLIFTERS
(Christian emphasis) meets at
The Grove Community Church
Contact Sheri 951/789-6564
s1-matsumoto@sbcglobal.net

For Support People:
NAMI - Riverside Mental Health Administration Building
4095 County Circle Dr. (off Hole Ave. near Magnolia)
7:00 pm, 1st Monday each month 951/369-1913 - Rosanna
No meeting July or August

GAY, LESBIAN, BISEXUAL AND TRANSGENDERED
FRIENDS OF THE INLAND EMPIRE

Gays In Search of Hope

http://www.geocities.com/gayhope1/index.html

THIS IS A GAY, LESBIAN, BISEXUAL
AND TRANSGENDERED
DEPRESSION AND BIPOLAR SUPPORT GROUP
Parents, family and friends are welcome here and are encouraged to participate in the support group in a relaxed non-threatening atmosphere. Please join us!
No One Should Suffer in Silence!!!

WHERE: County of Riverside,
Mental Health Administration Building
4095 County Circle Drive, Room A
Riverside, CA 93503

WHEN: The 2nd and 4th Saturdays, 1p to 2:30p

Kevin: (951) 359-0739
E-Mail: gdbsa@aol.com

Flyer Updated 1/7/2006

Calling all interested consumers!

NAMI—In Our Own Voice:

Living With MentaI Illness

We are looking for consumers who are interested in sharing their personal recovery stories. In Our Own Voice: Living With Mental Illness *(IOOV)* is a recovery-education program conducted by trained presenters for other consumers, family members, friends, and professional and lay audiences. Individuals need not be active in mental health advocacy at this time, but

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

Stipends will be paid for presentations.

For more information, or to be put on a waiting list,please call:
Allison Hoover, IooV Coordinator
951/ 686-5484

A collaborative effort brought to you by:
—The Riverside County Mental Health Department—
— NAMI, Western Riverside County —
—Jefferson Transitional Programs—

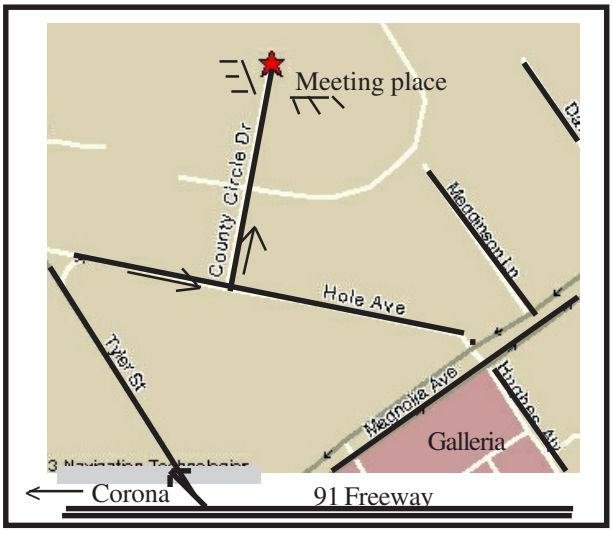
DBSA– Riverside

Map Legend

★ Meeting Location

/ / / / = Parking

Due to route changes, no RTA regular bus crosses County Circle Drive anymore. However, several routes stop at the Galleria (Tyler Mall), which is only a three-block walk from where we meet. Those routes include Canyon Crest, Corona, Country Village, Hemet, La Sierra, Perris, Norco, and Sun City.* For meeting-day route times, please call RTA at 800/266-6883 toll free. If you qualify for Dial-a-Ride, a door-to-door service for the handicapped, info is available at the same phone number. * as well as other parts of Riverside.



About DBSA-Riverside

DBSA of Riverside is a support group for people who have depression or bipolar (manic-depressive) disorder and who have sought or are seeking treatment for their illness. DBSA 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 JoAnn Martin on the Saturday afternoon following the last sharing 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 JoAnn or Leroy at 951/ 780-3366. Our sharing meetings are held every Saturday of each week 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. We welcome professional care providers and adult family members and friends. Please note our new area code - 951, effective on July 17, 2004.

MEMBERSHIP INFORMATION

Individual membership for the Depression and Bipolar Support Alliance of Riverside is $20.00 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 $10.00 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, please indicate below.

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

DATE _____ **Please Print** ❒ New ❒ Renewal

NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE ____

ZIP _____ E-MAIL ADDRESS _____

Please check one of the following:

I have: ❒ Bipolar Disorder (Manic-Depression) ❒ Depression

I am a ❒ Family Member ❒ Professional

None of the above

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

Enclosed is my payment for DBSA Membership _____ $20.00 (includes newsletter).

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

I would like a subscription to the newsletter only. $10.00 (12 issues per year).

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