The Thermometer Times

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

VOL. 18 NO. 4 *Out of darkness . . .* *April, 2006*

Dates to Remember

****

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 directions)

Every Saturday, 10 am–12 noon

This month: April 1, 8, 15, 22 & 29

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

Guest Speaker: Tom Wootton

Author of "*The Bipolar Advantage*"

On March 18, 2006, at the special St. Patricks Day DBSA Saturday Support Group meeting held at JoAnn Martin's home, Tom Wootton, author of *The Bipolar Advantage*, was our guest speaker. We had over 45 members in attendance, one of the biggest turnouts ever. Following Tom's inspring presentation, we split into four separate Care & Share groups; after which JoAnn served a traditional corned beef and cabbage meal for everyone.

Tom shared some of the positive and negative aspects of bipolar disorder and gave us insights to guide us into a more healthy lifestyle by minimizing the negative. He also told us that he had his first bipolar episode as early as nine years old, but wasn't diagnosed until he was forty-five. He described how his disorder manifested itself over the years and how he gained knowledge and insight to overcome it. He holds workshops and lectures to share this wisdom with others. His website is: **www.BipolarAdvantage.com**

The following is an article, written by Tom, that he read to us at the conclusion of his talk:

I want to be a better person

I have finally settled on a motto that says it all for me - "I want to be a better person." For me that simple phrase addresses many of my issues; my arrogance, my bad behavior, my admission of having done wrong, my acceptance of who I really am, and most of all my need for hope. "I want to be a better person" reflects my belief that in spite of my bipolar condition I can overcome my bad tendencies and become someone to admire instead of someone to fear or feel sorry for.

My journey to wanting to be a better person was long and convoluted, painful, yet even funny some times. My hope is that by sharing some of it with you I will have an even greater desire to live up to my dreams and perhaps give someone else hope as well. There are of course countless details left out and no doubt many details gotten wrong, but the general path may help to paint a picture of how I got to this point in my life.

Long before my diagnosis as Bipolar I, I had exhibited behaviors that should be considered horrible, to put it mildly. I thought I was smarter and better than anyone and could justify my behavior as the fault of whoever was my victim at the time. It was always "your" fault that I am being an asshole and if it wasn't for "you" I would be a saint. My extreme rages were more than outdone by my delusions and denial that I was responsible for my behavior, or even that my behavior was not perfectly justified.

Continued on page 3 **(Tom)**

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

If you don't have the best of everything, make the best of everything you have.

--ERIK RUSSELL
College football coach

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Riverside Suicide Crisis Help Line

Call **(951) 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.**

Tom *(Continued from page 1)*

I finally got sick of my own behavior and bought the estate next door to the monastery that I once lived in. I volunteered to manage the computer systems department and was put under the direction of Lee, a senior monk whom I have known for over 20 years. One day I had a falling out with a friend of mine that I had hired to do some work for the monastery. We ended up in a heated email exchange that was rapidly escalating to the point that it was harming the monastery. Lee stepped in, and because I was representing the monastery, insisted that all emails that I sent needed to be approved by him. It has been almost five years now, but that experience is one that I have finally grasped.

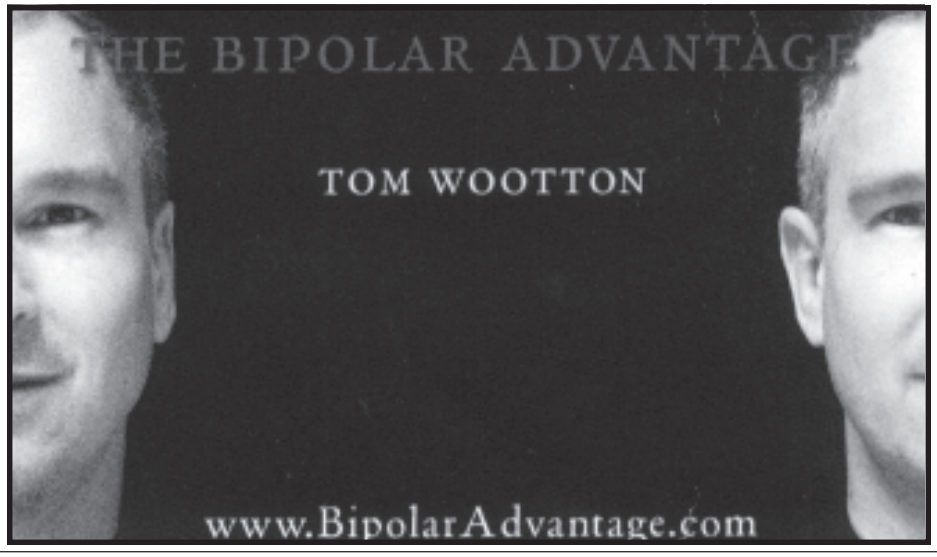
Mike would send mean email that was pretty rude; at least my deluded mind thought so. I of course wanted to reply with the full force of my rage, but knowing Lee would not approve it I would rant and rave around the office until I calmed down enough to write the first draft. I would read my draft to my coworkers and they would tell me "no way is Lee going to let you say that." I would go for a walk, try to soak up some of the peace from the monastery, and go back for another try. My coworkers would again tell me "no way" and I would repeat the effort all day. Finally by the end of the day, or sometimes the next day, I would have a draft ready for Lee. He would calmly change what I had written into something that sounded like a saint would write it.

The process of receiving an email and taking all day to respond went on for over a month. Good thing I was working for a monastery or I would have been fired for accomplishing nothing all month. Towards the end I told Lee that he was expecting me to act like a saint, to which he replied "did you expect anything less?" Finally I quit that job (is that what you call something you do for free?) and went back to my old ways.

A year or so later I was diagnosed with bipolar and by then was back in form. The delusions had taken over and I was sure everyone was out to get me. I was doing preemptive strikes and would vent my rage at anyone I thought was a danger, literally everyone. The lesson Lee had tried to teach me had not only failed to sink in, I never noticed it in the first place. The diagnosis seemed like the worst thing that ever happened to me, but now I see it as the best. I finally saw that I was acting inappropriately and there was a reason for it. I resolved to get a handle on my 'disorder' and Lee stepped in again and tried to help me to understand. He told me that it was not a 'disorder,' it is a 'condition' that I have to overcome. I put together a workshop so that I could gain the insight of other bipolar people and decided to call it 'Bipolar In Order' because I wanted to get the 'disorder' under control. I have learned so much from the workshops and will continue to facilitate them for as long as I can afford to.

Like most of what Lee tries to teach me, it took many years to understand what he meant by 'condition.' Does it really matter whether my actions are the result of a mental illness or just the accumulation of bad habits? I don't think so. It is who I am today and I finally realize what Lee was trying to help me understand. I now want to be a better person and that desire makes me try to say and do the right thing whether Lee is there to correct me or not. Everything that happens to me; a post on a bulletin board that I do not agree with, an event that happens on the street or in a store, my daily interactions with my wife, my friends, and everyone I meet, creates the same process in me. My first thought is to go into a rage. I then think "I want to be a better person" and try to temper my reaction. If I am doing well I choose to not react right away and I think about how I would react if Lee was there. I sometimes even act in ways that would make him proud.

I am finding that my desire to do the worst is starting to go away. My ability to do the right thing, or at least something approaching the right thing is getting stronger. Very slowly I am becoming a better person. I don't beat myself up about it, but I do put a lot of thought into analyzing my efforts. My introspection is getting easier because I can now honestly say that I have become a better person than even six months ago. My desire is so strong that "I want to be a better person" is now my motto. It might sound simple, but putting it into practice is the hardest challenge I have ever faced. It is also the most rewarding. Some day I might even live up to Lee's hopes and become that saint.



Psychiatric Advance Directives

Are they an alternative to forced treatment of psych patients?

by Vicki D. Lachman, PhD, MBE, APRN

Few would argue the U.S. believes in an individual's right to self-determination and choice. Our system of informed consent for procedures or participation in clinical trials is based upon the fundamental concept of respect for individual autonomy. We cannot force an individual to enter a hospital for treatment of his heart disease or her diabetes.

Why, then, can we force people to enter a hospital and undergo treatment for schizophrenia or major depressive disorder? Rather than debate this difference, let us discuss suggestions for more humane responses to the dilemas surrounding forced treatment.

Origin of Psychiatric Advance Directives

The Patient Self-Determination Act, enacted in 1990, gave the right to formulate psychiatric advance directives (PADs), indicating what treatment the individual would accept or refuse.[1] Like advance directives for end-of-life care, PADs are either instructional (living will) and/or agent-driven (durable power of attorney). They are legal documents that tell others treatment preferences. Advance directive statutes in most states, either expressly or by implication, apply to mental health. Seventeen states have explicit statutes to support PADs, and 29 states implicitly allow PADs within statutes of living wills and/or durable power or attorney for healthcare.[1,2]

The purposes of PADs are to:

- tell a doctor, institution or judge what types of confinement and treatment the individual wants and does not want; and/or
- appoint a friend or family member as agent to make mental health decisions, if the individual is incapable of doing so.

Although state laws vary, in most states a PAD is valid only if an agent is named.

The original intent was to ensure patients could communicate their wishes directly when they were unable to do so. It is a legal document expressing their choices about treatment. The National Mental Health Association supports the use of PADs as a tool for the expression of an individual's free will and self-determination.[3]

PADs were developed out of an intense reaction against polices of legally mandating psychiatric treatment; particularly the outpatient commitment law in New York.[1] A growing number of states authorized the advance appointment of proxy decision-makers for individuals with serious and persistent mental illness (SPMI). It was believed the need for coercion would be reduced significantly with SPMI who posed a threat to themselves or others.

PADs also support the recovery model, which is the psychosocial rehabilitation model utilized by all national organizations supporting the mentally ill. The Table illustrates the differences between the typical recovery and medical models.

Table: Recovery Model vs. Medical Model

Recovery Model	Medical Model 3
You can recover	Your illness is permanent
You are still fully human	You are your illness
Medications are helpful as you learn self-management skills	Medications should be used for the rest of your life
Work helps with recovery and provides meaning	You should not work until you are symptom-free

If PADs are appropriately implemented and executed, they can:

- promote autonomy and empowerment of the patient in recovery from mental illness;
- enhance communication between individuals and their families, physician and other treatment team members;
- protect the patient from ineffecti possibly harmful treatments; and
- help prevent crisis situations that result in involuntary hospitalizations or restraint and seclusion. [1-3]

How Do PADs Work?

Let's look at two typical cases where PADs might be helpful.

Donna, a 38-year-old woman with schizoaffective disorder, is very frightened as a result of her experiences in hospitals, since each hopitalization was more traumatic than the last. She has tried to tell them not to give her Haldol, but each time they dismiss her. Each dehumanizing experience leads her to believe she would rather be homeless again that be in a hospital.

Mr. and Mrs. Jones have seen their son Joseph be committed involuntarily at least 4 times. He has schizophrenia and periodically stops taking his medication. Each time, they have watched their son deteriorate, worrying his bizarre and unpredictable behavior will get him hurt.

*Continued on Page5 (**PADs**)*

Pads *(Continued from Page 4)*

When well, he expresses his gratitude for their support, but when ill he denies his need for treatment.

Both of these individuals may be subject to involuntary psychiatric commitment or treatment. Donna could protect herself from the Haldol in the section of PAD entitled "my preferences regarding medications for psychiatric treatment" by refusing Haldol and consenting to other medications. Joseph could make his parents his surrogate decision-makers in the "authority granted to my agent" section.

In both cases, the PAD would be created when the patient had capacity. [4,5] A mental health professional could conduct a mental status exam and note in the patient's record the individual was of sound mind at the time. The Competence Assessment Tool for Psychiatric Advance Directives can be used when doubts exist about a person's decisional capacity.[5]

A signed copy of a note designating capacity at the time of the PAD's creation should be attached to the PAD. A copy of the PAD should be part of the primary care and psychiatric healthcare providers' records. Of course, the heathcare proxy also should have several copies, as should the managed care firm, if the patient uses one. Additionally, it would be wise for the client to keep a form in her wallet indicating she has a PAD, where a copy is located, and the name and phone number of the agent for mental health decision-making.

What Should a PAD Include?

A PAD begins with a statement of intent, such as what follows: [1]

I, Vicki Lachman, being of sound mind, willfully and voluntarily execute this healthcare directive to assure that, during periods of incapacity or incompetency resulting from pschiatric or physical illness, my choices regarding my mental healthcare will be carried out despite my inablity to make informed decisions on my own behalf...I intend this document to take precedence over all means of ascertaining my intent while competent...

Specific instructions around several crucial issues are usually covered in the PAD. The major areas covered includes: [1]

- options to help avoid or minimize hospitalizations;
- activities that are comforting and helpful reducing distress;
- helpful medications and dosages, as well as those the patient does not want to receive;
- other interventions that could be considered (e.g., ECT);
- activities or situations that exacerbate symptoms (desires for alternatives to restraints and seclusion);
- people who should be contacted during time of crisis;
- names of facilities or healthcare professionals the patient wants involved in care;
- people who can help (i.e., pay bills, care for children or pets);
- people the patient does and does not want visiting, if hospitalized;
- preferences concerning drug trials and experimental studies;
- preferences about revocation of healthcare directive during period of incapacity; and
- designation of healthcare agent and authority granted.

Templates for PADs can be obtained online from the Bazelon Center for Mental Health Law. [1]

Who Should Be the Agent?

The agent should be someone who is trustworthy and who will advocate for the patient. This person needs to be assertive enough to say what the individual does and does not want.

Since the individual will supervise patient care, she needs to be available during times of crisis. Also, the person will need to understand how to navigate the mental health system.

Revocability

Some individuals maintain the option to cancel their PAD, even in crisis or if they are dissatisfied with their agent's decision-making. Other patients recognize they do not make good decisions when ill and want their PAD to be irrevocable. This lack of revocability often is called the "Ulysses clause," where patient request healthcare providers to ignore their requests during incapacity. The name of this clause is taken from Homer's *Iliad*, when Homer ordered his crew not to obey him until they reached a location out of range to the seductive sirens' voices.[3,4]

Many states require the determination of capacity to revoke the PAD. The following states allow individuals to revoke their PAD while incapacitated. [3]

- Alaska;
- Hawaii;
- Illinois;
- Maine;
- Minnesota;
- Oklahoma;
- South Dakota;
- Utah; and
- West Viginia.

The National Association of Protection and Advocacy Systems (202-408-9514 or **www.napas.org**) can provide patients with information about their state's requirements or refer them to a lawyer who can.

Do All Providers Honor PADs?

Not surprisingly, Srebnik, et al. found positive attitudes of clinicians toward PADs were associated with interest in supporting directives among individuals with SPMI. Very

*Continued on Page 6 (**PADs**)*

PADs *(Continued from Page 5)*

little is known about compliance with mental health advance directives. One pilot study, based on a very small sample, noted PADs were honored in a crisis. [6]

PADs are not a panacea to resolve all crisis situations, as many states have legal and procedural burdens that produce barriers.[4,7] State laws vary and enforceability will vary, too. Legal case law is still developing in this area.

Individuals need to be fully informed about the benefits and limitations of these legal instruments, especially around the issue of revocability. The worst-case scenario is the providers and judges would simply ignore a PAD, but many individuals find a PAD increases the likelihood choices will be honored. To further increase the likelihood of the directive being followed, the patient's statement of determination of capacity should be attached to the PAD. This indicates the person understood the nature and consequences of the proposed heathcare, including the risks and benefits.

Some providers see PADs as an erosion of medical decision-making. Advance directives have the potential to prevent all treatment, even if patients were ill enough to qualify for civil commitment under prevailing dangerous standards. [6,8] A hospital could petition the court to treat an incompetent patient with medications after 45 days, notwithstanding PAD. Others see the potential for misuse and coercion if the agent is ineffective.

Court Rulings

For the most part, courts have upheld the validity of PADs although the PAD is relatively new and will be tested. The landmark case of Hardgrave vs. State of Vermont raised some important issues. [8,9]

Nancy Hardgrave has paranoid schizophrenia and has had multiple admissions to Vermont State Hospital. Nancy was involuntarily medicated, in direct contravention of her wishes, expressly stated in her durable power of attorney for healthcare. She claimed she was discriminated against because her PAD was overridden.

Did Vermont have the right to override her durable power of attorney with involuntary psychiatric medications in a nonemergency situation, thereby depriving her from executing a durable power of attorney for healthcare? In a class action case, she challenged Title II of the Amercans with Disabilities Act, which states "no qualified individual with a disability shall, by reason of disability, be excluded from participation in services..."

On Aug. 1, 2003, the U.S. Court of Appeals held that Vermont's Act 114 discriminated against individuals with mental illness. Further cases testing PADs can be expected.

Personal Empowerment

PADs offer an approach to personal empowerment and crisis prevention that is not widely used. Although PADs cannot prevent all involuntary and/or forced treatment and hospitalization of individuals with psychiatric illness, they provide hope for individuals who want to exercise their freedom of choice and exert some measure of control over their chronic illness.

References

1. Bazelon Center for Mental Health Law. *Advance psychiatric directives*. Retrieved Oct. 14, 2005 from the World Wide Web: http://www.bazelon.org/issues/advancedirectives/index.htm

2. Homberg, R.S. National Alliance for Mentally Ill. *Advance directives*. Retrieved Oct. 14, 2005 from the World Wide Web: http://www.nami.org/legal/advanced.html

3. National Mental Health Association. *Psychiatric advance directives toolkit*. Retrieved Oct. 14, 2005 from the World Wid Web: http://www.nmha.org/position/advancedirectives/index.cfm

4. Vuckovich,P. (2003). Psychiatric advance directives. *Journal of the American Psychiatric Nurses Association,* 9(2), 55-59.

5. Srebnick, D., Appelbaum, P., & Russo, J. (2004). Assessing competence to complete psychiatric advance directives with competence assessment tool for psychiatric advance directives. *Comprehensive Psychiatry*, 45(4),239-245

6. Srebnick, D., & Brodoff, L. (2003) Implementing advance directives: Service provider issues and answers. *Journal of Behavioral Health Services & Research*, 30(3), 253-268.

7. Appelbaum, P. (2004). Psychiatric advance directives and treatment of committed patients. *Psychiatric Services*, 55 (7), 751-752,763.

8. Bazelon Center Mental Health Law. *2nd circuit holds Vermont durable power of attorney law discriminatory*. Retrieved Oct. 14,2005 from the World Wide Web: http://www.bazelon.org/newsroom/8-6-03hargrave.htm

9. Srebnik, D., et al. (2003) Interest in psychiatric advance directives among high users of crisis services and hospitalization. *Psychiatric Services*, 54(7), 981-986.

Article written by Vicki D. Lachman who is associate professor at Drexel University, Philadelphia.

Source: ***Advance for Nurses***
Southern California
February 6, 2006

Positive Interventions

When a member of a community behaves in ways disruptive to that community, the whole group gathers and encircles the person who is isolated alone in the center. Then each person in the community states what is positive about the person, true, accurate reflections of the person's attributes that are appreciated. The rounds continue until everyone's memory is exhausted, every positive contribution noted. Finally, the person is welcomed back to the group and there is celebration, music and dancing.

(This is a tribal tradition that Peace Pilgrim noted in her journal. I don't have any more details. --Sylvia)

Source: www.peoplewho.org

What makes people happy

1. They live in the present. They really do strive to live each day as though it is their first --- and last.

2. They are not willing to be victims and are able to move on if a relationship is hurtful or destructive.

3. They understand that they are the only ones in charge of their lives. God will guide, but will not overrule their choices.

4. They like themselves, or make changes so they can like themselves.

5. They have clear priorities and don't waste time second-guessing them---or themselves. They're in control of how they spend their time.

6. They are open to developing close relationships throughout their life, and are willing to put in the hard work it takes to maintain relationships built on trust, openness, and honesty.

7. They mostly like and are challenged by their work. They don't stay in unrewarding or demeaning work.

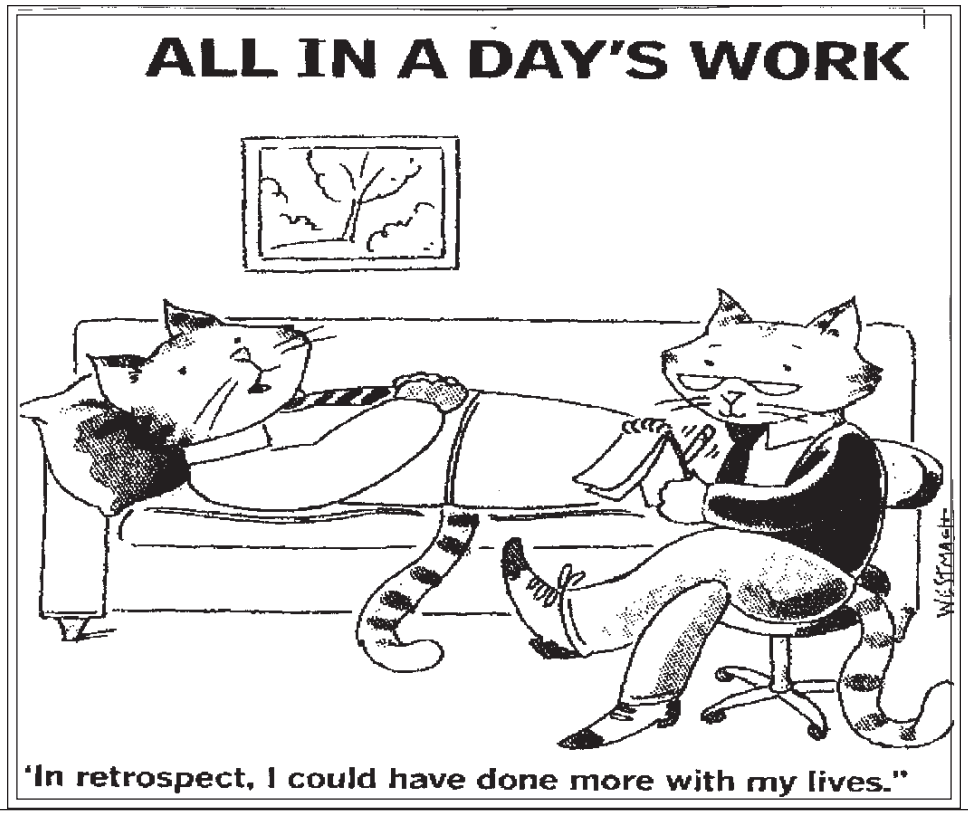
8. They enjoy activities that have nothing to do with their work and are not sedentary.

9. They savor the small pleasures of life---early morning sunlight, a shared moment with a friend, a child's smile, a flower, the sight of a loved one's face.

10. They have a strong faith in God.

11. Finally, happy people surround themselves with others who are also optimistic and positive.

Source: David Myers, PhD
Psychology Today



A Varied Assault on Depression Yields Gains

If one drug fails, a study finds, another often can be added or substituted with success

By Thomas H. Maugh II
Times Staff Writer

March 23, 2006

In the long and frustrating battle against depression, persistence does pay.

A major government study reports today that at least a quarter of clinically depressed patients who failed to achieve a complete remission with one antidepressant succeeded by adding a drug or by switching drugs.

Overall, about half of the nearly 1,500 patients achieved remission — the virtual absence of symptoms — by completing two treatment steps, and at least a quarter more showed improvement.

The six-years, $35-million study is intended to provide the first scientifically based roadmap for treating depression.

Since the introduction of powerful antidepressants in the late 1980s, most treatment "has been driven by anecdotes — small series of case reports, 10 patients helped by one combination, 15 by another," said Dr. Andrew Leuchter of UCLA, who helped conduct the study.

"This is the largest study ever to look at what is the best next step if you don't get well in the first step" of treatment, he said.

The study, sponsored by the National Institute of Mental Health, is the first part of a series of studies designed to formalize the procedures for a therapy that until now has largely relied on a doctor's intuition and experience.

"They are trying to find some science for what is now an art," said Dr. Jan A. Fawcett of the University of New Mexico, a spokesman for the mental health advocacy group NARSAD.

The study addressed one of the biggest problems with antidepressants: Many patients give up if they don't respond quickly to the first drug they try or if they suffer unpleasant side effects.

The study showed that results often took six to 12 weeks, much longer than expected.

The message to patients and physicians is "Hang in there," said Dr. A. John Rush of the University of Texas Southwestern Medical Center, who led the trials, which are reported today in the New England Journal of Medicine.

"For the depressed person, it may not matter so much what drug is being prescribed, but that the person moves forward and keeps trying," he said.

Depression affects nearly 15 million Americans each year and is the leading cause of disability between the ages of 15 and 44.

It is "an utter sense of hopelessness," said Dr. Thomas R. Insel, director of the National Institute of Mental Health. "Just getting up out of bed and going to work or to school become insurmountable challenges."

The disorder is responsible annually for 30,000 suicides and $86 billion in lost productivity.

More than 189 million prescriptions for antidepressants are written each year, with total sales of about $12 billion.

Still, half of depressed patients receive no treatment.

The Sequenced Treatment Alternatives to Relieve Depression study, commonly known as STAR*D, was designed to determine the optimum protocol for treating depression.

The study initially enrolled nearly 3,000 patients who had suffered from depression for an average of 16 years.

Two-thirds had other medical problems, and 40% were unemployed because of their condition.

All the patients received the antidepressant citalopram, trade-named Celexa. That drug was chosen because it was relatively new at the time, could be given in various doses easily and seemed to be well-tolerated. Nonetheless, about 20% of patients dropped out because of side effects, including nausea, sleep problems, tremors and sexual dysfunction.

About one in three patients given the drug went into remission. Remission was chosen as an endpoint because of "the growing recognition that improvement in symptoms is not enough," said Fawcett, who was not involved in the study. "Usually, it doesn't last."

The doses used were often higher than those in everyday practice, and patients were followed for as long as 12 weeks — a crucial change, according to Rush. Often, patients and doctors abandon a drug if they don't see results within four weeks, he said. But about half the patients in the study who improved did not show benefits until eight to 10 weeks into the study.

In the second level of the study, patients who did not go into remission were given the option of having a second drug added to their regimen or of switching drugs.

Of those, 727 chose to switch and were randomly assigned to receive either sertraline (trade-named Zoloft), bupropion

(Continued on Page 9) **Depression**

Depression *(Continued from Page 8)*

(Wellbutrin) or venlafaxine (Effexor). In that group, about 25% achieved remission within 14 weeks.

Somewhat surprisingly, Rush said, the three drugs all produced about the same results even though they work differently.

The 565 patients who chose to add a drug to their citalopram were randomly assigned to receive bupropion or buspirone (BuSpar).

Among those, 30% achieved a remission, with both drugs equally effective, although those receiving bupropion had slightly fewer symptoms and side effects.

Patients who did not achieve remission on either regimen had the option of proceeding to levels 3 and 4 of the trial, which incorporated other drugs and talk therapy into the regimen. Those results are to be reported this fall.

In an accompanying journal editorial, Dr. David R. Rubinow of the University of North Carolina at Chapel Hill said the study was encouraging because more than half of the patients went into remission, but discouraging because nearly half did not.

That indicates a need for new drugs and a better understanding of the basic biology of depression, he said.

Source: Los Angeles Times
latimes.com.
http://www.latimes.com/news/science/la-sci-depression23mar23,01461575.story

Words of Wisdom

Author Unknown

After a while you learn the subtle difference
between holding a hand and chaining a
soul, and you learn that love doesn't mean
leaning and company doesn't mean security
And you begin to learn that kisses aren't
contracts and presents aren't promises
And you begin to accept your defeats with
your head up and your eyes open, with
the grace of an adult, not the grief of a child
And you learn to build all your roads on today
because tomorrow's ground is too uncertain
for plans
After a while you learn that even sunshine
burns if you get too much
So plant your own garden and decorate
your own soul, instead of waiting for
someone to bring you flowers.
And you learn that you really can endure...
that you really are strong, and you really
do have worth.

mha Mental Health Association of Orange County

12th Annual Conference
"MEETING OF THE MINDS"
"Transformation and Recovery through Collaboration"

Tuesday, May 16, 2006, 8 am - 4:30 pm
Disneyland Hotel

- Targeting professionals, educators, care providers, consumers, families, and community leaders
- Law Enforcement hack for First Responders; Police Officers, Fire Fighters, and Medical Emergency personnel
- Professional track for Continuing Education Units; Ph.D, MFT, LCSW, RN, CATS & CML
- Providing informative and topical workshops to update your knowledge & skills (AM Session, PM Session)
- Offering showcase of community resources — Exhibit space available
- Networking luncheon
- Keynote Presentation: "The Psychological Aftermath of Critical Incidents. Speaker: Officer Joel Fay, Ph.D. — San Rafael Police Department and Founder of West Coast Post-Trauma Reheat
- Anticipate 500+ in attendance
- Full program & registration forthcoming

FOR MORE INFORMATION,
CALL (714) 547-7559

Meeting of the Minds

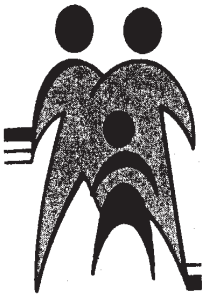
DBSA Bipolar Resource Center
714/744-8718
www.dbsalliance.org

What makes you Tick?

Monochronic People	***Poluochronic People***
Do one thing at a time	Do many things at once
Concentrate on the job	Are highly distractible and subject to interruptions
Take time commitments seriously	Consider time commitments to be an objective to achieve
Are low-context and need information Want to see things clearly, need explicit written instructions	Are higholy context and already have information needed
Are concerned about disturbing others, follow the rules of privacy consideration	Are more concerned with famiy, friends, and close business associatiates as a priority than privacy
Show respect for private property Seldom borrow or lend	Borrow and leds things often and easily
Emphasize promptness	Base promptness on the relationship (importance of relationship)
Are accustomed to short-term relationships	Have strong tendency to build lifetime relationships
Keep "to do" list	Use internal clock
Wear watches	Talk in loops, indirect
Speak concisely, as specific as possible	"I'm hungry, I'll eat now"
Eat on timed schedule	

Source: The Rollercoaster Times, DBSA-Orange County, Spring 2006

May is Mental Health Month



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)

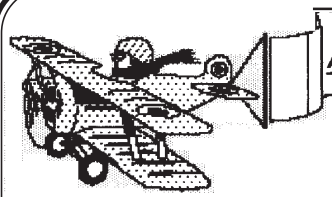
Phone Phriends

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



ANNOUNCEMENTS

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 1½–2 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—

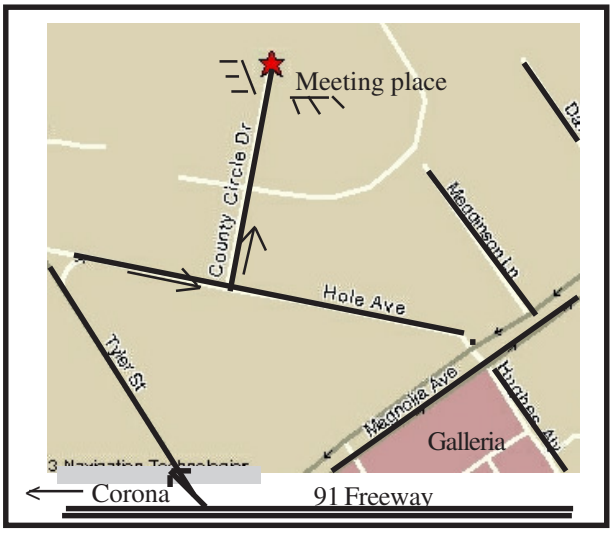
DBSA– Riverside

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. ❒