DBSA

The Thermometer Times

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

VOL. 18 NO. 5 *Out of darkness . . .* *May, 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: May 6, 13, 20, & 27

Memorial Day Picnic at Jo Ann's

See below for directions.

Monday, May 29, 12noon

See page 11; for details.

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

A Cry for Help

Depression is more common among teenagers than adults --- yet many parents are confused about the right way to help.

Gail Griffith's son, Will, 16, had been a popular, hardworking student and, at 6-foot-1, enjoyed playing on his high school intramural basketball team. But in the fall of 2000 his mood began to change. "His gait slowed down, as if he were covered in molasses," says his mother. "His speech became disjointed. He didn't react to jokes anymore, couldn't sleep and lost weight. It was as if he were evaporating before my eyes."

Will had recently moved in with his mom, stepfather and stepbrother in Washington, D.C., after living with his father in California and had enrolled in a new school. Griffith figured her son just needed time to adjust. Then one night in December of that same year, she found him lying face-down on his bed, books and papers strewn about him, his eyes red from crying. "I just can't do this anymore," he said, seemingly referring to the pressures of school. Griffith, who was being treated for depression herself, recognized his anguish. "Sweetie, we can fix this," she reassured him. "We'll get you help."

Will began therapy and started taking a newer generation antidepressant. But in February, Griffith noticed that her son was having trouble concentrating on his

Continued on page 3 **(Cry)**

a note from the Editor

This months Featured Member is Yen Cress. You can read her clever autobiography titled "Yen, the Movie" on page 8. I'm sure you'll enjoy it.

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

Not truth, but faith it is that keeps the world alive.
--Edna St. Vincent Millay (1892-1950)
Poet

The Thermometer Times
16280 Whispering Spur
Riverside, CA 92504
(951) 780-3366

Publisher & Editor in Chief
Jo Ann Martin

Senior Editor
Lynne Stewart

Copy Editor
Karen Cameron

Associate Editors
Nelma Fennimore
Karen Cameron

Staff Writer
Judy Kaplan

Medical Advisor
Andrew J. Rooks, M.D.
Child, Adolescent & Adult Psychiatry
American Board of Psychiatry and Neurology

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.**

CRY *(Continued from page 1)*

schoolwork and had complained of dizziness and nausea during basketball games. Then the boy announced he wanted to quit school and work full-time while studying for his GED. Although Griffith was devastated, she felt reassured when Will's spirits seemed to brighten. On the evening of Saturday, March 10 pm , he went bowling with his girlfriend and other friends. He arrived home a little before 11 pm and watched college basketball on TV before heading off to bed.

At 10 the next morning, Griffith went to wake Will. She was shocked to find him barely coherent, saliva bubbling from the corners of his mouth. Griffith called an ambulance and while ER doctors tried frantically to stabilize his vital signs, his stepbrother scoured his bedroom. Under Will's bed he found a slew of empty bottles of Will's prescription and suicide notes to four family members and friends. As Will later wrote in his diary, he had swallowed 50 or 60 pills "in two handfuls with a sip of iced tea."

Will's recovery was long and difficult and included nine months in a residential treatment center for adolescents in Montana. But that still makes him one of the lucky ones. Every year, some 2,000 kids between the ages of 10 and 19 succeed in killing themselves. Today Will attends community college in California, enjoys Sunday-afternoon baseball games with friends and, under a doctor's care, has discontinued his medication.

Thinking back to that dark night, Griffith is still bewildered by her failure to spot the depth of her son's depression. "If he harbored thoughts of killing himself, he never mentioned it to anyone,"she writes in her book *Will's Choice: A Suicidal Teen, a Desperate Mother, and a Chronicle of Recovery*. "No one suspected it."

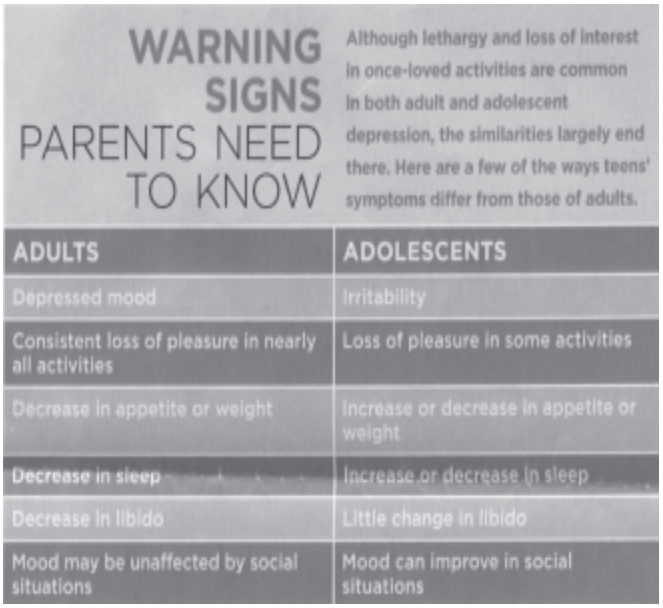
Will is part of a huge but often invisible demographic group—the estimated 3 million teenagers in the United States who suffer from clinical depression. In any given year, up to 8 percent of teens are depressed, higher than the adult rate, which hovers around 5 percent.

While the disorder can be effectively treated with medications, these drugs increase the risk of expressing suicidal thoughts in a small number of kids. Furthermore, news reports of violent incidents involving teens on antidepressant medications—Jeff Weise, the Minnesota teen who went on a shooting rampage at a local high school, and Christopher Pittman, a 12-year-old South Carolina boy who killed his grandparents, were both taking antidepressants—have, understandably, made many parents loath to medicate, despite the extreme rarity of these reactions. The result is that millions of youngsters are left untreated.

"Parents are understandably cautious about putting their children on medications," says Sharon Hirsch, M.D., acting section chief for child and adolescent psychiatry at the University of Chicago Pritzker School of Medicine. "There's so much we don't know about how these drugs work in kid's suicide rates have actually been declining since the 1990s, when the class of antidepressants known as SSRIs came into wide use (see "A Primer on Mood Drugs, page 5). "Studies on teens who have committed suicide have found that the majority were not on antidepressants at the time," says John Walkup, M.D., associate professor of child and adolescent psychiatry at Johns Hopkins Children's Center, in Baltimore. "It's underdiagnosis and undertreatment of depression that are the issues, not overtreatment."

WHAT'S NORMAL, WHAT'S NOT

Most parents expect teens to be emotionally volatile and "they're not wrong," says Harold Koplewicz, M.D., founder and director of the Child Study Center at New York University. "Moodiness is part of being a teenager." That's because the teen brain is still developing.



WARNING SIGNS PARENTS NEED TO KNOW

Although lethargy and loss of interest in once-loved activities are common in both adult and adolescent depression, the similarities largely end there. Here are a few of the ways teens' symptoms differ from those of adults.

ADULTS	ADOLESCENTS
Depressed mood	Irritability
Consistent loss of pleasure in nearly all activities	Loss of pleasure in some activities
Decrease in appetite or weight	Increase or decrease in appetite or weight
Decrease in sleep	Increase or decrease in sleep
Decrease in libido	Little change in libido
Mood may be unaffected by social situations	Mood can improve in social situations

The prefrontal cortex, which controls impulses and inhibits dangerous thoughts, is one of the last parts of the brain to mature. The way it functions continues to change until the early 20s, which may explain why teens have trouble reining in their moods.

"There's a much greater appreciation now versus 10 years ago that adolescence is a time of profound changes in brain development, and those changes affect emotional processes," says Daniel S. Pine, M.D., chief of child and adolescent research in the mood and anxiety disorders program at the National Institute of Mental Health, in Bethesda, Maryland. "Problems in the way the brain matures and develops might also give rise to depression."

So if teenagers' baffling behavior is hard-wired, how does a parent distinguish between depression and the normal Sturm und Drang of adolescence? Observe very carefully, and forget your preconceived notions, because the disorder can affect teens differently than it does adults (see "Warning Signs Parents Need to Know;") . Two particular red flags are trouble

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CRY *(Continued from page 3)*

concentrating (most evident in a drop-off in a teen's academic performance) and negative statements about the world and her place in it, ("Tm stupid" or "I can never do anything right," for instance). Girls are likelier to suffer from depression, but in boys the symptoms manifest themselves in less-obvious ways (see "The Blues in Boys Versus Girls, page 5).

The disorder may also come with some unsavory bedfellows, including promiscuity, smoking or substance abuse, often unbeknownst to parents. "A behavioral problem may actually be just a symptom of depression," warns Liza Anne Bonin, Ph.D., clinical training director of the Learning Support Center for Neurobehavioral Psychology at Texas Children's Hospital, in Houston.

Most confusing, perhaps, is the fact that unlike depressed adults teens often temporarily snap out of it. "They may even appear happy-go-lucky with friends," says Alec L. Miller, Psy.D., director of the adolescent depression and suicide program at Montefiore Medical Center of the Albert Einstein College of Medicine, in New York City. "Parents think, 'he can't be depressed,' but it doesn't mean he's not."

THE SEARCH FOR THE RIGHT TREATMENT

If you suspect your child is depressed, get help immediately. The average untreated episode lasts nine months, the equivalent of a school year. Research shows that it's hard for kids to catch up. "Depression has a ripple effect," says Dr. Miller. "You can't concentrate, so you don't do well in school, which means you don't do well socially."

Happily, most kids can be successfully treated. Start with your child's pediatrician, so she can rule out medical problems that can cause depression-like symptoms, such as anemia, infections or hormonal imbalances.

If your child has no physical illnesses, ask your doctor for a referral to a psychologist, therapist or psychiatrist who specializes in adolescent mental health. Not only can these professionals root out signs of a psychiatric condition, they know how to get kids to open up.

But if the diagnosis is depression, you face your toughest task: determining the best treatment. Like many parents, you'll probably look for information online, where first-person horror stories abound. Yet to make an informed choice you have to focus on the scientific data. The Treatment for Adolescents With Depression Study, sponsored by the National Institute of Mental Health and published in 2004, evaluated 439 12- to 17-year-olds hospitalized for moderate to severe depression. The results? Therapy plus medication was the most effective treatment, with a cure rate of 71 percent. Medication alone had a success rate of 61 percent, followed by cognitive behavioral therapy alone (43 percent) and placebo (35 percent).

The prevailing wisdom is that kids with mild depression may be able to skip medication, at least initially, and be treated solely with therapy. Weekly individual therapy for three months to a year can help kids examine and correct distorted thoughts that contribute to their depression; similarly, such kids are also helped by small group therapy sessions of about six to eight kids. Family therapy can also help. "Some depressed teens have problems at home that can contribute to their depression," says Louise Schneider, M.D., assistant chief of psychiatry at the Kaiser Pernanente San Francisco Medical Center. With severely depressed kids, however, research clearly indicates that the best chance of a cure lies with medication as well as therapy.

A parent's most pressing concern, of course, is drug safety. In 2004, the FDA analyzed 24 studies involving 4,400 children and adolescents who took a variety of antidepressants and found that 4 percent of those on medication contemplated or attempted suicide, versus 2 percent who took a placebo. No one, however, actually committed suicide, nor can researchers explain why some kids on medication were more likely to think about it.

In response to the research, the FDA now requires the manufacturers of all antidepressants to include a prominent black box in their package inserts warning of the "risk of suicidal thinking and behavior in children and adolescents with major depressive disorder." (In June the agency also issued a public health advisory about such risks in adults.)

Antidepressant makers, meanwhile, insist their drugs are safe and point out that depression itself increases the risk of suicidal thoughts and behaviors. In a statement, Pfizer, the maker of the SSRI drug Zoloft, noted that, prior to treatment, up to 60 percent of depressed kids have thought about suicide and 30 percent have attempted it. The statement also expressed the drugmaker's concern that the FDA's black-box warning could have "the unintended outcome of unnecessarily preventing patients and their families from seeking therapy or discontinuing what may already be effective treatment?"

"Any medication has side effects, including aspirin and Tylenol," says Ellen Sholevar, M.D., director of child and adolescent psychiatry at Temple University School of Medicine, in Philadelphia. "You've got to look at the decreased quality of life that goes with depression and balance that against potential side effects". Before starting your child on any antidepressant, familiarize yourself with the possible side effects. If your child doesn't respond or responds negatively to a certain drug, the doctor can try another one.

A HAPPIER FUTURE

Looming almost as large as the question of whether to medicate is when and how to stop. Once the depression lifts, will a teen be able to function drug-free? In many cases, yes. Teens who have had only mild depression or a single episode usually do fine when they gradually taper off from medications they've taken for six months to a year, according to the American Academy of Child and Adolescent Psychiatry, in Washington, D.C. But kids who have had

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CRY *(Continued from page 4)*

two or more episodes should probably remain on antidepressants for several years. Those with multiple severe depressions and those who are suicidal or who have a high risk of relapse owing to, say, a family history of the disorder may need to stay on medication even longer.

Regrettably, depression is often a recurring illness. "About 40 percent of kids go on to have a second episode within two years," says David Fassler, M.D., cofounder of Walden Behavioral Care, an inpatient treatment center for kids in Waltham, Massachusetts. "So they need to know the early warning signs and ask for help if they need it"

Gail Griffith's son, Will, now 21, is fully aware of the risks but feels up to the challenge. "I would be hard-pressed to handle it worse than I handled it the first time" he writes in the epilogue to his mother's book. "If my life comes apart again, I'll fix it again. But like a puzzle I've already solved, I now know where the pieces go:'

A PRIMER ON MOOD DRUGS

Antidepressants work by affecting neurotransmitters, which are certain brain chemicals, including serotonin, norepinephrine and dopamine, that regulate mood. The newest research is identifying genes that affect the production of neurotransmitters; this may one day enable doctors to pinpoint who will likely respond to, resist or significantly improve on a particular drug. Such customization of mental health care is on the horizon, but for now treatment is largely by trial and error. Your doctor can choose from more than two dozen antidepressants that fall into four major categories:

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs) boost the amount of serotonin in the brain and are effective for teens (though they are even more effective in adults).

DUAL-ACTION, OR ATYPICAL, ANTIDEPRESSANTS, the newest drugs, work on two or more brain chemicals (serotonin, norepinephrine, dopamine or epinephrine) simultaneously. Data on their results in teens is still scarce.

TRICYCLICS (TCAs), an older class of drugs that increase concentrations of epinephrine, serotonin and to a lesser extent dopamine, appear to be less effective in kids and pose a greater risk of overdose.

MONOAMINE OXIDASE INHIBITORS (MAOIs), another older class of drugs that affect serotonin, norepinephrine and dopamine, are not widely used in teens because of severe health risks.

For safety, a teen should be started at a low dose and gradually worked up to the full therapeutic dose. The FDA recommends weekly doctor visits for the first four weeks of treatment, every other week for the next four, once again at 12 weeks, then as clinically directed. Make your child aware of the importance of taking drugs as prescribed. "It's not unusual for kids to take their meds for two days, then go off them for three, because they're going to be drinking," says Richard Macur Brousil, Psy.D., director of the child and adolescent behavioral health program at Mount Sinai Children's Hospital, in Chicago. "But the treatment won't work that way."

The Blues in Boys Versus Girls

Depression often manifests itself differently in boys and girls. The former are likelier to engage in aggressive behavior or acting out, while the latter experience anxiety, an eating disorder or self-cutting. Being female clearly increases the risk. Before puberty, depression rates are low in both sexes. By age 15, the incidence in boys has dropped even lower, while in girls the rate is double that of boys—and it stays that way for the next 40 or so years. One culprit is more dramatic fluctuations in levels of the sex hormones estrogen (produced by the ovaries) and testosterone (produced by the adrenal cortex), which can act on the brain and affect mood.

Social and developmental changes also play a role. At puberty, for instance, girls begin to seek out emotional intimacy and place a higher value on interpersonal relationships than boys do. Some of this behavior may be attributable to the hormone oxytocin, which is triggered by estrogen and progesterone to prime a woman for motherhood.

Research from the Western Psychiatric Institute & Clinic at the University of Pittsburgh further suggests that girls who never had secure attachments to their parents have more psychological distress when, as is normal in adolescence, they shift attachments from parents to friends or potential romantic partners. What's more, girls tend to show more distress than boys when faced with the same negative events, especially those involving relationships. In some girls, a combination of social, developmental and biological factors makes for what Michelle Ascher Dunn, CSW, a psychoanalyst in private practice in New York City, calls a "potent depression cocktail."

For both sexes, however, the most important risk factor is family history. A 20-year study conducted at the Columbia University Medical Center, in New York City, is the first to track depression across three generations of families. "The pattern was very consistent," says Myrna Weissman, Ph.D., professor of psychiatry and epidemiology at Columbia. "The offspring of depressed parents had two to three times increased risk." This could be because depressed parents inadvertently model negative patterns of thinking and behaving; a more likely reason is genes. One long-term British study found that people with certain gene patterns were more likely to develop depression in the face of stress or trauma. "Those without those genetic components," says Dr. Weissman, "did not become depressed under the same stressors."

Is your teen at risk? Log on to: www.lhj.com/depression

Source: LADIES' HOME JOURNAL
December 2005

What To Do For Someone Feeling Suicidal

* listen
* be nonjudgmental
* give them hope that this will pass
* encourage them to get further help
* get them further help by calling 911 or crisis help line

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

ERIK RUSSELL
College football coach

*In the News...*Newsweek Magazine
January 16,2006

Omega-3 Fatty Acids - In 2001 a series of ads appeared in Boston newpapers. "Are you extremely moody? Do you often feel out out control? Are your relationships painful and difficult?" The ads came from Harvard psychologist Mary Zanarini, one of the nation's leading researchers in borderline personality disorder. She was seeking volunteers to test a potential treatment for the ailment-a fish-oil component called EPA.

Fish oil? As medical treatments go, it may sound more like snake oil. But a growing body of research suggests the omega - 3 fatty acids in fish oil benefit not just the heart but also a range of psychiatric and neurological problems, from bipolar disorder and schizophrenia to depression, ADHD, Alzheimer's and yes, borderline personality disorder. The brain is an astonishing 60 percent fat, and it needs omega 3s for optimal function. Studies suggest these nutrients help build membranes, boost levels of the brain chemical serotonin and increase the number of connections between neurons.

"It's like neuronal fertilizer," says Dr. Joseph Hibbeln, a psychiatrist at the National Institute of Health. "Brain cells given omega-3s may even be good for bone-building cells in the periosteum, the membranes that cover the long bones. "It's the part that hurts when you bang your shin," says Watkins. "I call it 'the brain of the bone' because it contains a lot of nerve tissue and controls a lot of bone metabolism." Nourish it with omega-3s, he advises, because its bone-building cells lay down the protein matrix on which calcium and other minerals are deposited.

Where can you find omega -3s? Food contains two basic varieties-the short-chain version (called ALA) found in walnuts, flax seed, and canola oil and leafy greens, and the long-chain versions (EPA and DHA) in seafood and omega-3-enriched eggs. The long chain forms appear to have the greatest benefits, particularly for ' the brain. The American Heart Association also recommends eating fatty fish at least twice a week for the prevention of heart desease. For patients who already have heart trouble, it prescribes one gram of EPA and DHA a day, from fatty fish or supplements.

Source: Life In Balance
DBSA of Metro Detroit
March/April, 2006

Entering The No Comfort Zone

In the long run, we shape our lives, and we shape ourselves. The process never ends until we die. And the choices we make are ultimately our own responsibility.

ELEANOR ROOSEVELT (1884-1962)
First Lady and humanitarian

Los Angeles Times
latimes.com

The future holds more than pills

By Marianne Szegedy-Maszak
Special to The Times

March 27, 2006

Some people — no matter what they take, no matter how many therapy sessions they might attend — simply do not respond to antidepressants.

For them, a number of other options besides medication are available. Some are still in development; others have been around for years.

Steve, a postal carrier in Texas, has spent most of his life trying desperately to control the agonies that depression exacted. He knew that even as a child he was troubled, that an irreducible darkness skirted around the edges of his mind. But in 1998, after the breakup of a relationship, he "went over the edge" and tried to kill himself.

Thus began a revolving-door experience with medication and psychiatric hospitals, one after another for a year. The cycle was relentless: new medication, a few weeks of fragile hope, then suicidal despair and a hospital trip.

"They changed my medicine, added more, changed what I had again and put me back into the hospital," recalls the 41-year-old, who didn't want his real name used.

Of the 18.8 million people who suffer from depression, Steve is one of the 30% whose depression is known as "treatment resistant." His psychiatrist finally suggested "shock treatment," technically known as electroconvulsive therapy, or ECT.

Research on the brain as an electrical organ, one that actually responds to magnetic treatments, has led to improvements in such therapies, and their use is on the rise.

In 1980, 30,000 people received ECT; in 2001, nearly 100,000. Although there are still side effects, headaches and memory problems primarily — seizures, bitten tongues and broken bones are largely a thing of the past. And the response rate, especially for treatment of drug-resistant depression, is as high as 70%.

Steve still takes "about five or six medications, I can't even remember all of them" to keep him stabilized after the shock therapy. But he takes them to prevent a rapid deteriora-

Continued on page 7 **(Future)**

Future *(Continued from page 6)*

tion after the more effective therapeutic jolt from the ECT.

And he considers the dry mouth and 40 extra pounds from the medications to be far less debilitating than the fact that, by themselves, the medicine simply didn't work.

His combination of patience, therapy, medication and ECT — and sheer grit — has not only kept him alive, but also propelled him toward a new life. He is now taking online college courses, not only to possibly advance himself, but to occupy a mind that has been so destructively rebellious.

ECT is only the beginning of the depression treatments that doctors and researchers are exploring. The following are some of the most promising:

Rapid transcranial magnetic stimulation: Much like the way a defibrillator works in the heart, this form of stimulation uses a powerful magnet to deliver an electric jolt to the brain. In clinical trials, many patients who failed to respond to several other treatments improved within a week of the first round of RTMS sessions, and the vast majority were significantly better after two weeks of daily 20-minute sessions.

Vagus nerve stimulation: This treatment, originally designed to reduce epileptic seizures, uses constant stimulation via a device surgically inserted under the chest wall, much like a pacemaker. It's connected to the left vagus nerve in the neck, a nerve that threads throughout the body, including the brain. The electrical impulses that the device sends out stimulate the production of serotonin and other brain chemicals. Some people with chronic, treatment-resistant depression have responded well to the procedure, but the cost is high: The device itself runs about $12,000, and surgery can be nearly $15,000.

Deep brain stimulation: This is the most invasive treatment for depression, requiring an electrode implanted directly into a particular part of the brain. It was originally used to treat movement disorders such as Parkinson's disease by targeting one area of the brain. But researchers found — by serendipity — that if the electrode was slightly misplaced, it could either cause or alleviate the symptoms of depression, including hopelessness and suicidal thinking.

Selegiline patch: This is a new delivery system for an old antidepressant, one of the monoamine oxidase inhibitors. Although an often-effective treatment for depression, the MAOIs required patients to avoid foods and medicines — such as pickles, wine and decongestants — that contained high levels of the amino acid tyronine. That substance can interact with the antidepressant and cause a sharp increase in blood pressure that can, potentially, cause a stroke. Often, patients simply got tired of having to be so cautious and discontinued the drugs.

The new patch, however, bypasses the stomach altogether. As the American Journal of Psychiatry reported while the patch was being tested in 2002: It "was an effective and well-tolerated treatment for adult outpatients with major depression. The typical side effects commonly seen with traditional monoamine oxidase inhibitor antidepressants were not observed." In February, the FDA approved the patch, with the brand name Ensam.

Genetics: Although the future may hold promise for gene therapy in treating mood disorders, psychiatrists generally put it in the category "of blue sky stuff," says Dr. Fred Goodwin, former head of the National Institute of Mental Health. But some progress is being made in determining the genetic predisposition for a response to antidepressant medications.

In a study that will appear in May in the American Journal of Human Genetics, researchers at the National Institutes of Health discovered that some people have two copies of a gene related to the brain's mood-regulating system. They are 18% more likely to respond to an antidepressant medication than those who have two copies of another, much more common, gene that is also related to mood regulation.

This means that in the future, it may be possible to target antidepressant treatment to particular patients with the genetic predisposition to respond to those particular medications, thereby reducing the long trial and error period that so compromises depression treatment.

Quantitative electroencephalogram: Figuring out who might respond to what drugs has been a basic problem in depression treatment. Dr. Andrew Leuchter and his colleagues at UCLA are using the QEEG — a noninvasive and easy to use brain mapping technique — to tease out the various types of depression and the response to a range of antidepressants.

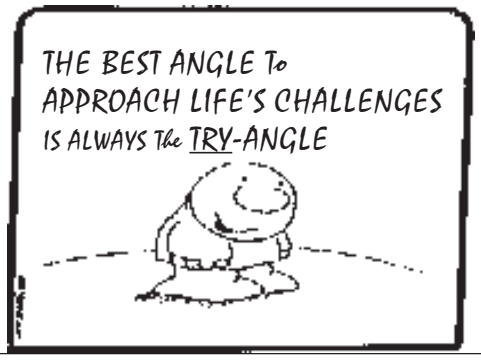
At nine sites throughout the country, depressed patients are having their brains mapped before treatment, 48 hours after receiving their first dose of an antidepressant and several weeks later. Researchers will then see how the medication works over time and how people describe the progress, and possibly the lifting, of their depression.

The researchers hope to eventually determine within a week if a particular treatment works or not, thereby increasing the likelihood of quickly finding the right medicine.

Future drugs: In the past, antidepressant drugs focused primarily on the neurotransmitters serotonin and norepinephrine, but pharmaceutical companies are now looking at drugs that target other neurotransmitters, such as the stress hormone corticotropin-releasing factor, or CRF.

Depressed people often have abnormally high levels of this stress hormone, and drugs that block it have been found to alter moods.

Source: http://wwwlatimes.c ures/health/la-he-depressedide27mar27,02802314.story



Featured Monthly Member

Yen, The Movie

In a weird and amazing twist of fate, were I to become a scriptwriter/film producer, would you want to see my autobiographical movie?

In it, a young girl would be seen struggling against poverty and abuse to acquire an education at a series of church-supported schools, from California to New England and back. The dark-haired, blue-eyed lass graduates from her academy with honors and scholarships and goes off to support herself at college, where she falls in love with a fine young man, quits school, and marries him. They move to Oregon, then to Loma Linda where he teaches, and finally they find a rustic house in the nearby mountains where they raise their three sons. It seems like a lovely, idyllic dream.

Still, she longs to resume her interrupted education, knowing she is capable of advanced degrees, but now financial limitations and parenting responsibilities block her way, and her husband sees no need for her to go back to school. Her early-life difficulties are still affecting the young woman, and she can't seem to break out of the cage she feels closing in around her. She learned her early lessons well — defer to everyone around her and ignore her own needs and desires. Insidiously, depression sets in and begins to erode the little family's happiness.

A doctor advises her to go to school. Joyfully, she enrolls at San Bernardino Valley College. Alas, her husband sees this as an abdication of the marriage, and he files for divorce, listing the day she started her first class as the date of separation.

There is now no turning back. She lives very frugally, defraying her expenses by tutoring Vietnamese students in English. She graduates with honors, then she earns a certificate in Teaching English as a Second Language at UCR.

In the process of getting acquainted with the Vietnamese people, she attends their cultural events. This begins a new phase of her life as her vocal talents are put to work, first performing "The Star-Spangled Banner" to open programs, then memorizing and singing Vietnamese language popular and folk songs with a Vietnamese partner. Her talent is her way of contributing, and she receives only gas money and delicious meals in payment, but she enjoys the experience wholeheartedly and spends most weekends performing in shows to raise money for the refugees.

Financial problems overwhelm her, she loses her apartment and her vehicle, and depression again interferes with her quality of life. This time, she finds a depression support group in Riverside. She has been with the group, now known as DBSA, ever since then, learning as much as she can, helping where she is needed, and making lifetime friends among other members of the group. During the next five years she moves 21 times and is hospitalized several times. She settles in Riverside where her new friends are. She even edited this paper for a couple of years.

She marries another bipolar gentleman from the DBSA group but, sadly, the marriage soon fails. By now she is a white-haired grandmother of eight, and she is again on her own. Her faith, her family and friends, her pets, and her writing are the joys of her life. She is currently working on a mental health project that she believes will contribute to the prevention of mental illness and the maintaining of mental wellness. She also enjoys using the computer to do research in various scientific areas and has been able to locate friends from long ago with whom she now corresponds regularly.

Life seems to be taking another turn for the better. She has learned the hard way that she alone has the ultimate responsibility for taking care of herself and seeing that she stays healthy and happy. She works hard at keeping her attitude positive and yet realistic, knowing that giving in to negativity or self-pity even for a little while will be her undoing.

The movie is not over. Will fame and fortune appear in the closing scenes? Will there be another "Prince Charming"? Will the lady ride off into a glorious sunset with no more troubles? Probably not. But you can be sure this movie will have a very happy ending. After all, "Yen, the Movie" is not a tragedy but the story of a real-life woman in progress, a woman who has overcome many challenges, who has had a lot of fun along the way, who has learned to understand herself pretty well, and who is still very enthusiastic about LIFE!

~~Yen Cress

3 P.M. to 6 P.M.
4095 County Circle Drive, Riverside
for more information contact Jane McCoy @ (951) 358-4603

Consumers...Mark this Annual Event!

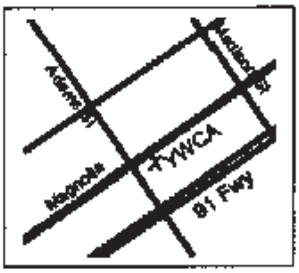
California Network of Mental Health Clients

The Far South Region
MEMBERSHIP MEETING
Monday – JUNE 19, 2006
11:00 AM – 4:00 PM

Come and get acquainted with the Network! Learn about advocacy. Meet new friends!

Meeting Location:

YWCA
8172 Magnolia
Riverside, CA 92504



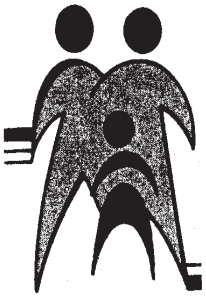
For more information
Contact your regional
director Kathi Stringer
(951) 515-6214

Orange, Riverside, Imperial, San Bernardino, San Diego

AGENDA

11:00 am – 11:15 am	Introductions
11:15 am – 11:30 pm	Report on last year's project
11:30 am – 12:00 pm	Brainstorm and selection of next year's project
12:00 am – 1:00 pm	Lunch
1:00 pm – 2:00 pm	Continued – Brainstorm and selection of next year's project
2:00 pm – 3:00 pm	Message from the Executive Director on the current issues and the history of the NETWORK
3:00 pm – 4:00 pm	Election of Regional Director and 2 alternates

916 / 443-3232 **800 / 626-7447**



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

Memorial Day Picnic

Monday, **May 29**, 2006
at **noon** at Jo Ann's

Swimming, badminton, spa, food and more..

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

Other Holidays include:
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)

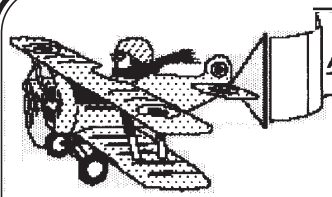
Phone Phriends

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—

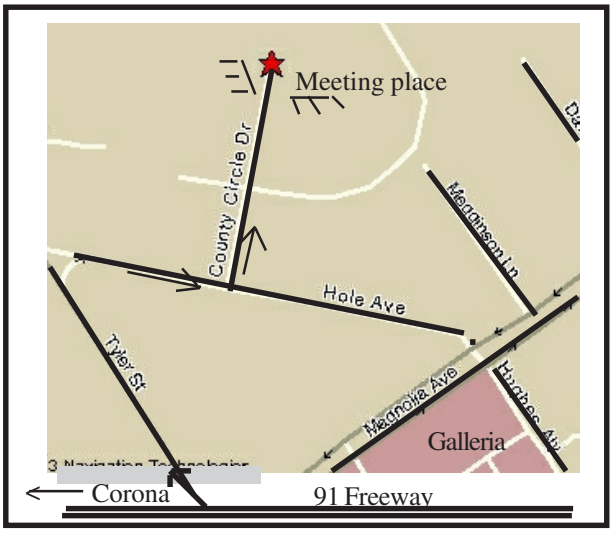
DBSA– Riverside

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. ❒