DBSA

The Thermometer Times

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

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Dates to Remember

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CARE & SHARE GROUP

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 & map)

Saturday 10:00 am - 12 noon
November 3, 10, 17 & 24

Thanksgiving at Jo Ann's, Thurs., Nov. 22 at 12noon, See page 11

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

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Rethinking Posttraumatic Stress Disorder

What is a traumatic event and how does it produce symptoms?

"It could go on for years and years, and has, for centuries:" wrote the author of the Sumerian epic of Gilgamesh in the third millennium, B.C., describing the suffering of a character who survived a violent encounter that killed his friend. That terrifying experiences often have lasting psychological consequences was well known for thousands of years before 1980, when the American Psychiatric Association classified posttraumatic stress disorder (PTSD) as a psychiatric disorder in the third edition of its diagnostic manual (DSM-III). PTSD is one of the few psychiatric conditions to which the manual ascribes a definite cause. Although no one today doubts that emotional trauma can have devastating effects, a debate about this diagnosis has been ignited, and changes may be in store.

War is a mother lode of traumatic experiences and the chief source of the concept of PTSD. In the American Civil War, the resulting symptoms were sometimes described as battle fatigue. In the First World War, it was called shell shock, and in the Second World War, combat neurosis or traumatic neurosis. Soldiers in those wars who succumbed to posttraumatic stress were sometimes regarded as weak or inadequate, but that view changed as understanding of their experiences improved. Physicians and mental health professionals came to see the symptoms as, in a sense, normal responses to abnormal circumstances. By the middle of the Korean War, DSM-I included a diagnosis of "gross stress reaction" and DSM-II described a "transient situational disturbance."

Establishing the diagnosis

At the time DSM-III was compiled, professionals had begun to emphasize more lasting effects of trauma. We were in the aftermath of the Vietnam War, and some critics of the diagnosis of PTSD have suggested that it served a political purpose, in effect making the case that war is dangerous to mental health. The creators of DSM-II1 certainly sympathized with the veterans of a war many regarded as unjustified, and they looked for a pattern in the resulting suffering. At the same time, the women's movement was drawing new attention to the effects of sexual and physical abuse on women and children. All of this history influenced the psychiatric understanding of PTSD.

As the disorder is defined today, it involves three kinds of symptoms:

1. ***Hyperarousal.*** Individuals with PTSD are irritable, easily startled, and constantly on guard. They sleep poorly and have difficulty concentrating.

2. ***Re-experiencing or intrusion.*** They recall the traumatic event involuntarily in the form of vivid memories, nightmares, and flashbacks. They may feel or even act as though it is happening again. Any object, situation, or feeling that reminds

Continued on page 3 **(Rethinking PTSD)**

a note from the Editor

We invite you to submit material for review and possible publication in the newsletter. Your 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.

Articles, poetry and/or drawings can be on anything pertaining to experiences you have to share regarding depression and/or Bipolar Disorder; what it is to live/cope with it; how you learned of it, what helps, what doesn't. You may write on any other mental health issue or problem that you are passionate about. You can tell us about yourself and how you spend your time and what's important to you. You may want to write a report on a mental health event you attended or a mental health book you have read. We would appreciate that, too.

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: ***The Thermometer Times***
% Jo Ann Martin
16280 Whispering Spur
Riverside, CA 92504

E-mail it to: Jo AnnMartin1@aol.com

FAX to: 951/780-5758

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

Movie Night At Jo Anns*

2nd and 4th Tuesday of November

5:30 PM

Tuesday, November 13

"NOBODY'S CHILD"
Starring Marlo Thomas

Tuesday, November 27

WHAT KILLED REBECCA RILEY?
A revealing look at psychiatric medicatons and bipolar in children...60 minutes
Also: HEALTHY BODY - HEALTHY MIND
The Best Doctors in the World are making House Calls on Public Television.
Understanding Bipolar Disorder

*Diresctions to Jo Ann's home on page 1, bottom of column 1 of this Newsletter.

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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.

them of the trauma may cause intense distress.

3. ***Avoidance and emotional numbing.*** They avoid feelings, thoughts, persons, places, and situations that evoke memories of the trauma. They lose interest in their usual activities. They feel estranged from other people and even from their own feelings.

These three sets of symptoms have a common theme—fixation on the trauma. The traumatic event dominates and controls the lives of people with PTSD. They have not assimilated the experience, so they repeatedly reexperience it in its original terrifying form. They are both emotionally numb and constantly on guard against a danger that no longer exists because they feel desperately conflicting needs for vigilance and repose.

What is a trauma?

In DSM-III, a trauma was defined as an event beyond the range of ordinary human experience, one that would be distressing for almost anyone. Since then the definition has changed. In the present edition of the diagnostic manual, DSM-IV-TR, a "text revision" of the DSM-IV published in 2000, a traumatic experience is defined as one that involves a threat (or reality) of death, serious injury, or damage to physical integrity, and inspires intense fear, helplessness, or horror. The victim may experience the event directly, witness it, or be confronted with it in some other way.

Some have interpreted these changes as shifting the focus away from the traumatic event itself and toward individual responses. The event is no longer necessarily utterly out of the ordinary or one that would be distressing to almost everyone. What arouses intense fear, helplessness, and horror in one person may have little effect on another. And in the DSM-IV-TR description, even immediate experience of the trauma is no longer necessary; being confronted with it could be interpreted to include hearing about it. There is no longer such an intimate relationship between a definite set of symptoms and a distinct kind of experience, so the theme of fixation on the trauma that links the symptoms is no longer so clear.

By the DSM-IV-TR definition, many kinds of events can be described as traumatic and many people can be said to have undergone a traumatic experience. The National Institute of Mental Health's Epidemiologic Catchment Area study found that more than 60% of men and more than 50% of women in the United States have had such an experience. The vast majority of people who have had a traumatic experience do not develop PTSD—nearly 90% of women and more than 97% of men in one large German study. In another recent study, researchers at Duke University interviewed hundreds of children and their parents at yearly intervals from ages 9 through 16, asking about traumatic events and symptoms of PTSD. More than two-thirds of the children had experienced at least one traumatic event, and a third had experienced more than one. The most common was witnessing or learning about a trauma suffered by another person. Only 13% reported any symptoms typical of PTSD, and fewer than 1 in 200 had PTSD itself.

Just as trauma only occasionally causes PTSD symptoms, the symptoms associated with this diagnosis are not always the result of trauma. Some research suggests that people who experience "normal" stresses like illness, divorce, bereavement, or job loss develop such symptoms at the same rate as those who undergo traumatic stress. In a questionnaire survey of 600 undergraduates at Temple University, about 70% reported having had an experience they regarded as traumatic. About half of these events—for example, a romantic breakup or the anticipated death of a relative—were not traumatic by DSM-IV-TR or most other standards. But students who had had these apparently milder experiences reported just as much distress as those who suffered a catastrophic trauma.

Effects of gender

It has become clear that people who do develop PTSD differ from those who don't in a number of ways unrelated to the nature of the traumatic experience itself. To begin with, women seem to be two to three times as susceptible as men. They may be more biologically vulnerable for genetic or hormonal reasons. They also tend to undergo different kinds of trauma. Men suffer more non-sexual physical violence, women more rape and childhood sexual abuse. It is possible that female trauma is more often prolonged— the battered wife versus the street fighter, for example—and long-term stress can have more profound effects than single events. But even when both sexes have the same experience, women are more likely to develop PTSD. Six months after the bombing of the federal building in Oklahoma City, 45% of women exposed to the bombing had the disorder, and only 23% of the men did.

Differences in social support may be a factor; for example, wives may be better at soothing husbands than the other way around. Maybe women are more willing to admit that they have the symptoms and seek help, instead of retreating into solitary misery or disguising their problems with drinking and aggression. In a recent survey of 10,000 Australians, women reported the following traumatic symptoms more often than men did: avoiding thoughts and feelings related to a trauma, disturbed sleep, and intense startle reactions. Men reported one symptom more often than women did—emotional and social withdrawal.

Other individual differences

Many other individual differences influence vulnerability. PTSD is more likely to arise in someone who has suffered previous traumatic experiences. Intentional injury—physical or sexual assault—creates a greater risk of PTSD than a natural disaster or an accident. The risk is even higher for victims who feel guilty because they believe that they bear some responsibility for the event. High IQ may blunt the impact of a traumatic experience on mental health, and low IQ may exacerbate it.

Depression, anxiety, alcohol and drug abuse, childhood behavior disorders and adolescent delinquency, antisocial

Continued on page 5 **(Rethinking PTSD)**

Depression

It's Not Just in Your Head

Everyone, at various times in life, feels sad or "blue." It's normal to feel sad on occasion. Sometimes this sadness comes from things that happen in your life: you move to a different city and leave behind friends, you lose your job or a loved one dies. But what's the difference between "normal" feelings of sadness and the feelings caused by *clinical depression?*

While it's normal for people to experience ups and downs during their lives, those who have clinical depression experience specific symptoms daily for two weeks or more, making it difficult to function at work, at school and in relationships.

Clinical depression is a *treatable* medical illness marked by changes in mood, thought and behavior. That's why doctors call it a *mood disorder.*

How to Recognize Depression

Depression is not a character flaw or sign of personal weakness. You can't make yourself well by trying to "snap out of it" or "lighten up." And you can't catch it from someone else, although it can run in families. To understand what depression is, it's important to recognize the symptoms:

- Prolonged sadness or unexplained crying spells
- Significant changes in appetite and sleep patterns
- Irritability, anger, worry, agitation, anxiety
- Pessimism, indifference
- Loss of energy, persistent lethargy
- Unexplained aches and pains
- Feelings of guilt, worthlessness and/or hopelessness
- Inability to concentrate, indecisiveness
- Inability to take pleasure in former interests, social withdrawal
- Excessive consumption of alcohol or use of chemical substances
- Recurring thoughts of death or suicide

If you or someone you know has thoughts of death or suicide, contact a medical professional, clergy member, loved one or friend *immediately.*

If you experience five or more of these symptoms for more than two weeks or *if* any of these symptoms interfere with work or family activities, contact your doctor for a thorough examination. This includes a complete physical exam and a review of your family's history of illness. Do not try to diagnose yourself. Only a health care professional can determine if you have depression.

Types of Depression

It is now believed that depression is the sign of an imbalance in brain chemicals called *neurotransmitters.* Although the direct causes of the illness are unclear, it is known that body chemistry can bring on a depressive disorder due to the presence of another illness, altered health habits, substance abuse or hormonal changes.

People who have major depressive disorder have had at least one *major depressive episode* — five or more symptoms for at least a two-week period. For some people, this disorder is recurrent, which means they may experience episodes every so often: once a month, once a year or several times throughout their lives. Each person is different.

Dysthymia is a chronic, moderate type of depression. People with dysthymia usually suffer from poor appetite or overeating, insomnia or oversleeping, and low energy or fatigue. People with dysthymia are often largely unaware that they have an illness because their functioning is usually not greatly impaired. They go to work and manage their lives, but are frequently irritable, always complaining about stress or not getting enough sleep.

Who Gets Depression?

People of all ages, races, ethnic groups, and social classes have the illness. Although it can occur at any age, depression frequently develops between the ages of *25* and *44.* More women experience depression than men.

Children and Depression

As many as one in 33 children and one in eight adolescents has depression. If your child has five or more symptoms for at least two weeks and it interferes with his or her daily activities (e.g., going to school, playing with friends), then your child may be clinically depressed. Other warning signs of childhood depression include headaches, frequent absences from school, social isolation and reckless behavior.

Childhood depression is *not* caused by poor parenting. It may have many origins — genetics, biochemistry and a variety of other factors. Fortunately, treatment for childhood depression is highly effective.

Depression and the Elderly

Depression is not a normal part of aging. However, of the 32 million Americans over the age of 65, nearly five million experience serious symptoms of depression and one million suffer from a major depressive disorder. Elderly people with untreated depression are more likely to have worse outcomes from co-existing medical illnesses. Untreated depression is the most common psychiatric disorder and the leading cause of suicide among the elderly

Women and Depression

If you are a woman, you are almost twice as likely as a man to experience depression. In fact, one in four women will experience clinical depression in her lifetime. The hormonal and life changes associated with menstruation, pregnancy, miscarriage, the postpartum period and menopause may contribute to or trigger depression. The lifetime prevalence of major depression is 24 percent for women; for men, it's 15 percent.

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RETHINKING PTSD *(Cont'd from pg. 3)*

personality, and other personality disorders also heighten vulnerability to PTSD. German researchers interviewed a group of firefighters— for whom PTSD is an occupational hazard—immediately after their basic training and again periodically for two years. They found that men who showed more hostility and less confidence in their own abilities were more likely to develop PTSD symptoms. Twin and adoption studies suggest that heredity is a factor. In one study of identical twins, only one of each pair was a Vietnam combat veteran. About half of the veterans had been diagnosed with PTSD. Tests revealed subtle deficiencies in cognitive functioning that distinguished them from veterans who did not develop PTSD. But their identical twins who had not been in combat had the same deficiencies—which suggests that these were risk factors for PTSD rather than consequences of the traumatic experience.

Surprisingly, there is even some evidence that what happens to a person after the traumatic event influences the chance of developing PTSD as much as or more than what happens before. And we tend to revise our description of experiences in the light of later symptoms. In a study of veterans of the first Iraq war, 70% recalled a traumatic experience two years after returning but not after a month. Most veterans remembered more such experiences as time passed, especially the kind that did not involve a direct threat of death or physical injury to themselves.

Because memory is malleable and events before and after the trauma have so much influence on it, there is a risk that symptoms with other causes will be mistakenly attributed to a traumatic event. Many disability claims for PTSD have been made recently by Vietnam-era veterans whose service ended 30 years ago. Critics point out that there are many reasons why people might want to make sense of their problems by ascribing them to a long-past experience. These critics fear that researchers and practitioners are not being careful enough to distinguish possible "pseudo-PTSD" from the real thing.

A distinctive diagnosis?

The symptoms of PTSD overlap with the symptoms of other psychiatric disorders, especially depression and anxiety. In a Duke University study of children and adolescents, for example, being exposed to trauma did not result in PTSD symptoms but nearly doubled the rate of other psychiatric disorders. Researchers at Harvard studying men and women who volunteered for a study of depression found that by DSM-IV-TR standards, nearly 80% had undergone a traumatic experience and many also formally fit the diagnosis of PTSD.

Australian psychologists tried to disentangle PTSD and depression among more than 350 people with serious injuries resulting from traffic accidents. Three months after the accident, 4% to 12% were diagnosed with PTSD, and another 16% to 30% were diagnosed with both PTSD and depression. In half of these patients, the diagnosis shifted from PTSD to depression or the other way around in the course of a year. The researchers suggest that PTSD symptoms are difficult to single out in reactions to traumatic stress.

Changes in store

As a result of the many questions raised by research, experts are reconsidering how to describe traumatic stress, PTSD symptoms, and the relationship between them. The fifth edition of the American Psychiatric Association's diagnostic manual may put less emphasis on the diagnosis of PTSD and more on a range of responses that depend on much besides the traumatic event alone. In the future, research may concentrate more on individual vulnerability and the lives of patients before and after the experience. With more long-term studies beginning immediately after an event, relying too much on memory may no longer be necessary.

For now, it is important to remember that not all traumas are alike, that any trauma will affect different people differently, and that PTSD should not necessarily be the default diagnosis when symptoms appear after any particular traumatic experience. But however present controversies are resolved, the knowledge consolidated in the last century will not be lost—that traumatic events are a threat to mental health, that the effects can be lasting, and that sufferers often need and deserve help.

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Source: Harvard Mental Health Letter
August 2007

DBSA *Featured Member of the Month*

A New Life

By Susie Phillips

Arcadia, California is where I was born in 1953. My childhood was happy and ordinary, playing with friends in my neighborhood and going to school. Nothing remarkable happened until I was in my Junior year of high school.

I attended a Christian oriented camp that put emphasis on accepting Jesus in order to go to heaven and if you didn't you would go to hell. They emphasized the second coming of Christ and that put a lot of fear in me. I went home and tried to get family and friends to believe as I did. I spent many nights staying awake all night reading books on the topic.

I became divorced from reality and had to go to a psychiatric hospital. They diagnosed me schizophrenic and medicated me for a while. Eventually after I left the hospital I was weaned off the medication.

After high school I went to Long Beach State University and had two breakdowns while I was in college due to staying up late. I feel like my dad taught me persistence because he used to stay up late doing my math homework with me until I got it right in my younger years.

The persistence I learned kept me pursuing my college degree and I kept going back after each breakdown. It took me from 1971 until 1986 to get my degree. In between there I worked a lot, I got married, I had a baby and had two breakdowns.

I got married in 1977, and from traveling and staying up late I had a breakdown and was diagnosed bipolar and put on lithium. Most of my adult life I've been on lithium. I worked different jobs in the education field while raising my daughter. At that time I got a lot of support from the Twelve Step Program, counselors, and inner-child work.

In 1995, I had come to see myself as precious and felt my husband was not treating me as precious. He was very self absorbed and had little time for me. We were divorced in that year.

My experience in my family was that I had been ignored by them. I was determined to raise my daughter giving her lots of time and attention. We had fun shopping, camping, watching TV and play acting with her toys and stuffed animals.

When I was growing up, my dad expressed a lot of anger towards my mother by yelling at her. My husband was paraplegic. He walked with crutches. When he walked into something or dropped something, he would yell. It reminded me of my father. I think I gained a lot of maturity through Twelve Step Programs, also a lot of friends.

In 2002 I married one of my friends from the Twelve Step Programs and we remain so today.

My life changed in 2004. My psychiatrist discovered that the lithium was imparing my kidney. He took me off the lithium and put me on mood stablizers. I had two psychiatrists prescribing other medications and the changes were drastic. I went psychotic and got lost. I was trying to walk to Redlands from Riverside. My family and friends put posters up and were looking for me. Finally the police found me after three days and put me in a hospital.

After recovering from this, my life started to even out. Two months ago I got a new psychiatrist. He has the reputation of being good with meds. I still feel like my medications are getting balanced. I still suffer from some paranoia and agoraphobia, but I force myself to go out.

My life today consists of the pleasure of knowing my 24 year old daughter is enjoying her life in Berlin, Germany, a satisfying relationship with my husband who is learning to understand and accept that I am a person who has bipolar illness, as well as many interests. We help each other with our hobbies. I recently had my greeting cards put in an art gallery in downtown Riverside. I attend a church where I am making many friends. We had been living in a small trailer in a trailer park for two years. Just recently we bought a fifth wheel trailer and we love it. I do volunteer work two days a week at a nature center. I love the people I work with and the things I do. We give tours to elementary schools and I help with every aspect of it.

I have lost many friends from my talking too much. It is something I am working on. I am working on listening more. I go to DBSA meetings almost every Saturday for the Share and Care. I meet all kinds of people and hear their stories of how they cope with depression and bipolar illness. I am learning to shorten up my story so everyone can get a turn.

Two months ago my family suffered the loss of my brother. He was bipolar, also. From a deep unrelenting depression, he chose to commit suicide. I just wish he had had more hope and perhaps DBSA

When I go to DBSA on Saturdays, I'm able to become part of the healing of other people, and vice versa. The people are really special because they understand my disability like no one else can.

Photo by Jo Ann Martin

Bipolar Soars as Diagnosis for the Young

By BENEDICT CAREY

The number of American children and adolescents treated for bipolar disorder increased 40-fold from 1994 to 2003, researchers report today in the most comprehensive study of the controversial diagnosis.

Experts say the number has almost certainly risen further since 2003.

Many experts theorize that the jump reflects that doctors are more aggressively applying the diagnosis to children, and not that the incidence of the disorder has increased.

But the magnitude of the increase surprises many psychiatrists. They say it is likely to intensify the debate over the validity of the diagnosis, which has shaken child psychiatry.

Bipolar disorder is characterized by extreme mood swings. Until relatively recently, it was thought to emerge almost exclusively in adulthood. But in the 1990s, psychiatrists began looking more closely for symptoms in younger patients.

Some experts say greater awareness, reflected in the increasing diagnoses, is letting youngsters with the disorder obtain the treatment they need.

Other experts say bipolar disorder is overdiagnosed. The term, the critics say, has become a catchall applied to almost any explosive, aggressive child.

After children are classified, the experts add, they are treated with powerful psychiatric drugs that have few proven benefits in children and potentially serious side effects like rapid weight gain. In the study, researchers from New York, Maryland and Madrid analyzed a National Center for Health Statistics survey of office visits that focused on doctors in private or group practices. The researchers calculated the number of visits in which doctors recorded diagnoses of bipolar disorder and found that they increased, from 20,000 in 1994 to 800,000 in 2003, about 1 percent of the population under age 20.

The spread of the diagnosis is a boon to drug makers, some psychiatrists point out, because treatments typically include medications that can be three to five times more expensive than those for other disorders like depression or anxiety.

"I think the increase shows that the field is maturing when it comes to recognizing pediatric bipolar disorder, but the tremendous controversy reflects the fact that we haven't matured enough," said Dr. John March, chief of child and adolescent psychiatry at the Duke University School of Medicine, who was not involved in the research.

"From a developmental point of view," Dr. March said, "we simply don't know how accurately we can diagnose bipolar disorder or whether those diagnosed at age 5 or 6 or 7 will grow up to be adults with the illness. The label may or may not reflect reality."

Most children who qualify for the diagnosis do not proceed to develop the classic features of adult bipolar disorder like mania, researchers have found. They are far more likely to become depressed.

Dr. Mani Pavuluri, director of the pediatric mood disorders program at the University of Illinois, Chicago, said the label was often better than any of the other diagnoses often given to difficult children.

"These are kids that have rage, anger, bubbling emotions that are just intolerable for them," Dr. Pavuluri said, "and it is good that this is finally being recognized as part of a single disorder." The senior author of the study, Dr. Mark Olfson of the New York State Psychiatric Institute at the Columbia University Medical Center, said, "I have been studying trends in mental health services for some time, and this finding really stands out as one of the most striking increases in this short a time."

The increase makes bipolar disorder more common among children than clinical depression, the authors said. Psychiatrists made almost 90 percent of the diagnoses, and two-thirds of the young patients were boys, said the study, published in the September issue of The Archives of General Psychiatry.

About half the patients were identified as having other mental difficulties, mostly attention deficit disorder.

The children's treatments almost always included medication. About half received antipsychotic drugs like Risperdal from Janssen or Seroquel from Astrazeneca, both developed to treat schizophrenia.

A third were prescribed so-called mood stabilizers, most often the epilepsy drug Depakote. Antidepressants and stimulants were also common.

Most children took a combination of two or more drugs, and 4 in 10 received psychotherapy. The regimens were similar to those of a group of adults with bipolar diagnoses, the study found. "You get the sense looking at the data that doctors are generalizing from the adult literature and applying the same principles to children," Dr. Olfson said.

The increased children's diagnoses reflect several factors, experts say. Symptoms appear earlier in life than previously thought, in teenagers and young children who later develop the full-scale disorder, recent studies suggest.

The label also gives doctors and desperate parents a quick way to try to manage children's rages and outbursts in an era when long-term psychotherapy and hospital care are less accessible, they say.

In addition, drug makers and company-sponsored psychiatrists have been encouraging doctors to look for the disorder since several drugs were approved to treat it in adults.

Last month, the Food and Drug Administration approved one of the medications, Risperdal, to treat bipolar in children. Experts say they expect that move will increase the use of Risperdal and similar drugs for young people.

"We are just inundated with stuff from drug companies, publications, throwaways, that tell us six ways from Sunday that, Oh my God, we're missing bipolar," said Dr. Gabrielle Carlson, a

Continued on page 8 **(Bipolar Youth)**

Psychotherapy Aids Bipolar Treatment

Psychotherapy enhances emotional stability in people receiving standard medications for bipolar disorder, a new study finds.

Scientists earlier reported that only about one-quarter of bipolar patients receiving mood-stabilizing drugs get substantially better, whether or not they take anti-depressant medication.

The same researchers, led by psychologist David Miklowitz of the University of Colorado at Boulder, have now studied 293 patients receiving medication for bipolar disorder. The team randomly assigned the participants to one of three types of psychotherapy or to a brief educational program. Patients entered treatment in the early stages of a depression episode.

Psychotherapy lasted for up to 30 sessions over nine months. One approach required family participation in boosting a patient's coping and communication skills. Another method explored distorted thinking and destructive behavior in bipolar disorder. A third technique established daily routines and addressed relationship problems.

The brief program occurred in three sessions and provided information about bipolar disorder and strategies to avoid relapses.

When assessed one year after the study began, two-thirds of the patients receiving any of the psychotherapies displayed good emotional health, compared with half of those who received the brief intervention. The new report appears in the April Archives of General Psychiatry.

Source: Science News April 21, 2007 Vol. 171
As seen in The Rollercoaster Times Fall 2007

BIPOLAR YOUTH *(Continued from page 7)*

professor of psychiatry and pediatrics at the Stony Brook University School of Medicine on Long Island. "And if you're a parent with a difficult child, you go online, and there's a Website for bipolar, and you think: 'Thank God, I've found a diagnosis. I've found a home.'"

Some parents whose children have received the diagnosis say that, with time, the label led to effective treatment.

"It's been a godsend for us," said Kelly Simons of Montrose, Colo., whose son Brit, 15, was prone to angry outbursts until given a combination of lithium, a mood stabilizer, and Risperdal, which was often given to children "off label," several years ago. He now takes just lithium and is an honor roll student.

Other parents say their children have suffered side effects of drugs for bipolar disorder. Ashley Ocampo, 40, of Tallahassee, Fla., whose 8-year-old son is being treated for bipolar, said that he had tried several antipsychotic drugs and mood stabilizers and that he had improved. "He has gained weight," Ms. Ocampo said, "to the point where we were struggling to find clothes for him. He's had tremors and still has some fine motor problems that he's getting therapy for. But he's a fabulous kid. And I think, I hope, that we're close to finding the right combination of medications to help him."

NewYork Times News Service
September 4, 2007

DEPRESSION *(Continued from page 4)*

Postpartum Depression

Many women feel especially guilty about having depressive feelings at a time when they should be or are expected to be happy. It's extremely important to talk about postpartum feelings, as untreated postpartum depression can affect the mother-child relationship and, in severe cases, may put the infant's and/or mother's life at risk.

One in ten mothers meets the criteria for depression in the postpartum period. Although most of these women have only depression, a rare few develop postpartum psychosis — symptoms of depression and mania appearing in the postpartum period. Both require immediate treatment when symptoms appear.

Depression and Other Illnesses

Depression often co-exists with other mental or physical illnesses. Substance abuse, anxiety disorders and eating disorders are particularly common mental conditions which may be worsened by depression, and vice versa. Research is currently being done into the relationship between depression and physical illnesses. Several recent studies have noted that when co-existing depression is treated, prognoses are substantially improved for conditions such as heart disease, AIDS, cancer, Parkinson's disease and diabetes. It is important to tell your doctor about all of the symptoms you are experiencing and all other illnesses for which you are receiving treatment.

The Good News

Of all psychiatric illnesses, depression is one of the most responsive to treatment. With proper care, approximately 80 percent of people with major depression demonstrate significant improvement and lead productive lives — even those with severe depression can be helped. That's why it's crucial to learn about the symptoms of depression and act promptly.

Source: Guide to Depression and Bipolar Disorder
Depression and Bipolar Support Alliance (DBSA)

Bipolar Disorder: Handling the Holidays

With a little planning you can avoid holiday depression, anxiety, and mania — and enjoy the season.

By R. Morgan Griffin
Reviewed by Brunilda Nazario, MD

WebMD Feature

The holidays can be a tricky for anyone. But people with bipolar disorder may anticipate November and December holidays with real dread — and depression.

"The holidays can be very hard for people with bipolar disorder," says Raymond L. Crowel, PsyD, vice president for mental health and substance abuse services at the National Mental Health Association. You'll probably face loads of possible triggers: relatives, stress, exhaustion, and the temptation to overindulge, to name a few. Slipping into a mood swing may be much easier than usual.

So what should someone with bipolar disorder do when the holidays roll around? Be a Scrooge and opt out? Hibernate?

You don't have to do either. WebMD talked to experts about how people with bipolar disorder can weather the holidays —with tips on avoiding depression and mood swings, planning, enjoying the season, and more.

Bipolar Disorder: Why the Holidays Can Be Hard

Experts say many things come together to make the holidays tough for people with bipolar disorder, including:

Disrupted schedules. "The biggest single problem with the holidays for people with bipolar disorder is that they take them out of their routine," says Ellen Frank, PhD, director of the depression and manic depression prevention program at the University of Pittsburgh's Western Psychiatric Institute and Clinic.

Studies show that people with bipolar disorder do best when they're on a schedule — getting up, eating, exercising, and going to bed at roughly the same time each day. Even the loss of just one night of sleep can trigger a mood swing. But during the holidays — when you may be traveling across time zones, partying, or staying up until the wee hours — it's all too easy to get off track.

Over-stimulation. Shopping, decorating, and preparing for the holidays can leave you excited and anxious. Some family reunions aren't always happy. Any excess stimulation can trigger a swing toward holiday depression or mania.

Shorter days and longer nights. Some people with bipolar disorder find their mood swings are related to the seasons. Depression is more common in the fall and winter in the northern hemisphere, says Michael E. Thase, MD, professor of psychiatry at the University of Pittsburgh Medical Center.

Holiday "cheer". The holidays are a time when excessive drinking is often tolerated, even encouraged. Though unwinding with alcohol can be tempting, it can be bad for people with bipolar disorder. Not only can it interfere with medicine, it may also ruin sleep and make you more prone to mood swings.

Excessive spending. It's the season when it seems everyone is running up their credit cards. If you have a history of excessive spending and grandiose gift-giving during hypomanic or manic episodes, you are clearly at risk.

Missing your medication. When you're busy, it's easy to forget about your medication. You may even feel tempted to skip a few doses on purpose: it might make it easier to tolerate alcohol, or being a little hypomanic may give you the energy to get errands done. But when you have bipolar disorder, skipping your meds is always risky, since it makes your mood less stable.

Believing the hype. We all know how we're supposed to feel at the holidays: brimming with joy, good will, and love. But a lot of us don't really feel that way. Being depressed during the holidays can really make you feel out of step, which adds to feelings of isolation.

Planning for Holiday Success When You Have Bipolar Disorder

It's very easy to let the holidays dictate your life. You *have* to go shopping. You *have* to go to your office party. You *have* to bake four batches of Christmas cookies. It can make you feel completely powerless. Your own needs become irrelevant.

The key is to take control before that happens. "Where is it written that you *must* do all these things?" says Frank. The key to a successful holiday is to plan for it well in advance, she says. Here are a few tips that may help ease your holidays:

Scale back your expectations. Be easy on yourself. "The gifts don't have to be perfect," Crowel tells WebMD. Nei-

Continued on page 10 **(Holidays)**

HOLIDAYS*(Continued from page 9)*

ther do the decorations. Or the turkey. Or *anything.*

Think twice before playing host. The preparations for a holiday dinner— shopping, cooking, cleaning — can be overwhelming for a person with bipolar disorder. So make sure you are really up to it. If you do host, simplify. Pare down the guest list. Cook something you can prepare in advance. Ask for help from friends or family.

Be open and direct with your family. Tell them what you need this year. If the usual family gathering of dozens seems like too much, see if your family might cut down the guest list. Obviously, this could cause conflict with the rest of the family. But if the extended family members really care about the person with bipolar disorder they should understand, Frank says.

Make this year different. If holidays have not gone well in the past, make changes. Instead of doing the usual dinner at home, go to a restaurant. If staying with your in-laws hasn't been good for you, check into a nearby hotel instead. Or simply get away from all the holiday hub-bub and go on vacation.

Spread out the vIsiting. Frank suggests shifting some of your visits into October and January, instead of trying to fit in everyone in November and December.

Increase the number of check-ins. You might want to step up the schedule of appointments with your therapist or check-ins with your family and friends. lt's a good way of staying grounded.

Facing Holiday Parties

For a lot of people with bipolar disorder, it's the holiday get togethers — family dinners, office parties, neighborhood caroling expeditions — that cause the most anxiety. Here are some tips for getting through them unscathed.

Say "no" sometimes. "Don't overbook yourself," says Crowel. Most of us have more holiday obligations than we can handle. Decide which ones are most important and which aren't. Some events may simply be overwhelming. It's okay to say "no".

Have an ally. If going to a party is making you anxious, go with a friend, relative, or co-worker. Arrive and depart together. And your partner could watch your back, helping you avoid alcohol and other temptations.

Leave early. Going to a party doesn't mean you have to stay all night. Decide beforehand when you'd like to leave and stick to it. Even stopping in for just a few minutes is okay. Having a getaway plan may relieve a lot of anxiety.

Stick to your schedule. If you're having fun, of course you don't want to leave a party to make your bedtime. But you need to follow your regular non-holiday schedule as closely as possible. And make sure to keep up your normal exercise routine too — or at least get out for quick walks.

Try not to overindulge. It's hard, but you really must stay away from alcohol, especially if you've had problems with it in the past. And despite the allure of all those sweets, try to stick to your normal diet.

Weigh the pros and cons. Even if it makes you anxious, it's generally a good idea to try going to your family's holiday dinner. But there are exceptions.

"If you have a really stormy family history, and seeing your family tends to trigger problems, then staying away could be the right move," says Thase.

But make this decision carefully. Weigh the benefits and the risks. Can you handle the guilt of not going? Most importantly, make sure you have something else planned. Don't just say no and then spend the holidays alone.

Bipolar Disorder & Shopping Sensibly

It's very easy to get caught up in the frenzy of the season and become fixated on finding everyone the perfect gift. But again, you need to stay in control — especially if you're prone to unhealthy buying sprees. Here are some suggestions:

Keep perspective. Don't get too caught up in finding the best gift for everyone. It's not worth the anxiety — and besides, your nephew would probably be happy with a check anyway.

Stick to a budget. If you have a problem with overspending, come up with an explicit budget well before the holidays arrive. You may want the aid of a friend or family member to help you stick to it.

Spread out the shopping. Try to shop ahead. Frank suggests Halloween (or earlier, if you can manage it) as a great time to start looking.

Shop online. If you have access to the Internet, online shopping is a low-stress way to avoid the mall's hassles. For a little extra, some sites may even gift wrap.

Go for gift certificates. Just about everyone loves a gift certificate. And they don't have to be impersonal. Choose one that fits the person: get your sister one from her favorite boutique and your uncle one from a restaurant he likes.

Caring for Yourself

The holidays are a time when we're encouraged to think about other people instead of ourselves. That's fine, to a point.

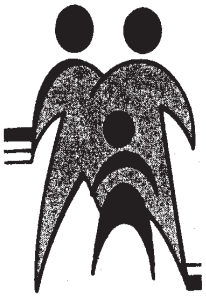
But if you focus so much on other people that you neglect yourself, you're at higher risk of descending into mania or depression. That's not good for anyone.

"Your first order of business during the holidays has to be taking care of yourself," says Thase. "If you don't, all sorts of bad things can happen."

Thase compares living with bipolar disorder to diabetes. "Just as diabetics can't eat all of the sweets during the holidays, people with bipolar disorder have to take extra precautions," he tells WebMD. "But if you take those precautions, the holidays really can go well."

So this holiday season, plan ahead, keep to your schedule, and scale back your expectations. If you do, you can beat holiday depression, mania, anxiety, and hassles — and enjoy the season. That's good for you as a person living with bipolar disorder — and for your loved ones too.

Source: WebMD
Reviewed November 6, 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
951 / 358-4987 or 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 friends of DBSA-Riverside

At Jo Ann Martin's*

for

Thanksgiving

Thursday, November 22
12 noon

Friendly sharing and good company
~
Bring a salad, main dish,
or dessert.
If you can't bring a dish, come anyway.
Meat & beverage will be furnished.

*See page 1, lower left column of newsletter for directions. to Jo Ann's home.

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
7 a.m. to 9 p.m.
951/686-5047

Georgia
6 a.m. to 9 p.m.
951/352-1634

Yen
951/315-7315

Kevin
knenstiel@sbcglobal.net

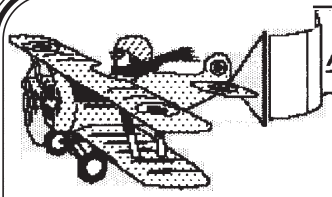
Gays In Search of Hope
Online Support Group

Gays In Search of Hope is a Depression and Bipolar peer support group (Yahoo Group) for the Lesbian, Gay, Bisexual, Transgender, Intersexual and Questioning Community (LGBT). Please Check our website for more info and resources.

Gays In Search of Hope Website:
http://geocities.com/gayhope1/index.html

Kevin, Founder and Moderator
E-mail Address: gays4hope@yahoo.com
Phone: (951) 359-0739

I am available by phone from 8am to 10pm. If I am unavailable, please leave a message and I will return your call as soon as possible.



ANNOUNCEMENTS

TEMECULA DMDA
Mark Monroe
951/926-8393

UPLAND DMDA

Meet Thursday evenings
Call David or Samantha Johns
909/944-1964 OR
e-Mail dmjbf@aol.com

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)

THE UPLIFTERS
(Christian emphasis) meets at
The Grove Community Church
19900Grove Community Drive
(off Trautwein) Riv. 92508
951/571-9090 - meets 1st & 3rd
Saturday, Room # D-4.
Contact Sheri 951/565-8131
smatsumoto@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

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 a component 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:
Lisa Partaker, IOOV Coordinator
(951)686-5484, ext. 102

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

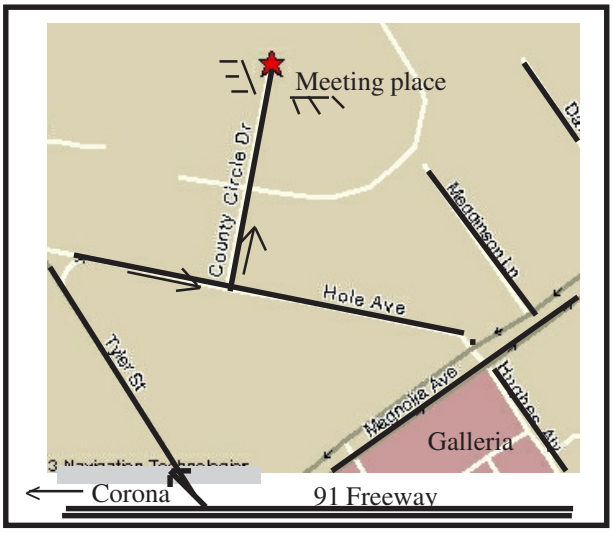
DBSA– Riverside

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. ❒