DBSA

The Thermometer Times

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

VOL. 19 NO. 6 Out of darkness . . . June, 2007

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 11 for address & map)

Every Saturday
10 am–12 noon

June 2, 9, 16, 23 & 30

Speaker Saturday, June 16
Pat Poor, MFT
"Dealing with Past Pain"
(bad past experiences that have left an emotional mark)

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

The Quandary of Mental Illness as Stigma

by Kathi Stringer
August 20, 2003

Can the phrase "mental illness" be destigmatized? We have seen the natural progression that "mental illness" equates to "mental sickness," and sickness when associated with "mental" is instantly stigmatized and can immediately become an insult: "Man, you are one SICK puppy!" Now we see the dilemma: how can the mentally ill distance themselves from "the SICK puppies?" They can't. Not until they distance themselves from the word "sick." History offers an important lesson on this futile effort. Before I discuss this further, let us examine the natural flow of the early generational views of language as the decades sailed by. Idiot: What if people began wearing a button that said, "Stop the stigma of being an Idiot?" And, what if there was a massive organized movement that exposed the film industry and contemporary literature as agents that are stigmatizing the mentally challenged individual with the inappropriate use of "idiot" as a demeaning adjective? Suppose the mission of the organization was to destigmatize the idiot, the imbecile and the moron. Do you think a movement like this could be successful? Could "idiot" be clarified and reassigned it's original meaning without insulting the mentally challenged with a renewed association that was lost over time? Further, would it be possible that the mentally challenged and their loved ones would embrace such a crusade? Or rather, would it be likely they would try and put distance between the word and its meaning? Before answering these questions, let's examine the formation of stigma.

In 1940 it was proper to refer to the "mental deficient" as the idiot, the imbecile and the moron. A textbook titled Psychiatry for Nurses by Kamosh and Gage (1940) carefully instructs the student on the correct classifications that have evolved into today's insult. Below is a direct quote from Psychiatry of Nurses (1940 - p. 237.)

"Types of Mental Deficiency:
Idiot

The idiot is one whose mental capacity is below the third-year level; they are clumsy, awkward, untidy and require constant supervision in the performance of the simplest requirements of living. Most idiots learn a few simple words but rarely learn to talk intelligently.

Continued on page 3 **(Stigma)**

a note from the Editor

We invite you to submit 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.

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

Don't Forget!!!

WRITING CONTEST

see flyer enclosed in this issue

Deadline: June 30, 2007

Please note that articles in *The Thermometer Times* are collected from many sources. They do not necessarily reflect the views of DBSA Riverside, nor do we make recommendations based on these articles. Editors.

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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.

STIGMA *(Cont'd from pg. 1)*

Imbecile

The imbecile may attain a mental level of six or seven years. Imbeciles can generally talk with a very crude vocabulary, can be taught simple manual tasks.

Moron

The moron ranges in mental accomplishment between the eight-year level and the lower adult normal which is ordinarily reached at about the fifteenth year. Constituting more than 80 percent of all forms of mental defect, the morons are one of the serious problems of modern times. Having no gross physical defects, they present themselves as a shiftless, unstable group which gravitates to the lowest level of manual labor and social activity. Out of this class are the recruited, the petty criminal, the prostitute, and the ne'er-do-well."

In 1940 the idiot, the imbecile and the moron were terms that were classifications, and were not meant to stigmatize the individual. However, through the generational shift these terms were adapted as an insult to the "normal" public that did not apply themselves, or to basically devalue a person. The terms became so stigmatized that the mentally challenged and their loved ones divorced themselves from these expressions and advocated they are not politically correct. With effort, a new association emerged away from the idiot, imbecile and moron, and mental retardation (mild, moderate and severe) replaced the classification of these stigmatizing terms.

This is an important paradigm to examine when facing the prospect of destigmatizing a word imbued with devaluation. For example, the post idiots, imbeciles and morons did not wear a button stating, "I'm proud to be an idiot" or "Stop the stigma of idiots." They did not rally in masses at public parks, or stop people on the streets to explain that they are "idiots" and educate the public that they are harmless. Rather, they removed themselves from any association of the words, and quickly. Now shifting from the idiot to mentally ill, how is it possible to reassign a new meaning that is politically correct for the mentally ill? How will the mentally ill divorce themselves from the "sick puppies?" I suggest these questions are certainly worth considering since the mentally challenged used considerable intelligence to walk away from heavily stigmatized labels. The question now is, "Can the mentally ill do the same?" How much money and energy will be invested until we look for other less stigmatized terms? Consider the difference: "I am mentally ill" or "I have a chemical imbalance."

Stigma Soup

The chef that cooked up "mentally ill" managed to make it a concoction that encompassed the reach of every synaptic threat against mankind, financially or dangerously. For example, the severely depressed are in the same stew as the pathological serial killer. We may see on the news wire, "A mentally ill pathological serial killer was found and arrested today in the wake of dozens of roadside murders" and in the same breath "...and in another local city a mentally ill woman perched high on a bridge stalled traffic until a crisis team was able to calm her and talk her down." The viewer of course, is introduced to the impression that the mentally ill are in the same pot as the poisonous serial killer. And, according to the "Diagnostic and Statistical Manual of Mental Disorders" (DSM), the psychiatrist handbook for assessments, that would be correct.

Physical Illness

Physical illnesses are usually addressed as a "medical" problem and respectfully accepted as scientific in nature. These illnesses include cancer, cardiovascular complications and diabetes. There is much less stigma associated with physical illness. For example, we do not usually hear, "A physically ill serial killer was arrested today..." A physical illness tends to generate empathy and understanding rather than caution and avoidance.

Personality Disorders (not to be confused with deranged)

This is another interesting and confusing label. "Disordered" suggests a defective personality structure at birth, when in fact it may be very much "ordered" in direct relation to the environment. I am suggesting the environment was disordered and the personality adapted to survive (effective). For every environmental ZIG, the surviving personality had to adapt and ZAG. The weaker and non-adaptive personalities (disordered) perished.

Authors and theorists, Otto Kemberg M.D. and Vamik Volkan M.D., to their credit realized the stigma of "disorder" and referred to the DSM's Borderline Personality Disorder (BPD) as Borderline Personality Organization. This rings appropriate since the personality had to"'organize" defenses to survive. Those defenses are largely the result of a healthy response based on available and age appropriate resources at the time. The personality that is actually "highly ordered" as a survival defense, is now stigmatized as disordered and lumped in with the serial killers as "mentally ill." This categorical approach appears to put surviving personality at risk for stigma — a failure based approach.

Another interesting contradiction is that "Post-Traumatic Stress Disorder" (PTSD) is NOT viewed as a personality disorder but for the most part as a "natural" and accepted response to a harmful environment, UNLIKE the closely related and stigma tagged survivor diagnosed with Borderline Personality Disorder.

DSM & Mental Illness

It is interesting that "mental doctors," authors of the 943-page handbook titled "Diagnostic and Statistical Manual of Mental Disorders," were also ambivalent about the book's title. They anticipated that the word "mental" could have far reaching implications and this dilemma perplexed them as well. Yet, for the lack of more suitable word, "mental" was adapted into the book's official title.

Continued on page 4 **(Stigma)**

STIGMA *(Cont'd from pg. 3)*

The adaptation of "mental" is problematic because the brain is an organ (physical), and the mind (mental) is a complex of psych structures that are developed through life experiences. The brain is an organ with tissue as are other organs within the body. A statement that suggests the "brain" is the "mind" muddies the waters. Mental illness invites stigma that arises when the depressed individual (physical brain illness) is lumped into the serial killer psychopath (mental derangement). Is it any wonder the prefix "mental" is alarming?

Until advocates for the chemical imbalanced, i.e. bipolar, depression and schizophrenia (brain diseases) take a hard look at what is getting thrown into the same mixing pot with the (serial killers and child molesters), there is little or no chance to lift the stigma around "mental illness" as a brain disease. This is similar to a metaphor of mixing a few drops of red food coloring (serial killers) into a pot of water. The entire lot is now "colored" as the mentally deranged. For example, it is highly unlikely that most parents would feel comfortable living next to a "mental" person that is identified in the same line-up as the child molester.

Seventy-five years ago it was perfectly acceptable for a straight man to say, "I feel so gay today!" However, not likely nowadays!

Perhaps until there is a hard look at exploitation of "mental" (DSM) that blankets across diseased brains, (dis)organized minds AND deranged minds, the stigma will remain.

Perhaps "mental" people and their advocates could learn a lot from the idiot, the imbecile and the moron. Only time will tell.

References:

- Psychiatry for Nurses by Kamosh and Gage (1940 - p. 237.)
- Diagnostic and Statistical Manual of Mental Disorders — DSM-IV-TR
- Borderline Conditions and Pathological Narcissism — Otto Kernberg M.D.
- Six Steps in the Treatment of Borderline Personality Organization — Vamik Volkan

Counseling Better for Depressed Senior Adults

Senior adults prefer talk therapy over taking anti-depressants for depression. Research indicates that talk therapy is more effective than medication for many seniors. Working with primary care physicians is critical in determining the treatment for symptoms, however. Many of the symptoms of depression may be a byproduct of an existing medical problem or may be a side-effect of medications the senior is already taking.

Adapted by Tom Kennedy, Ed.D. from:
wwwnim.nih.gov/dlineplus/news/fullstory_4 1884.html

Source: DBSA Greater Houston MoodPoints Spring, 2007

Shocks Can Treat Depression

Dear Dr. Donohue: I have **a** much-loved son-in-law who is very depressed and has been for many years. Doctors and mental health professionals cannot find anything to help him. He has been given many medicines, but nothing works. He is scared of shock therapy because he's been told it will erase all his memory. A suggestion has come up about an operation that entails putting a wire through his head to suppress feelings. Please tell me more about this. — RD.

For depression that doesn't respond to medicine and talk treatment, shock therapy often succeeds. It's not done as it's often portrayed in movies. The patient is sedated and muscles are relaxed, so there is no violent thrashing during the treatment. The whole procedure is over in less than a minute. If you were to observe it, you would hardly realize it had taken place. Close to 87 percent of people who undergo this treatment have a remarkable improvement in their mood. One's entire memory isn't erased. If memory loss occurs — and it doesn't always happen — it's a selective loss of memory, and it almost always returns in time.

The technique you mention is deep brain stimulation. Electrodes — tiny metal filaments — are placed in a particular brain location that regulates feelings. Wires run under the skin to a battery-powered generator implanted beneath the skin of the chest. The trickle of current that comes from the electrodes suppresses activity of nerve cells producing depression.

Deep brain stimulation has been used for other conditions, like Parkinson's disease and unremitting pain. The brain areas stimulated in those conditions are different from the ones stimulated for depression. It's a new technique. If the doctors treating your son-in-law are experienced in it and approved to use it, and if the hospital is prepared to handle the procedure, it's worth his consideration.

Letters to Dr. Donohue can be addressed to him in care of The Press-Enterprise, P.O. Box 792, Riverside, CA 92502-0792.

NORTH AMERICA SYNDICATE

Source: The Press-Enterprise April 1, 2007

Lisa's Journey

by Judy Kaplan

Lisa grew up in spite of her parents and moved successfully through high school and college. Receiving a bachelor's degree, she found herself unable to make it in her field, systems analysis. So she's working at a local supermarket. Even that job stresses her, and Lisa depends on her friends' support. They want to see her more often, but just getting through the day leaves little time for visiting. Her family doesn't help. In contemporary jargon, they're dysfunctional. Thank goodness, Lisa often thinks, she has so many warm-hearted women around. With an abundance of loving qualities, they form a perfect circle of comfort.

To understand Lisa's story, you must meet them. Iris has confidence in everything she does. Blond, athletic, slender and average- looking, she judges no one and seeks the best in people. Joan has let her hair grey although she looks youthful. She asserts herself but does so without rancor and attacks no one. She shows her affection but doesn't intrude. Everyone loves Joan. A looker, Cynthia rounds off the group. Her beauty never makes her feel superior, and she's a pleasure to be with.

If Lisa can't visit during the day, she contacts them at bedtime. "Guys, everything's getting tougher. My parents fight daily. I don't know how they stay together. Work is impossible. My supervisors time how long it takes me to cash out the people on my line. They're boobs. If I rush, the packing suffers, because I can't watch the baggers. More than once, I've had shopper complaints about cracked eggs they've found under large bottles of soda. Management tells me when I can pee, eat, and sit. I'm aware that the supervisors don't have a whole lot of smarts, and I understand the pressure that management's under. Today's workplace befriends no employee, management or not.

"Because I have a degree, they want me to learn the computer in the office. I'm not getting what they're showing me. Demonstrating it orally and physically, they expect I'll pick it up.

"Do this ... ***finger action*** ... then this ... ***finger action*** ... then hit this key ... ***finger action*** ... two spaces with the underline ... and you're finished.

"It means nothing to me. I can't see which keys they're using because their hands get in the way. As far as I know, hands are not transparent. I asked if they could give me the training manual. No, they say it's at the main office. Is that dumb or what?"

"Sounds awful," says Joan.

"Really bad," echoes Cynthia.

"You should get out," directs Iris.

"Right," says Lisa. "Get out and do what? Who pays the rent my parents expect? Where would I go?"

"Come stay with us. There'd be no pressure,"says Joan.

"At least think about us when things get tough at work and while your parents fight," says Iris.

"We love you, and we're good for you," says Cynthia.

"I'll try it. We'll see. I can't visit for too long, but I'll take all of you to work," replies Lisa.

She does in fact take them to work. They relieve the pressure, just what she needs. Whenever a supervisor watches her, recording her speed, she visits her friends. When her parents fight, she hangs out with all three.

Life changed just about then. At first, if you didn't know, she looked like the person she'd always been. Her concentration stayed intense, and she talked personably to her customers. But it was getting harder to think about Iris, Cynthia, and Joan and work at the same time.

Her eyes lost their look of fierce intelligence. They became distant and expressionless. The periods when she seemed absent and far away lengthened as the months passed.

"I told you if I decided to stay with you, there'd be trouble. I'm on probation at work, and my parents want me to see a shrink," Lisa told the group. "But when I'm with you, there's no pain, no anger, no rejection. I'm hardly ever hungry. And I don't worry about paying the rent.

"It's not your fault I came to stay with you. I had a choice. You know I still have a choice, and I am going to stay. When I'm around you, life improves," said Lisa.

For a longtime, Lisa plugged into the world she was leaving to see and hear whether work and her parents had gotten any better.

"Lisa, your check out time isn't fast enough. In fact, you're slowing down. Pick up the pace, and spend more time with the computer. We know you can do it," one of her supervisors said impatiently.

"So what did you think would happen if you didn't cook dinner? You expect it to materialize abracadabra on the table? I'm hungry," said Dad.

At home her parents were still at each other. "I don't care if it's on the table or not. Hungry? Well ... cook. I've been busy all day. I'm not doing it," responded Mom.

Lisa listened for a while and returned to her friends'.

After Lisa left to stay with Iris, Cynthia, and Joan, she was unable to hear people talking to her. She just saw their mouths moving. Sometimes she watched the world she had grown up in, seeing it through a haze.

Lisa now lives in a world of her own design. She created her friends and left the old world to live with them. In her perfect community, pain, anger and rejection are just memories.

When her parents could no longer look after her, Lisa was taken to an institution. She didn't care. She was happy. No one could hurt her.

A Note

Many people loved Lisa. Most were aware of her sensitivity. She was born one of the too-gentle souls, and life left her in pain. Her loved ones had to deal with the problem of whether they should continue to give her medicine and send her for therapy, because Lisa appeared content and worry free. Would it be a gift to return her to the real world?

Continued on page 7 **(Lisa)**

Bipolar Disorder Information Center

What Causes Bipolar Disorder?

Doctors don't completely understand the causes of bipolar disorder. But they've gained greater understanding in the past 10 years.

Bipolar disorder often runs in families, and researchers believe there is a genetic component. There is also growing evidence that environment and lifestyle have an effect on the disorder's severity. Stressful life events — or alcohol or drug abuse — can make bipolar disorder more difficult to treat.

Experts believe bipolar disorder is caused by an underlying problem with the balance of brain chemicals. When the levels are too high, mania occurs; when the levels are low, there is depression.

Source: Reviewed by the doctors at The Cleveland Clinic Department of Psychiatry and Psychology. WebMD Medical Reference provided in collaboration with The CIeveland Clinic

What are the Symptoms?

The primary symptoms of bipolar disorder are dramatic and unpredictable mood swings. The illness has two strongly contrasting phases.

In the manic phase:

- Euphoria or irritability
- Excessive talk; racing thoughts
- Inflated self-esteem
- Unusual energy; less need for sleep
- Impulsiveness, a reckless pursuit of gratification - shopping sprees, impetuous travel, more and sometimes promiscuous sex, high-risk business investments, fast driving
- Hallucinations and or delusions

In the depressive phase:

- Depressed mood and low self-esteem
- Low energy levels and apathy
- Sadness, loneliness, helplessness, guilt
- Slow speech, fatigue, and poor coordination
- Insomnia or oversleeping
- Suicidal thoughts and feelings
- Poor concentration
- Lack of interest or pleasure in usual activities

Call Your Doctor If:

- You notice some of these symptoms in a family member. Note: Persons with bipolar disorder often deny anything is wrong, especially in the manic phase. If you are worried about a family member or close friend, a doctor can offer advice on how to handle the situation.

- You notice some of these symptoms in yourself.

Because of the stigma still attached to bipolar disorder (and to many other mental diseases), patients are frequently reluctant to acknowledge that anything is amiss and doctors often fail to recognize the disorder. In addition, the symptoms may sometimes seem to be merely exaggerated versions of normal moods. In any event, research suggests that almost 75% of cases go untreated or are treated inappropriately.

The American Psychiatric Association has established a long list of specific criteria for recognizing the disorder. Evaluation involves investigating the patient's history and any family history of mood swings or suicide. Other disorders must be ruled out — particularly such childhood problems as school phobia and attention deficit disorder, as well as dementia, schizophrenia, and psychotic states induced solely by alcohol or drugs. Drug or alcohol abuse is common in persons with bipolar disorder and can mask the symptoms, thus complicating diagnosis and treatment. Recognizing and treating any drug abuse is a priority, since it is a strong predictor of suicide, especially in men.

Before treatment begins, the patient receives a careful physical exam, and blood and urine are tested to detect conditions that could put medical constraints on the choice of treatment. A thyroid analysis is particularly important both because hyperthyroidism can look like mania and because lithium — the principal drug treatment for bipolar disorder — is known to lower thyroid function. During treatment, frequent blood tests are necessary to see that adequate drug levels have been reached and to detect adverse reactions at an early stage.

Source: WebMD Medical Reference

"Only those who risk going too far can possibly find out how far they can go."

T.S. Eliott

Mentally ill die 25 years earlier, on average

By Marilyn Elias, USA TODAY - 3/5/2007

Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's widened since the early '90s when major mental disorders cut life spans by 10 to 15 years, according to a report due Monday.

"We're going in the wrong direction and have to change course," says Joseph Parks, director of psychiatric services for the Missouri Department of Mental Health. He's lead author of the report from eight states — Maine, Massachusetts, Rhode Island, Oklahoma, Missouri, Texas, Utah and Arizona — that will be released at a meeting of state hospital directors in Bethesda, Md.

About 60% of the 10.3 million people with serious mental illness get care in public facilities, 90% as outpatients, Parks says. They have illnesses such as schizophrenia, bipolar disorder and major depression. Although the mentally ill have high accident and suicide rates, about 3 out of 5 die from mostly preventable diseases, he says.

Obesity is a serious problem. These patients often get little exercise, and many take a newer type of anti-psychotic, on the market for 18 years, that can cause drastic weight gains, promoting diabetes and heart disease, Parks says. He thinks these drugs are contributing to deaths from cardiovascular disease.

Recent studies question the advantage of the newer drugs. "Many could be switched to safer medicines," Parks says. Schizophrenics are thought to have a higher risk for diabetes already, he says.

Mentally ill adults also are more likely than others to have alcohol and drug-abuse problems, and to smoke.

Because of their mental disorder, patients often aren't good health advocates for themselves, says Andrew Leuchter of the UCLA School of Medicine. When patients do seek help, "I hear of great difficulty getting appointments even for simple problems like high blood pressure. The public health system is underfunded, and it's gotten worse over the years."

Medical needs of the mentally ill are least likely to fall through the cracks when psychiatrists and primary care doctors practice in the same facility, according to a 2003 report from the Bazelon Center for Mental Health Law. But integrated clinics are "quite rare," says Bazelon policy director Chris Koyanagi.

Sometimes internists disregard medical symptoms of the mentally ill, chalking them up to the patient's disorder, says Kenneth Duckworth of the National Alliance on Mental illness. And needed treatment may be harder to get. He points to a study showing that after the mentally ill suffer heart attacks, they're less likely than other patients to get state-of-the-art care.

Parks thinks agencies such as the Centers for Disease Control and Prevention should track the health of adults with mental illness, just as they do other vulnerable groups, to identify problems and solutions. "Many struggle for decades to overcome mental illness," he says, "and after all that struggle, it's particularly cruel to think that you would die young."

SPECIAL NOTICE!!!

If you have not renewed your subscription to the Thermometer Times, this is the time to do so. Those with past due dates on the front of their newsletters will be dropped, stating with the July issue.

DBSA -- Riverside Seeks Under 30 Volunteer to Lead Newly Forming Youth Group.

DBSA Riverside is looking for someone who is under 30 years old and is willing to volunteer some time on a consistent, regular basis. Frequency can be discussed. This would be to lead a self-help group for young men and women age 16 thru 24, who are persons with either clinical depression or bipolar disorder. The group would give them an opportunity to talk among their peers.

If interested please call Leroy Merrill
(951) 686-5047

ODDS ARE NOT GOOD

People with serious mental illness die at age 51, on average, compared with age 76 for Americans overall. Their odds of dying from the following causes, compared with the general population:

Cause	Times more likely to die
Heart disease	3.4
Diabetes	3.4
Accidents	3.8
Respiratory ailments	5
Pneumonia, influenza	6.6

Source: Joseph Parks, Missouri Department of Mental Health

Depression and Bipolar Support Alliance of Riverside
and *The Thermometer Times*

Wants to hear your story...
Your experience

What gives you strength and hope?

Announcing a Writing Contest!

What to write about:

- What gives you strength and hope?
- What is your experience with bipolar disorder or depression?
- What and how have you overcome your illness or disorder to live your life today? What have you learned? What has changed since your diagnosis?
- Who or what inspires you? Books...people...religion...art...music...other?
- What community mental health issue or problem are you passionate about? What insight has your experience given you?
- How do you spend your time? What's important to you?
- How has stigma affected your life and how have you dealt with it?

Contest Rules

- To enter the contest, choose from the suggestions listed above and write about it.
- The winning article will be published in *The Thermometer Times.*
- The winner will be awarded a $50.00 Gift Card to an agreed upon retailer.
- Submissions should be 1-2 pages long, typed or word processed, double spaced in 12-point font and no more than 500 words. It may also be legibly hand written.
- Submit your entry to: ***Writing Contest***
  %The Thermometer Times
  16280 Whispering Spur
  Riverside, CA 92504
- *Deadline*: Submissions should be postmarked no later than June 30, 2007

Treatment Resistent Depression

Depression is a brain disease that affects one out of every seven people. Medications and psychotherapy (talk therapy) remain the mainstays of treatment, but not all patients fully respond or achieve remission (become symptom-free) when treated with medications. Recent evidence from a large multi-site national research study shows that only one-third of depressed individuals are symptom-free after the first course of antidepressant treatment. Furthermore, only about one-quarter of patients are in remission after treatment with a second antidepressant. Individuals who have not yet improved after trying numerous individual medications and/or psychotherapy techniques are often categorized as having treatment resistant depression (TRD).

The University of Michigan's Depression Center's Treatment Resistant Depression Program, funded in part by a generous gift from the Noble Foundation of Wooster, Ohio, is part of the Center's Comprehensive Mood Disorders Clinics (CMDC). The CMDC provides extensive evaluations and innovative clinical programs for people suffering from TRD.

Melvin Mclnnis, M.D., director of the CMDC, says "There has been a shift in thinking about the treatment of depression. Remission and complete wellness are our goals. Getting partially or mostly better is not good enough."

To address the needs of patients with TRD, physicians turn to long-standing treatments as well as those that are relatively new. One option is to combine different kinds of mood-stabilizing and anti-psychotic medications. Another option, electroconvulsive therapy (ECT), is often used for patients with TRD and is the treatment that has the best evidence of achieving remission. In addition to these approaches, emerging strategies that offer hope for TRD include vagus nerve stimulation (VNS), repetitive transcranial magnetic stimulation (rTMS) and deep brain stimulation (DBS). These new techniques are sometimes referred to as neuromodulation treatments because they affect, or modulate, brain functioning.

The Depression Center is incorporating a range of neuromodulation techniques in the evaluation and treatment of patients with TRD who are seen in the Comprehensive Mood Disorders Clinics. Consistent with the Center's overall mission, the strategy with respect to TRD is to prevent its development by detecting and treating it earlier and more effectively, achieving remission and prevent recurrences and progressions.

Depression is often a recurrent illness with repeat episodes, or can also become chronic with persistent depressive symptoms. Thus, sometimes "TRD" and "chronic depression" are used interchangeably. The common definition of treatment resistance usually refers to an illness that has not responded to at least two or three courses of medication. Inadequate response to more than three medications, combinations of medications or even electroconvulsive therapy (ECT) is categorized as severe resistance. TRD generates enormous burdens for depressed individuals, and their families, and huge costs for society. Individuals with TRD have more physician visits and hospitalizations, more difficulties functioning in the workplace and are at higher risk of suicide.

"This article originally appeared in the Summer 2006 edition of Update, the newsletter of the University of Michigan Depression Center (www.depressioncenter.org), 800-475-UMICH. Copyright ©2007 The Regents of the University of Michigan, Ann Arbor, Michigan, 481 09"

Source: Life in Balance
April 2007

New rules for use of restraints, seclusion

February 6, 2007, BALTIMORE, MD—As of February, American health-care workers who use physical restraints and seclusion when treating people must now undergo new, more rigorous training to assure the appropriateness of the treatment and to protect patient rights, according to regulations published in the *Federal Register* by the Centers for Medicare & Medicaid Services (CMS).

The CMS said in a news release that health-care facilities participating in the Medicare and Medicaid programs are expected to protect the rights of patients. Through its new regulation, the CMS will hold all hospitals accountable for the appropriate use of restraints and seclusion, said Leslie V. Norwalk, acting administrator of the CMS.

Under the new regulations, hospitals must provide patients or family members with a formal notice of their rights at the time of admission. These rights include freedom from restraints and seclusion in any form when used as a means of coercion, discipline, or retaliation, or for the convenience of staff.

Source: bp Magazine
Spring 2007

Ask the Doctor

Question: Should I drink coffee and will it affect the medications I take or make my symptoms worse?

Answer by Jeffery J. Grace, M.D.:

Drinking coffee is a choice that varies from person to person. A cup of coffee, which contains about 100mg of caffeine, can have a different effect on everyone.

The average coffee drinker consumes between two and five cups of coffee daily. Such an amount has relatively few, if any, bad outcomes. It would be wise to test what effects coffee has on you. If it helps you be more attentive in the morning, serves as an after dinner treat that does not interfere with sleep or you just enjoy the taste, it makes sense to drink a cup or two of coffee daily.

While many people enjoy coffee without complications, that's not true for everyone. Some people become addicted and can experience withdrawal symptoms, such as headaches. In some cases, though, caffeine can also cause physical problems, such as trouble sleeping and heart palpitations or arrhythmias. It can also make you irritable and even trigger mania.

If any of the above is true for you, it's best to avoid caffeine in any form, be it coffee, tea, chocolate, soft drinks, analgesic drugs or appetite suppressants.

Coffee, if taken in excess, can cause emotional difficulties on its own, as well as have impact on the drugs prescribed... Whether those effects are good or bad have been a subject of debate. In some cases, caffeine can even assist your focus if your medication has a sedative side effect.

It is critical that you know yourself. It is important to discuss this issue with your doctor and the people who know you best, like family members, friends and other supportive partners.

Jeffery J. Grace, M.D. is a clinical assistant professor of psychiatry at the State University of New York at Buffalo and a practicing psychiatrist.

Source: The Rollercoaster Times
Spring 2007

The only normal people are the ones we haven't gotten to know yet.

HAROLD H. BLOOMFIELD
Physician

Smoking Increases Anxiety, Course of Illness, and Suicide Attempts

Everyone knows smoking is bad for them, but nicotine use among people who have bipolar disorder also raises the risk of suicide attempts, substance abuse, anxiety, and a worsening course of the disorder, new research has found.

Michael J. Ostacher, MD, and colleagues evaluated 399 out-patients who have bipolar disorder and found about 39 percent of them had a history of smoking. This history was associated with an earlier age of onset of the first depressive episode and the first manic episode, a history of anxiety disorder, a history of alcohol or substance abuse, a worsening course of the illness, and having made a suicide attempt.

The researchers said their findings indicate that more research is needed into the impact of smoking on bipolar disorder.

The study was entitled The Association Between Smoking, Suicidality, and Clinical Course in Bipolar Disorder.

Source: bp Magazine, Summer 2006
As seen in: The Rollercoaster Times
Spring, 2007

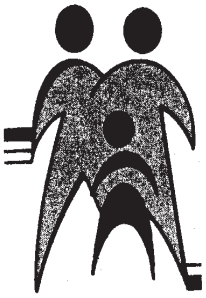
"I hate how she seems to think that she's so much more depressed than everybody else."

Lilly settles Zyprexa claims with some who claimed it caused diabetes

Earlier this year, Eli Lilly and Co. announced that it had settled most of the lawsuits brought against it by patients who claim Zyprexa caused them to gain weight, a risk factor for diabetes. The settlement was about $500 million for 18,000 claims.

Many of the claims were dated prior to September, 2003, when the FDA required Lilly and other makers of atypical antipsychotics to improve the package warning to make the risk of diabetes clearer. Prior to that, patients claimed the possible link between Zyprexa and elevated blood sugar or diabetes wasn't clear on the labeling.

Source: ADAMhs ADVANTAGE
March/April



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

DBSA-Riverside says,

Join us for the

Holidays

Picnics or dinners
at noon at Jo Ann's

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

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

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

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

Check us out on the web!

Website for DBSA Riverside:
http://californiadbsa.org/dbsariv.html
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

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

Yen
951/315-7315

Kevin
knenstiel@sbcglobal.net

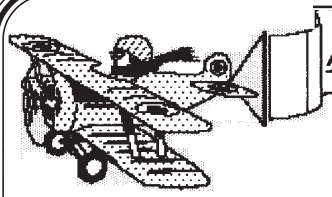
Gays In Search of Hope
Online Support Group

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—

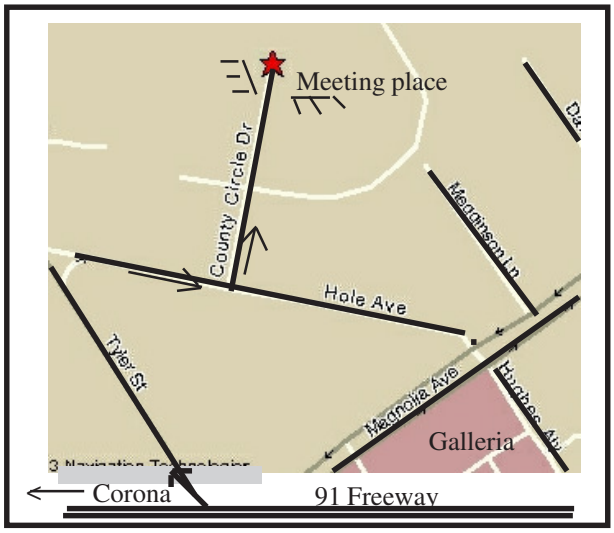
DBSA– Riverside

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. ❒