The Thermometer Times

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

VOL. 19 NO. 9 Out of darkness . . . September, 2007

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)

Every Saturday
10 am–12 noon
September 1, 8, 15, 22 & 29

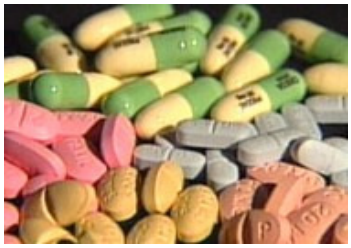
***Guest Speaker* -**
Saturday, Sept. 22
Angela Holloway, (MFT)
Topic: "Overcoming Our Irrational Beliefs"

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



Antidepressants and Suicide

The history of the controversy and where it stands today.

An often bitter dispute about the risks of antidepressant drug use began nearly 20 years ago and peaked at an emotional 2004 FDA hearing. It may now be coming to a tentative resolution with new recommendations for prescription labeling and further analysis of surveys and clinical trials. The story provides some lessons on the difficulty of making decisions about drug regulation in a context of political controversy and the complications involved in balancing risks and benefits when prescribing psychiatric drugs.

In 1990, Harvard researchers reported that six patients had developed intense and violent suicidal preoccupations soon after starting to take fluoxetine (Prozac), which had been approved for the treatment of depression only two years earlier—the first of the now famous selective serotonin reuptake inhibitors (SSRIs). An FDA expert panel found no evidence for a serious risk in its analysis of clinical trials comparing fluoxetine to a placebo.

In the next decade, while prescriptions for fluoxetine and other antidepressants increased steadily, public and professional attention to the issue faded. But the controversy was revived when the same concerns surfaced in children. In 2002, physicians had begun prescribing antidepressants for children and adolescents. The FDA had not granted specific approval for this, but "off-label" prescribing is a common and accepted practice. In 2003, based on controlled studies, fluoxetine was approved for the treatment of depression in patients age 18 and under. (Since then, fluoxetine, sertraline [Zoloft], and fluvoxamine [Luvox] have been approved for obsessive-compulsive disorder in children and adolescents.) But in that same year, reports of young people attempting or committing suicide while taking antidepressants began to attract attention.

In October 2003, the FDA issued an advisory to physicians and requested an expert analysis of clinical trial data. In March 2004, after a hearing at which parents and adolescent patients presented testimony, the FDA issued a public health advisory covering the SSRIs fluoxetine, sertraline, paroxetine (Paxil), and fluvoxamine, as well as some newer antidepressant drugs, including venlafaxine (Effexor) and bupropion (Wellbutrin). Although the advisory said that it was still uncertain whether these drugs contributed to suicidal thinking, it asked manufacturers to strengthen warnings on the labels and encourage close monitoring of users. Clinicians were told to instruct families and patients to be alert for symptoms suggesting a serious risk of suicide.

Continued on page 3 **(Antidepressants)**

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*

3rd and 4th Tuesday

5:30 PM

Tuesday, September 17

"Out of the Shadow" a film by Susan Smiley

Her mother is a person who has schizophrenia and raised Susan and her sister on her own. They are adults now with families of their own. The film explores their relationship with their mother throughout their lives.

Tuesday, September 25

"A BEAUTIFUL MIND"

starring Russell Crow

*Directions 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.

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

In August 2004, the FDA released the results of a meta-analysis of 24 placebo-controlled trials involving 11 antidepressant drugs and nearly 4,500 children and adolescents. The reviewers searched published and unpublished records for language suggesting increased suicide risk—suicidal thinking, suicide attempts, apparent preparations for suicide, and self-injury with possible suicidal intent. Most individual trials showed no difference between drugs and placebos, but when all the studies were taken togeth-er, 4% of patients taking antidepressants and only 2% of patients taking placebos were found to have definitely or possibly thought about killing themselves or taken actions that might have led to suicide. There were no completed suicides.

Balancing this risk against the then-known modest benefits of antidepressants for children, an FDA advisory panel, in a split vote, recommended the addition of a black box warning—the most serious kind issued by the agency—to prescription drug labels for all antidepressants in common use.

The warning, ordered in October 2004, describes the results of the meta-analysis and states that antidepressants raise the risk of suicidal thoughts and behavior in children and adolescents.

The warning adds that patients and families must be advised of the risk, and that adults taking antidepressants should also be closely observed for worsening symptoms. For most antidepressants, the warning states specifically that they are not approved for patients age 18 and younger. A special medication guide for families and patients was issued in February 2005 as a package insert.

Antidepressant prescriptions for children and adolescents began to decline as early as the 2003 FDA advisory, and by the time of the new labeling decisions, professional organizations were pushing back. In 2005, the American Medical Association, spurred by the American Psychiatric Association and the American Academy of Child and Adolescent Psy-chiatry, adopted a resolution stating that antidepressants had not been shown to raise the risk of completed suicide in chil-dren and adolescents, and that children should not be denied possibly life-saving medication on the basis of equivocal evidence. The resolution says that SSRIs should be available for children subject to clinical judgment, and recommends that the FDA evaluate the impact of the black box warning and other labeling changes.

In June 2005, the FDA asked manufacturers to provide information from clinical trials for a review of suicidal behavior and thinking in adults treated with antidepressants. The results were announced 18 months later, in December 2006. Two separate analyses of more than 400 clinical trials involving more than 100,000 adult patients came to similar conclusions. They found a slightly higher risk for suicidal thinking and behavior in patients taking antidepressants, compared to placebo, up to age 25. There was no difference at ages 25 to 30, and a slightly decreased risk for older patients, which decreased further after age 65.

On the release of this report, 15 national mental health advocacy and professional organizations issued an open letter emphasizing the risks of untreated depression and urging the FDA to consider carefully the influence of public statements about the risks and benefits of the drugs.

The report was followed by a public hearing at which, in contrast to the 2004 hearing, many speakers opposed further warnings or restrictions. In another split vote, in May 2007, the *FDA'S* advisory committee on psychopharmacological drugs recommended expanding the black box warning to include patients up to age 25. But it also recommended the addition of language that is unusual for a black box warning—references to the protective effect of antidepressants for older patients and to the suicide risk of untreated mental illness. The FDA is not required to accept the recommendations of its advisory committees but usually does.

A postscript appeared in the form of an April 2007 article in the *Journal of the American Medical Association.* The authors analyzed findings on more than 5,000 patients age 19 and younger who participated in 27 clinical trials, including several that were not part of the earlier FDA meta-analysis. Fifteen of the studies involved major depression, six involved obsessive-compulsive disorder, and six involved anxiety disorders.

Antidepressants were a little more effective than placebos in treating all three kinds of disorder. The difference was smallest for major depression and greatest for anxiety disorders. The authors estimated that compared to a placebo, an antidepressant would be helpful for 1 out of every 3 young patients treated for anxiety disorders, 1 of every 6 young patients treated for obsessive-compulsive disorder, and 1 of every 10 young patients treated for major depression. Most of the drugs showed an advantage only for adolescents, floexetine alone was found effective in children ages 12 and younger. There were no suicides in any of the trails, nbutn suicidal thinking and behvior were slightly more common in patients taking antidepressants—about 3% compared to 2% for placebos. The difference was not statistcally significant for any of the tree disorders taken separately, nbut only when results from all trials were combined.

The debate will not end with this study or the new FDA recommendations. Placebo-controlled trials are the most reliable way to judge the risks and benefits of drugsk, but they also have limitations. Clinical trials might over-estimate the

Continued on page 5 **(Antidepressants)**

Depression Facts

- Of the estimated 17.5 million Americans who are affected by some form of depression, 9.2 million have major or clinical depression
- Two-thirds of people suffering from depression do not seek necessary treatment
- 80% of all people with clinical depression who have received treatment significantly improve their lives
- The economic cost of depression is estimated at $30.4 billion a year but the cost in human suffering cannot be estimated
- Women experience depression about twice as often as men
- By the year 2020, the World Health Organization (WHO) estimates that depression will be the number two cause of "lost years of healthy life" worldwide
- According to the U.S. Centers for Disease Control and Prevention (CDC), suicide was the ninth leading cause of death in the United States in 1996
- Major Depression is 1.5-3.0 times more common among first-degree biological relatives of those with the disorder than among the general population

Source: Washington University in St. Louis, Washington School of Medicine
http://www.psychiatry.wustl.edu/depression/depression_facts.htm

Depression Facts in older adults

- Depression is NOT a normal part of aging.
- An estimated 20% of older adults in the community and as many as 50% in nursing homes suffer from depression.
- Older Americans have the highest suicide rate of any age group, and depression is its foremost risk factor. Although older adults comprise only 13% of the population, they account for 20% of the suicide deaths in our country.
- Depression in older adults not only causes distress and suffering but also leads to impairments in physical, mental, and social functioning.
- Because depression tends to be a recurrent disorder, many older adults will have experienced previous bouts of depression and will be at increased risk.
- Risk factors for late-onset depression include: widowhood, physical problems, educational attainment less than high

Continued on page 6 **(Depression Facts)**

Bipolar Facts

Bipolar disorder (also known as manic depression) is a treatable illness marked by extreme changes in mood, thought, energy and behavior. It is not a character flaw or a sign of personal weakness. Bipolar disorder is also known as manic depression because a person's mood can alternate between the "poles" of mania (highs) and depression (lows). This change in mood or "mood swing" can last for hours, days, weeks, or months. Bipolar disorder affects more than two million adult Americans. It usually begins in late adolescence (often appearing as depression during teen years) although it can start in early childhood or later in life. An equal number of men and women develop this illness (men tend to begin with a manic episode, women with a depressive episode) and it is found among all ages, races, ethnic groups and social classes. The illness tends to run in families and appears to have a genetic link. Like depression and other serious illnesses, bipolar disorder can also negatively affect spouses and partners, family members, friends and coworkers.

Symptoms

Bipolar disorder differs significantly from clinical depression, although the symptoms for the depressive phase of the illness are similar. Most people who have bipolar disorder talk about experiencing "highs" and "lows"—the highs are periods of mania, the lows periods of depression. These swings can be severe, ranging from extreme energy to deep despair. The severity of the mood swings and the way they disrupt normal life activities distinguish bipolar mood episodes from ordinary mood changes.

Symptoms of mania - the "highs" of bipolar disorder

- Increased physical and mental activity and energy
- Heightened mood, exaggerated optimism and self-confidence
- Excessive irritability, aggressive behavior
- Decreased need for sleep without experiencing fatigue
- Grandiose delusions, inflated sense of self-importance
- Racing speech, racing thoughts, flight of ideas
- Impulsiveness, poor judgment, distractibility
- Reckless behavior
- In the most severe cases, delusions and hallucinations

Symptoms of depression - the "lows" of bipolar disorder

- Prolonged sadness or unexplained crying spells
- Significant changes in appetite and sleep patterns

Continued on page 6 **(Bipolar Facts)**

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

risks, because in the real world, the most common alternatives to an antidepressant is no treatment at all, which is riskier nthan a sugar pill that is accompanied by hope-generating sympathetic attention. It is also possible that, instead of having more suicidal thoughts, patients who take antidepressants are simply more willing to admit such thoughts because the drugs make them less withdrawn and more communicative.

There are also reasons why clinical trials might underestimate the risks. They last only a few months, but many patients take psychiatric drugs for years. Besides, the trials can reveal only suicidal thinking and behavior because suicide itself is so rare. A study large enough to detect a statistical difference in completed suicides might require hundreds of thousands of subjects—especially since researchers will not risk giving only a placebo to a person who seems to be suicidal, and some ethics review boards will not approve trials in which depressed children are given placebos.

So it is also useful to consider surveys in which the numbers are large enough to correlate antidepressant prescriptions with actual rather than potential suicides. Studies consistently find that the suicide rate in both adolescents and adults fell throughout the 1990s, while antidepressant use—vastly increased. In the year after the FDA's 2003 advisory, according to a 2007 report from the Centers for Disease Control and Prevention, the number of suicides among persons younger than age 20 climbed by 18%. In December 2006, researchers reported that the suicide rate among children and adolescents in the Netherland had risen by more than 40% since 2003, when prescriptions for antidepressants in that group began to decline.

Another approach is relating antidepressant use to suicide rates by geographical region. A study published last year found that in the years 1996 through 1998, after adjusting for age, sex, race, and access to mental health care, a higher rate of SSRI prescriptions (number of pills per person) in a given region of the United States was associated with a lower suicide rate in children ages 5 to 14.

But correlations derived from a survey of historical trends or a comparison of different locations cannot demonstrate cause and effect. Changes from time to time and differences from place to place might reflect the availability of treatment, willingness to accept treatment, or some other factor influencing both antidepressant use and suicide.

Further evidence comes from research published last year in the *Archives of General Psychiatry.* In this study, each of 263 patients hospitalized for depression who attempted or completed suicide was compared with several matched controls, also hospitalized for depression, who did not become suicidal. Antidepressant use was not more common among patients age 19 and older who became suicidal than in controls who did not.

But there was a difference among children and adolescents. Of patients aged 18 and younger who attempted suicide, 46% had taken antidepressants, compared with 36% of matched controls. Three of the eight young people who died by suicide had taken antidepressants, compared with three of 39 matched controls. Surprisingly, patients who attempted or completed suicide were *not* more likely to have taken SSRIs, except sertraline. They were more likely to have taken the newer antidepressant venlafaxine or one of the older tricyclic antidepressants. Compared to a historical or geographical survey, this kind of study, which is called a case-control study, has the advantage that matched controls exclude some sources of error in interpreting the data. In this case, its advantage compared to clinical trials is the ability to record actual suicides, as opposed to suicidal thinking and behavior. But, like surveys, case-control studies reveal only correlations, and there is no guarantee that cases and controls are properly matched; for example, in this study, children and ado-lescents who were given antidepressants might have had more serious depression to begin with.

The uncertainties will not soon be entirely resolved. By most standards, including the chance of death by an accidental or deliberate overdose, SSRIs in particular are remarkably safe drugs. But no drug can be guaranteed to do no harm. Some patients who take anti-depressants may risk suicide because they recover the ability to act before their mood returns to normal. A few develop the side effect of akathisia, a kind of extreme restlessness and agitation that can make life seem intolerable. Antidepressants may be prescribed for what turns out to be bipolar disorder. This condition is particularly difficult to diagnose in children (see *Mental Health Letter,* May 2007), and some believe antidepressants can make it worse.

The best way to get the benefit of antidepressant treatment while decreasing the risk of suicide is careful monitoring and regular follow-up by a clinician. Parents should be warned that suicidal thoughts may come on abruptly. They should contact the prescribing clinician if a child begins to feel worse, develops new symptoms or shows a noticeable change in behavior or thinking. Examples are a change in appetite, sleep or energy becoming anxious, irritable, hostile or socially withdrawn, or revealing uncharacteristic thoughts or preoccupations. The danger is greatest in the first few weeks after starting a new medication or changing the dose. Pediatricians without psychiatric training have become more cautious about prescribing antidepressants for children, and that is probably wise. Surveys show that they are now more likely to refer children with serious depression to mental health professionals, who will also be more cautious. But the danger should not be exaggerated. In a survey conducted last year, nearly 10% of college students said they had seriously considered suicide, and 1% had attempted suicide. Mental disorders —especially depression, anxiety, or psychosis—are among the most serious risk factors for suicide. So, for many adults and children, antidepressant

Continued on page 6 **(Antidepressants)**

DEPRESSION FACTS *(Cont'd from pg. 4)*

school, impaired functional status, and heavy alcohol consumption.

- Depressed older adults tend to utilize health services at high rates, engage in poorer health behaviors, and evidence what is known as "excess disability."
- There are a variety of well-established treatments for geriatric depression, including psychotherapy, psychosocial interventions, and/or pharmacological interventions.
- Research suggests that 83% of older adults want to be treated for their depression.
- A variety of barriers reduces the accessibility of older adults to appropriate treatment of depression, including the lack of parity for mental health services in private insurance and Medicare, poor diagnosis and referral services in primary care, and an insufficient geriatric mental health workforce.

Psychological Treatment of Depression in Older Adults

- Research suggests that older adults who are given thorough descriptions of interventions state a preference for receiving psychologically based treatments.
- A variety of well established psychological interventions for depression exist, including:
- Cognitive Behavioral Therapy is designed to modify thought patterns, improve skills, and alter the emotional states that contribute to the onset or perpetuation of mental disorders.
- Interpersonal Therapy focuses on role disputes, role transitions and interpersonal deficits. It can be especially meaningful for older adults given the multiple losses, role changes, social isolation, and helplessness associated with late-life depression.
- Problem Solving Therapy postulates that deficiencies in social problem solving skills increase the risk for depression and other disorders. By improving these skills, individuals are given the tools to be able to cope with stressors, thereby reducing symptoms of depression.
- Brief Psychodynamic Therapy focuses on the resolution of interpersonal conflicts, adaptation to loss and stress, and reconciliation of personal accomplishments and disappointments.
- Reminiscence Psychotherapy is an intervention developed specifically for older adults based on the premise that reflection upon significant positive and negative life experiences enables the individual to overcome feelings of depression and despair.

Source: American Psychological Association, September 2003
http://www.apa.org/ppo/issues/olderdepressfact.html

BIPOLAR FACTS *(Cont'd from pg. 4)*

- Irritability, anger, worry, agitation, anxiety
- Pessimism, indifference
- Loss of energy, persistent lethargy
- Feelings of guilt, worthlessness
- Inability to concentrate, indecisiveness
- Inability to take pleasure in former interests, social withdrawal
- Unexplained aches and pains
- 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, friend or hospital emergency room or call 1-800-273-8255 (TALK) or 911 immediately.

Source: Depression and Bipolar Alliance
http://www.dbsalliance.org

ANTIDEPRESSANTS *(Cont'd from pg. 5)*

treatment can make a vital contribution to *reducing* suicide risk. In the effort to prevent suicide, focusing on one risk to the exclusion of all others may ultimately do patients a disservice.

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For more references, please see www.health.harvard.edu/mentalextra.
Further information is also available at the FDA Web site, www.fda.gov.

Source: Harvard Mental Health Letter
July 2007

Featured Monthly Member

Happiness is a Choice

by Barbara Allen

I grew up in St. Lewis, Missouri in a physically, emotionally and sexually abusive home environment. As a child I was very powerless and helpless. The worst parts of my childhood happened without my knowledge because I was brainwashed. My father's best friend, a doctor, used hypnosis so I would forget the abuse. That is why the memories were so buried and hard to recover. It wasn't until forty-years later that I began to recover the memories and learn the truth.

However, there were some happy memories that sustained me through my childhood. When I spent weekends with my grandmother we'd go to the movies or the opera on Friday nights and shopping on Saturdays. It wasn't so much the activities we did together, but that she provided a refuge from my home situation and a place to be safe. I learned the meaning of love from the love she gave to me, and nurtured my spirituality by teaching me of God's love. This spirituality is what has sustained me my entire life.

I was able to grow up, go to school, and get my Masters degree in Social Work. I worked as a social worker for over twenty-five years, mostly in mental health. I was married and raised two children. My husband was an abusive alcoholic. After twenty-five years of this, I left. I went through a very traumatic divorce which was a financial disaster for me. My husband cancelled my health insurance, he got my car repossesed, and absconded with all our money. I also was forced to sell our home.

I had worked eight years for Riverside County Child Protective Services. At the time of my divorce I was transfered to an office which was an hour away from my house. I was reassigned to the Emergency Response Unit which answers hotline calls. I had a double caseload, was working about sixty hours a week and was assigned to all the sexual abuse cases. A particular case triggered intense flashbacks of my own, heretofore, deeply repressed sexual abuse. That was seven years ago.

I have been dealing with those flashbacks, as well as the emotional consequences ever since. I have received treatment through intense psychotherapy, EMDR (Eye Movement Desensitization & Reorganization), psychotropic medication, and, ECT (Electro Convulsive Therapy). I have been hospitalized 14 times. The first hospitalization was a real eye opener. I went from professional Social Worker to patient. I am diagnosed with post traumatic stress disorder (PTSD) and bipolar disorder.

Beside coping with the illnesses I was dealing with profound losses. I lost my home. I lost my job. I lost my pension. I lost my profession. I lost my health insurance. I lost my car. I lost my drivers license. I was sued. I was living in dire poverty. I was living on the edge. One more small loss and I would be on the street. The resulting anxiety over all this exacerbated my already intense illness.

A particularly frustrating blow came from the outright prejudice and discrimination against me because I have bipolar disorder. The Department of Motor Vehicles (DMV) suspended my drivers license solely because of my mental health diagnosis. I have a clean driving record and my doctor notified the DMV that it was safe for me to drive; however, the DMV persisted in denying me driving priviledges based on the DMV officer's bigoted view of bipolar disorder. I was denied an administrative hearing, being told that I was dangerous because I was bipolar. He said, "Bipolar people become suicidal and you might become suicidal and kill someone with your car." Because of the suspensions I couldn't put insurance on my car and my car was repossessed. Beware of the DMV!

However, I try to be philosophical and upbeat about all that has happened to me. I do not dwell on the negative. Today I volunteer as a group facilitator at weekly DBSA meetings. I'm in a newly formed education and advocacy group called OWLS. I'm glad I had the flashbacks because I know much more about myself now. The memories explain a lot about my conflicting
emotions and confusion over my childhood. I have more empathy toward other people. I have learned to start thinking positively and be grateful for what I do have. I have met the best people in the world. People who have a lot of insight and have a lot of compassison for other poeple. I understand myself better and have more self awareness than the average person. I also believe that if you have to have some kind of disease, bipolar is not the worst, because it can be helped by medication, therapy techniques, and there is a strong spiritual element to my recovery. I also learned that if my basic needs are met, that happiness is a choice.

The Thermometer Times
Announces
The Writing Contest Winning Story

Life-Sentence

By: Julie Nicholas

Full-of-life, outgoing, and independent is how my childhood is remembered. Despite being sexually, emotionally and physically abused. I was a happy-go-lucky child. A child stripped of innocence; damaged by other' s ignorance. With humor I shut out the turmoil and closed my eyes to such pain; hoping it would sustain; still.. .1 was hurting in silence.

Just 20 years young, despite the past, and determined to have a bright future, I was a working single-parent, attended and lived at a four-year college. Little did I know then, I was destined to inherit a *life-sentence* of mental illness. I went on a confusing, clouded journey to hospitals, conservatorship, and victimization by mental health professionals. In the distorted clouds of "Bipolar and Schizoid-affective Disorder", relationships became challenging, and began to crumble, while denial came between myself, and getting well.

My daughter and family became distant, and not of the distorted world I lived in. It was then when my immediate family and I had become passengers on a roller-coaster ride.

My family was then informed that I would never be able to live independently, or care for my daughter alone. For 1 7 years, I allowed this "illness" and "label" to take over and consume my soul; it had become my identity and what defined me. Like an enraged pit-bull, I'd become very angry, destructive, and violent to myself and those I once trusted. Given this, no matter how much I cut myself to mask the pain, internally I was still on fire. I couldn't shake the *life-sentence* of "Bipolar and Schizoid-affective Disorder. Not coping with paranoid thoughts, the ups and downs, and the intrusive voices, I planned to leap off the roller-coaster ride. I wanted to end my life and rid loved ones of this turmoil and roller-coaster they too endured.

It was then I called to make an appointment with my local county mental health facility. I was cradled with acceptance, compassion, and understanding by a supportive and caring staff. I'm learning to trust myself and gain tools to improve my self-esteem. While also absorbing and implementing the educational lessons in illness management skills.

Furthermore, I attended a group and had the pleasure of listening to clients who encountered and conquered obstacles from mental illness. The courage and power they gained strengthened and magnified my determination and hope. Their accomplishments were inspiring to see that, "I am a life worth saving". I no longer see mental illness as a *life-sentence;* it is a *life-experience.* Mental illness does not identify who I am, it is just a small part of many qualities I have within. Most of all, I'm now medication compliant and understanding how to live with my mental illness.

Since then, I enrolled in junior college and successfully completed courses. I need one more class to receive an A.A, degree with emphasis in Social & Behavioral Science. Then I too, can take my life-experiences, and one-day hopefully inspire other's who also may struggle with mental illness.

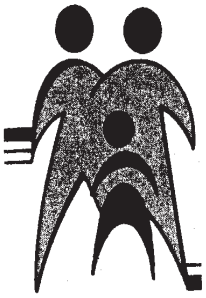
JUST A THOUGHT...

To handle yourself, use your head;
To handle others, use your heart.

He who loses money, loses much;
He who loses a friend, loses much more;
He who loses faith, loses all.

Great minds discuss ideas;
Average minds discuss events;
Small minds discuss people.

Yesterday is history,
Tomorrow is mystery,
Today is a gift.



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 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

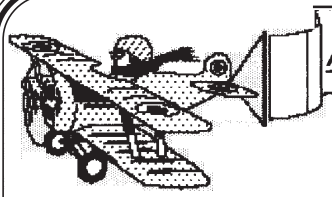
Gays In Search of Hope
Online Support Group

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-2.
Contact Sheri 951/565-8131
S1-matsumato@charter.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 1 1/2–2 hour workshops, during working hrs.*

Stipends will be paid for presentations.

For more information, or to be put on a waiting list,please call:
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—

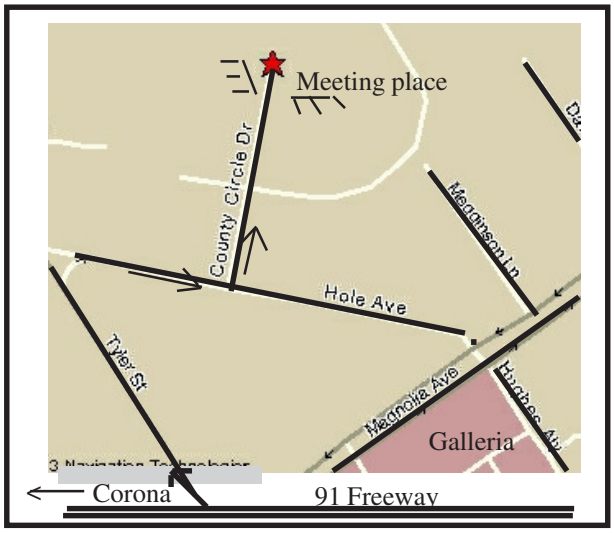
DBSA– Riverside

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. ❒