Take One!

The Thermometer Times

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

VOL. 26 NO. 12 Out of Darkness . . . December 2013

Dates to Remember

Weekly Support Group Meetings

No Cost

Saturday 10:00 am - 12 noon
December 7, 14, 21 & 28

Bring someone and come early for a snack. Bring a notepad and an attitude for pro-wellness, supportiveness, and open to shared ideas for coping.

See Page 9 for location & map

SPEAKER
Vicki Sorensen

"Therapeutic Behavioral Services"

Saturday - December 14th

See pg 9 for DBSA meeting location

Web Site for DBSA, Riverside:
http://DBSAtoday.com
E-mail for DBSA, Riverside:
DBSAtoday@yahoo.com
E-mail for DBSA,California:
DBSAtoday@yahoo.com
Please include your phone #

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

'Reality Therapy' psychiatrist

Elain Woo

Dr. William Glasser, a psychiatrist, education reform advocate and best-selling author whose unorthodox emphasis on personal responsibility for mental problems sold millions of books, caught the attention of educators and earned him an international following, died Friday at his Los Angeles home. He was 88.

He had pneumonia that led to respiratory failure, his son, Martin Glasser, said.

For The Record

Los Angeles Times Thursday, August 29, 2013 Home Edition Main News Part A Page 4 News Desk 2 inches; 57 words Type of Material: Correction William Glasser: In the Aug. 28 LATExtra section, the obituary of Dr. William Glasser, a psychiatrist and author, included an incomplete list of surviving family members. Besides his wife, Carleen; his son, Martin; five grandchildren and a great-granddaughter, he is also survived by a daughter, Dr. Alice Glasser; a brother, Henry; a sister, Janet, and another great-grandchild.Glasser was not a typical psychiatrist. He did not prescribe psychiatric drugs to patients, did not dwell on their past behaviors or subconscious thoughts, and largely ignored the standard diagnoses of mental disorders adopted by his profession. At the risk of sounding like a simpleton, which fit some critics' views of him, he often said there was only one problem that sent people into therapy. "They are unhappy," he said. In his 1965 book "Reality Therapy," he said unhappiness usually stems from a person's inability to fulfill two basic needs: "the need to love and be loved, and the need to feel that we are worthwhile to ourselves and to others." Glasser counseled patients to take responsibility for fulfilling those needs in a positive manner and believed even schizophrenics and manic depressives could benefit from his approach.

"Reality Therapy" sold about 1.5 million copies, according to HarperCollins executive editor Hugh Van Dusen, and provided an intellectual ba-

Continued on page 2 **("Reality Therapy")**

A Note From the Editor

As always I invite you to submit your stories, poetry and/or drawings for review and possible publication in the newsletter. Your articles allow us to get to know you in greater depth and to learn of your accomplishments and your many talents, interests and assets. They also contribute to our readers' well being and recovery.

Your work may be submitted to Jo Ann, 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: joannmartin1@aol.com

FAX to: 951/780-5758

I look forward to your contribution. Share your wisdom and experience with your DBSA friends through *The Thermometer Times.*

Thank you.

Lynne Stewart, Sr. Ed.

Materials submitted may or may not be published, at the discretion of the editors, and may be edited.

The Thermometer Times
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"Reality Therapy" *(continued from page 1)*

sis for the school reform program he described in his next book, "Schools Without Failure" (1969).

In that book Glasser called for building emotional ties between students and educators, making lessons relevant, and abolishing grades below A and B with an overall goal of helping students attain competence.

There are 17 schools in the United States and three in Australia, Ireland and Slovenia that have declared themselves Glasser Quality Schools with faculties trained by instructors from the William Glasser Institute based in Country Club Hills, Ill.

The extent of Glasser's influence in education is difficult to gauge, but in 1971 The Times reported that 600 schools and 8,900 teachers were using some of his ideas.

"A lot of schools are using the ideas without going through the official training," said Kay Mentley, who heads the 1,300-student, Glasser-inspired public charter school Grand Traverse Academy in Michigan. She credits the school's high academic achievement, trusting relationships and lack of discipline problems to Glasser's philosophy.

His progressive approach drew the ire of traditionalists, such as Charles J. Sykes, author of "Dumbing Down Our Kids: Why America's Children Feel Good About Themselves But Can't Read, Write or Add" (1995). Glasser's "Schools Without Failure," Sykes wrote, was "a veritable handbook for schools that would fail over the next two-and-a-half decades."

Glasser's interest in psychology stemmed from an eagerness to deal with his own intensely shy nature. The son of a watch and clock repairman, he was born in Cleveland on May 11, 1925, and earned a degree in chemical engineering in 1945 from what is now Case Western Reserve University.

After a brief, unhappy stint as an engineer, he returned to the university to study psychology. At the urging of a dean, he applied to medical school to become a psychiatrist and earned a medical degree from Case Western in 1953. He completed his medical residency under UCLA supervision at the Veterans Administration hospital in West Los Angeles, where he irritated his superiors with his anti-Freudian tendencies.

"What they taught, in effect, was that you aren't responsible for your miserable problems because you are the victim of factors and circumstances beyond your control," Glasser told The Times in 1984. "I objected to that.... My thrust was that patients have to be worked with as if they have choices to make. My question is always, 'What are you going to do about your life, beginning today?' "

At the end of his residency, he said, "I was thrown

Continued on page 3 **("Reality Therapy")**

"Reality Therapy" *(continued from page 2)*

off the staff."

His approach was welcomed at his next job as staff psychiatrist at the Ventura School for Girls, a reform school in Ventura, where he taught troubled girls to take charge of their own behavior. Many of the case histories were in "Reality Therapy."

"He would hold them responsible for their behavior, not accept the fact that they could get away with blaming their past or society," said Bob Wubbolding, a licensed psychologist in Cincinnati who was Glasser's director of training for 23 years. "A lot of psychologists functioned on that basis but it wasn't emphasized then, it wasn't part of their formal training. That is his major contribution."

Today most textbooks in graduate counseling programs include chapters on reality therapy, which Glasser later called control theory or choice theory, Wubbolding said.

Glasser wrote more than 20 books, including "The Quality School: Managing Students without Coercion" (1990) and "Warning, Psychiatry Can Be Hazardous to Your Mental Health" (2003).

"His therapy was so effective that people got well quick, so he couldn't make any money on it," his wife, Carleen Glasser, said of his private practice. "So he started to write these books."

She was his coauthor on three books, including "Getting Together and Staying Together: Solving the Mystery of Marriage" (2000). He also wrote several books with his first wife, Naomi Glasser, who died in 1992.

In addition to his wife and son, he is survived by five grandchildren and a great-granddaughter.

Source: LA Times 2013

Study shows men just as likely to be depressed as women

Melissa Healy

When researchers expand the symptoms list to include aggression, substance abuse and risk-taking behavior, depression is no longer just a 'woman's disease.

Depression can look very different in men and women. And many of its hallmarks — rage, risk-taking, substance abuse and even workaholism — can hide in plain sight.

Now researchers say that when these symptoms are factored into a diagnosis, the long-standing disparity between depression rates in men and women disappears.

That conclusion overturns long-accepted statistics indicating that, over their lifetimes, women are 70% more likely to have major depression than men. In fact, when its symptoms are properly recognized in men, major depression may be even more common in men than in women, according to a study published Wednesday by the journal JAMA Psychiatry.

The findings help unravel a mystery that has long puzzled mental health authorities: If men are so much less likely than women to be depressed, why are they four times more likely to commit suicide?

"When it comes to depression in men, to some extent we have blinders on," said Dr. Andrew Leuchter, a psychiatrist who studies depression at UCLA. "We have not been asking about and taking into account a range of symptoms that may be gender-specific."

Health policy researchers from the University of Michigan and Vanderbilt University set out to test the feasibility of two new checklists that might diagnose depression in men as well as women with greater accuracy.

It doesn't always look like this. Depression in men can manifest itself with symptoms like anger, substance abuse and other risky behavior, and when properly counted, men may actually be more likely than women to suffer depressive disorder.

In addition to familiar depression symptoms such as sadness, difficulty sleeping, feelings of guilt or worthlessness and loss of interest in pleasurable activities, the researchers expanded the list to include anger attacks, aggression or irritability, substance abuse, risk-taking behavior and hyperactivity. They devised two scales — one designed to be gender-neutral and one tuned toward the way the disease manifests itself in men.

The researchers tested these diagnostic criteria in a group of nearly 5,700 American adults who had been interviewed as part of a long-term study of mental health organized by researchers at Harvard Medical School; 41% of the participants were men.

The results of the analysis were striking.

Continued on page 4 **("Study shows men...")**

"Study show men..." *(continued from page 3)*

When assessed using the "gender inclusive depression scale" that included widely recognized depressive symptoms such as sadness and hopelessness as well as symptoms commonly seen in men, 30.6% of men and 33.3% of women were found to have experienced a depressive episode at some point in their lives. In research terms, that gap between men and women was so narrow it may have been a statistical fluke.

And when the subjects were evaluated with the "male symptoms scale," 26.3% of men and 21.9% of women were said to have experienced a major depressive episode in their lifetimes. That difference was large enough that it could not be due to chance, the researchers reported.

"Everything we think we know about depression is a reflection of how we defined it to begin with," Leuchter said.

That bias, he added, may have fostered the perception that depression is predominantly a "woman's disease" — and that men don't need treatment for emotional suffering.

Sigmund Freud, the father of psychiatry, portrayed depression as rage turned inward. But for many men today, depression's rage appears not so much directed at oneself as it is spat outward — at spouses, co-workers and friends.

While women may not feel shame in acknowledging their sadness and sagging self-esteem, mental health experts find that depressed men often respond to such feelings with actions that look like their opposite: They bluster and bully. They throw themselves into harm's way. They numb themselves with sex, drugs and endless workdays.

If the emotional pain of many men is to be understood for what it is, depression's definition should be expanded to include these "externalizing" symptoms — the opposite of "internalizing" symptoms that have long defined depression, some mental health professionals argue.

"These findings could lead to important changes in the way depression is conceptualized and measured," the study authors concluded.

If psychiatrists update their official diagnostic criteria to reflect these gender differences, that would be only a first step, Leuchter said.

Doctors, including primary care physicians who now diagnose most depression, would have to be educated to look for an expanded set of symptoms, he said. Researchers would not only need to understand how seemingly separate diseases such as substance abuse and depression relate to each other, they would also need to assess whether the treatments currently available — antidepressants and talk therapy — would help men with these symptoms, he said.

For men as well as women, the checklists now in wide use to diagnose depression may fail to capture the experience and language of the emotional distress they feel, said study leader Lisa Martin, a health policy studies professor at the University of Michigan.

"Word choice matters," she said.

Source: LA Times 2013

Don't break the bank: Bipolar & Overspending

Chris Swingle

During the highs of bipolar disorder, money can seem limitless and the desire to spend it feels urgent and wise. When the high ends in a crash, regret and reality set in. We're left with closets and cupboards stuffed with unneeded items or, at the worst, emptied savings accounts and enormous credit card bills.

Overspending splurges—whether buying the same sweater in 10 different colors or plane tickets for a round-the-world trip—can harm relationships, diminish quality of life, erase financial security, and upend plans for the future.

Yet mental health experts, certified financial planners, and people who've experienced bipolar-boosted buying say there are many good strategies to get back on your feet and prevent future overspending.

It goes almost without saying that the most effective way to avoid out-of-control purchasing is to avoid out-of-control highs. Reckless behavior is a defining symptom of mania, and excessive spending is one of the most common types of recklessness, says psychiatrist William Coryell, MD, the George Winokur Professor of Psychology at the University of Iowa.

"It's common enough that it's one of my screening questions," says Coryell.

As part of the mood shift, self-confidence and impulsive behavior increase while judgment and insight are compromised.

"It's kind of like a perfect storm for overspending," says

Continued on page 5 **("Don't break the bank")**

"Don't break the bank" *(continued from page 4)*

Dr. George Hadjipavlou, assistant professor of psychiatry at the University of British Columbia. "You totally underestimate risk and overestimate your ability to do things such as earn money and pay it back."

The altered thinking is quite obvious to Judy of Chicago.

"I am a very good money manager when I am 'OK,'" she says. Yet for many years she often wasn't OK because she didn't adhere to treatment.

During one manic binge, she bought three condos in a single day. Another time she rented a hotel suite, invited homeless people to shower and clean up there, and gave them new clothes. That episode racked up $6,000 on her credit card.

"It just seemed do-able," she says of her mindset at those times.

Nor is such behavior limited to full mania. A recent study found that risk-taking behavior such as significant spending is common during hypomania and often linked with serious consequences, including conflict with family members and financial hardship.

That Australian study, published in March 2013 in the Journal of Affective Disorders, found that most of the 93 participants said they had spent a large amount of money when hypomanic, ranging from $100 to $750,000, on items such as clothing, gifts, plane tickets, vehicles and real estate.

Source: bpMagazine, Fall 2013

Take a minute

Meditation practice improves your ability to manage work, organize tasks and focus in stressful situations

Robin L. Flanigan

Mindful multitasking may sound like a contradiction in terms. But proponents of the practice believe—and recent research confirms—that being calmly aware of the present moment can have a significant impact on productivity.

Even in times when focus and attention don't come easy.

"There's always a point in the eye of the storm—a balance within the imbalance," says Annellen M. Simpkins, PhD, who wrote The Tao of Bipolar: Using Meditation & Mindfulness to Find Balance & Peace with her husband, C. Alexander Simpkins, PhD. "You can develop skills for different kinds of meditation, for different types of moods. Then even if you can't meditate in the middle of a raging episode, you can recall that you have done it. You have a faith, a confidence. You can say, 'Yes, I have had moments of balance.'"

In a 2012 University of Washington study, researchers found that people who took part in an eight-week mindfulness course were better able to focus and had less stress while multitasking than those who took either an eight-week relaxation course or carried on with business as usual.

Progress often is subtle at first. With regular practice, however, you'll be better able to stay flexible and regulate stress, which in turn will make it easier to deal with multiple responsibilities simultaneously.

Randi, who has bipolar II and leads the Northwest Suburban Anxiety and Depression Support Group in Chicago, used to get so distracted before and during work that stable employment was difficult. The 49-year-old, currently a manager at Home Depot, now creates a to-do list of imperative tasks as soon as she wakes up.

She also has a back-up plan for when she's running late, such as an alternate hairstyle for mornings when she has no time to put together her favored look. And if she's still overwhelmed when she arrives at work, she allows herself time to walk around her department and reflect calmly on the day's duties.

"I just say, 'It is what it is,' and that keeps me grounded so when something doesn't go right, I don't get sideswiped by it," says Randi, who studied mindfulness during a six-week outpatient program after she was diagnosed in 2012. "Having a positive attitude really does make a difference. It takes you out of that victim position and puts yourself in a place of power."

Multitasking doesn't just mean juggling work, the kids, and meals. We tend to do a good job of it within our heads as well.

Source: bpMagazine, Fall 2013

Sleep Therapy Seen as an Aid for Depression

Benedict Carey

Curing insomnia in people with depression could double their chance of a full recovery, scientists are reporting. The findings, based on an insomnia treatment that uses talk therapy rather than drugs, are the first to emerge from a series of closely watched studies of sleep and depression to be released in the coming year.

The new report affirms the results of a smaller pilot study, giving scientists confidence that the effects of the insomnia treatment are real. If the figures continue to hold up, the advance will be the most significant in the treatment of depression since the introduction of Prozac in 1987.

Depression is the most common mental disorder, affecting some 18 million Americans in any given year, according to government figures, and more than half of them also have insomnia.

Experts familiar with the new report said that the results

Continued on page 6 **("Sleep therapy")**

Cancelled

Christmas

at

Jo Ann Martin's

Please be courteous and do not disturb the occupants at Jo Ann Martin's, 16280 Whispering Spur, Riverside, CA 92504 on these holidays.

Thank you in advance for your consideration.

"Sleep Therapy" *(continued from page 5)*

were plausible and that if supported by other studies, they should lead to major changes in treatment.

"It would be an absolute boon to the field," said Dr. Nada L. Stotland, professor of psychiatry at Rush Medical College in Chicago, who was not connected with the latest research.

"It makes good common sense clinically," she continued. "If you have a depression, you're often awake all night, it's extremely lonely, it's dark, you're aware every moment that the world around you is sleeping, every concern you have is magnified."

The study is the first of four on sleep and depression nearing completion, all financed by the National Institute of Mental Health. They are evaluating a type of talk therapy for insomnia that is cheap, relatively brief and usually effective, but not currently a part of standard treatment.

The new report, from a team at Ryerson University in Toronto, found that 87 percent of patients who resolved their insomnia in four biweekly talk therapy sessions also saw their depression symptoms dissolve after eight weeks of treatment, either with an antidepressant drug or a placebo pill — almost twice the rate of those who could not shake their insomnia. Those numbers are in line with a previous pilot study of insomnia treatment at Stanford.

In an interview, the report's lead author, Colleen E. Carney, said, "The way this story is unfolding, I think we need to start augmenting standard depression treatment with therapy focused on insomnia."

Dr. Carney acknowledged that the study was small — just 66 patients — and said a clearer picture should emerge as the other teams of scientists released their results. Those studies are being done at Stanford, Duke and the University of Pittsburgh and include about 70 subjects each. Dr. Carney will present her data on Saturday at a convention of the Association for Behavioral and Cognitive Therapies, in Nashville.

Doctors have known for years that sleep problems are intertwined with mood disorders. But only recently have they begun to investigate the effects of treating both at the same time. Antidepressant drugs like Prozac help many people, as does talk therapy, but in rigorous studies the treatments, administered individually, only slightly outperform placebo pills. Used together the treatments produce a cure rate — full recovery — for about 40 percent of patients.

Adding insomnia therapy, however, to an antidepressant would sharply lift the cure rate, Dr. Carney's data suggests, as do the findings from the Stanford pilot study, which included 30 people.

Doctors have long considered poor sleep to be a symptom of depression that would clear up with treatments, said Rachel Manber, a professor in the psychiatry and behavioral sciences department at Stanford, whose 2008 pilot trial of insomnia therapy provided the rationale for larger studies. "But we now

Continued on page 7 **("Sleep Therapy")**

"Sleep Therapy" *(continued from page 6)*

know that's not the case," she said. "The relationship is bidirectional — that insomnia can precede the depression."

Full-blown insomnia is more serious than the sleep problems most people occasionally have. To qualify for a diagnosis, people must have endured at least a month of chronic sleep loss that has caused problems at work, at home or in important relationships. Several studies now suggest that developing insomnia doubles a person's risk of later becoming depressed — the sleep problem preceding the mood disorder, rather than the other way around.

The therapy that Dr. Manber, Dr. Carney and the other researchers are using is called cognitive behavior therapy for insomnia, or CBT-I for short. The therapist teaches people to establish a regular wake-up time and stick to it; get out of bed during waking periods; avoid eating, reading, watching TV or similar activities in bed; and eliminate daytime napping.

The aim is to reserve time in bed for only sleeping and — at least as important — to "curb this idea that sleeping requires effort, that it's something you have to fix," Dr. Carney said. "That's when people get in trouble, when they begin to think they have to do something to get to sleep."

This kind of therapy is distinct from what is commonly known as sleep hygiene: exercising regularly, but not too close to bedtime, and avoiding coffee and too much alcohol in the evening. These healthful habits do not amount to an effective treatment for insomnia.

In her 2008 pilot study testing CBT-I in people with depression, Dr. Manber of Stanford used sleep hygiene as part of her control treatment. She found that 60 percent of patients who received seven sessions of the talk therapy and an antidepressant fully recovered from their depression, compared with 33 percent who got the same drug and the sleep hygiene therapy.

In the four larger trials expected to be published in 2014, researchers had participants keep sleep journals to track the effect of the CBT-I therapy, writing down what time they went to bed every night, what time they tried to fall asleep, how long it took, how many awakenings they had and what time they woke up.

When the diaries show consistent, seldom-interrupted, good-quality slumber, the therapist conducts an interview to determine if there are any lingering issues. If there are none, the person has recovered. The therapy results in sharp reductions in nighttime wakefulness for most people who follow through.

In interviews, several researchers noted that the National Institute of Mental Health had sharply curtailed funding for work in sleep treatment. Aleksandra Vicentic, the acting chief of the agency's behavioral and integrative neuroscience research branch, said that in 2009 the funding strategy changed for sleep projects.

In an effort to illuminate the biology of sleep's impact on behavior, the agency is now focusing on how sleep affects the functioning of neural circuits. But Dr. Vicentic added that the agency continued to fund clinical work like the depression trials.

Dr. Andrew Krystal, who is running the CBT-I study at Duke, called sleep "this huge, still unexplored frontier of psychiatry."

"The body has complex circadian cycles, and mostly in psychiatry we've ignored them," he said. "Our treatments are driven by convenience. We treat during the day and make little effort to find out what's happening at night."

Source: New York Times, November 18, 2013

Christmas Comes

Christmas comes with children singing,
Christmas comes with sleigh bells ringing,
Christmas comes with frosty nights,
Christmas comes with snowball fights.

Christmas comes with Santa Claus,
Christmas comes with snowy floors,
Christmas comes with robins and reindeer,
Chsitmas comes with a hearty cheer.

Christmas comes with gold, frankincense and myrrh,
Christmas comes with Jesus' birth,
Christmas comes with angels from afar,
Christmas comes with a wondrous star.

Christmas comes now, at last,
Christmas comes, like in the past,
Christmas comes after such a long wait,
Christmas comes and it will be great.

Amy Darnbrook

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:

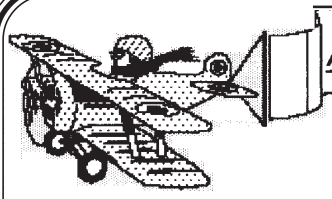
Riverside Co. Dept. of Mental Health
The Family Advocate Program
951 358-4987/1-800-330-4522

Phone Phriends

If you need someone to talk with:

Leroy
951 / 686-5047
6 a.m. to 9 p.m.

Ms. Carly Jenkins
951 / 522 - 3500
10 am to 8 pm



ANNOUNCEMENTS

Rancho Cucamonga DBSA
Meets Thursdays
Contact: Gena Fulmer
909 / 367 - 8944 OR
e-mail: genafulmer@yahoo.com

NAMI Recovery Support Group
(Various Mental Illnesses)
951/361-2721

Stigma Reduction and Suicide Prevention
AdEase/Riv.Cou.Mental Health:
Julia Sullivan 619 / 243 - 2290
www.adeaseonline.com

DBSA Temecula
Mike Clark @ 951 / 551-1186

DBSA Hemet
Trinity Lutheran Church
Mondays, 5 to 7 pm.
Lyla @ 951 / 658 - 0181

Rialto SPPT GR
Keith Vaughn
909 / 820-4944

DBSA Riverside (Uplifters)
Grove Community Church
Mon 7:00 pm. Room B8
951/571-9090

For Family Support People: NAMI
Riverside County Mental Health Administration Building
4095 County Circle Dr. (off Hole Ave. near Magnolia)
7:00 pm, 1st Monday each month
800 / 330 - 4522 (se habla espanol)
951/285-9890

RECOVERY INNOVATIONS

Invites you to

AFTER WORKS!

AFTER WORKS is a FREE art social event that takes place at Art Works Gallery on Fridays from 5-7 PM. The goal of the program is to bring local professionals, artists, peers and families together in a relaxing environment to create and to learn a new arts skill. Past programming included artist and exhibition receptions, poetry readings, as well as workshops such as mixed media collage, zine-making, and drumming. No experience required!

For more information, visit www.jtpfriends.org or call Art Works at (951) 683-1279.
Art Works Gallery
3741 Sixth Street
Riverside, CA 92501

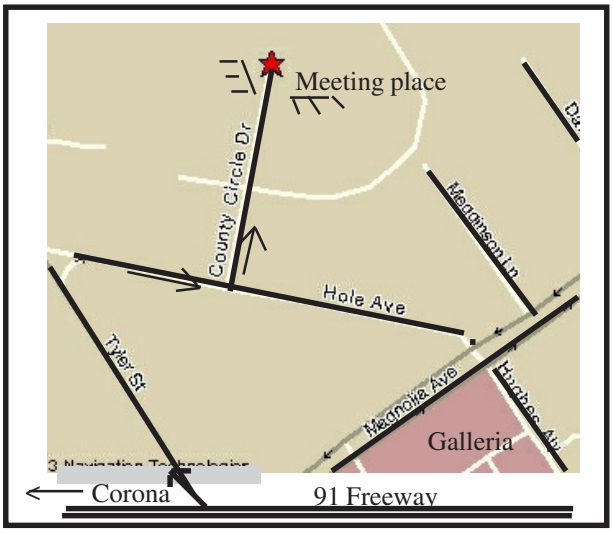
DBSA– Riverside

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. Zip: 92503** We welcome professional care providers and adult family members and friends.

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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. ❒

DBSA OF RIVERSIDE
16280 Whispering Spur
Riverside, CA 92504

HELP US KEEP COSTS DOWN

We’re using a computer mailing list

Please help us keep costs down by making sure your name and address are correct. If there is an error or if you are receiving more than one newsletter, please let us know.

Print legibly so that mistakes can be avoided.

Your help and patience are greatly appreciated.