"Education" MDDA "Support"

The Thermometer Times

Published by The Manic Depressive and Depressive Association of Riverside, California

VOL. 14 NO. 9 | Out of darkness . . . | September 2002

Dates to Remember

****

CARE & SHARE GROUPS

Clients and their guests are invited to come and participate. Professional care providers are always welcome.

Saturdays 7, 14, 21, & 28

10am–12 noon
at
Riverside County Mental Health Administration Building
(see page 9 for address)

Guest Speaker:
Katherine Alpert
September 28
Topic: Rapid Cycling and Mixed Mood States in Bipolar Disorder

Meetings will start promptly at 10A.M. Do yourself a good turn.
Be on time for announcements and other news that may be important to you.

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 right

16280 Whispering Spur
Riverside, CA 909/780-3366

For Better or Worse: Marital Therapy

From a talk by Lycia Alexander -Guerra, M.D.

Lycia Alexander-Guerra, M.D., spoke to the Tampa Bay DMDA on April 9, 2002 about marital therapy. Dr. Alexander Guerra, a psychoanalyst, psychiatrist and psychotherapist, spoke about the role of therapy in marital relationships. She described the attributes of an intimate relationship and the influences of our early life on relationships. Throughout her talk, Dr. Alexander-Guerra stressed the importance of open communication.

When two people decide to enter into marital therapy, it does not mean that their marriage is "on the rocks." To the contrary, marital therapy can be very beneficial to any couple who decides to work on issues that affect domestic harmony, as well as their quest for an improved relationship and for personal growth.

Marital therapy requires a commitment to change. People change when they decide to make an effort to do so, not because of the wishes of another person. When one partner changes, the relationship changes. For the relationship to continue, the partner adapts and changes in some ways, as well. States Dr. Alexander-Guerra, "Ultimately, it is only our own behavior that we can change. If we are accountable and responsible for our own actions, and we choose to change, the relationship can change."

One of the most common problems in marriages results from the psychological differences between males and females. Women generally need more verbal and emotional support than men; men need more physical connectedness in the relationship than women do. Bridging this gap requires a joint effort. When men provide more emotional support, women are more likely to increase physical intimacy. One affects the other and vice versa.

Intimacy: The cornerstone of a strong relationship is intimacy. Intimacy is the ability to know oneself and be known by another and not be afraid. Intimacy involves sharing mental, emotional, and physical joys, as well as disappointments and sorrows. In an intimate relationship, each partner feels safe in sharing without fearing ridicule. Neither partner attempts to control the other.

Love & Trust: Central to an intimate relationship are LOVE and TRUST. Through love we are motivated in our choice to build and sustain the relationship. States Lycia Alexander-Guerra: "Love is a daily decision; it is a choice we make." In loving another person, we want what is best for that person, as well as for ourselves.

Trust substantiates intimate relationships. Each partner needs to be reliable, accountable, honest, and faithful for an intimate relationship to be authentic. We begin to learn a sense of trust early in life. Infants that are fed when hungry, comforted when upset, and changed when wet develop a sense of trust. A sense of trust imparts self-trust. When trust is not learned early, there can be long-term sequalae. Broken trust is difficult to repair and is only reestablished when it is earned over time

When two people seek marital therapy, they must seek to improve themselves as well as the relationship. To that end, people need to become aware of the ways that

continued on page 2 (Marital Therapy)

Marital Therapy continued from page 1

they have been influenced throughout their lives. What irrational assumptions have they accrued, what parental role modeling have they learned when growing up, and how well do they know themselves? Our view of ourselves is influenced by our parents' early views of us.

Childhood Experience: Many couples never discuss children, household responsibilities or money before marriage. These responsibilities are bathed in long- held beliefs and values from early years. *Children* learn from the example of their parents and unwittingly bring these beliefs and values into a marriage. The addition of children into a marriage requires major adaptations by both partners. Finding a workable and mutual solution for child- rearing and household chores, while maintaning the intimate relationship requires major adjustments for both partners.

Long held beliefs about money, who earns it and how it should be spent or saved, also need to be examined with open communication. Contributions to the relationship and household, other than currency, are also valuable and need to be seen as such.

The experiences, beliefs, and values that are learned as children need to be recognized for what they are. We need to move beyond the constraints of our emotional baggage and recognize what is maladaptive or beneficial to the relationship. It is through exploring our long-held belief systems, that we can understand their influence and work toward resolving our maladaptive behaviors.

Sexual Intimacy: It is important that each partner recognize his/her needs in a marriage and be able to talk about what works in order to feel sexually aroused. It is no surprise that men and women respond differently. The male brain is wired with more specific areas corresponding to particular behaviors and men are more action oriented. Women, on the other hand, have more inter-connections to the verbal and emotional areas; they draw on more diverse areas of the brain at one time. Young men can be aroused

continued on page 3 (Marital Therapy)

Do you have a Medic Alert Bracelet? Do you wear it? Do you wear it all the time?

Let them know what medication you are prescribed at all times.

Wear your Medic Alert Bracelet, or if you don't have one, get one today!

Mood Challenge, June 2002

We are now officially on the web.
Check it out at:

http://www.geocities.com/mddariv/

The Thermometer Times
16280 Whispering Spur
Riverside, CA 92504
(909) 780-3366

Publisher & Editor in Chief
Jo Ann Martin

Senior Editor
Yen Cress

Copy Editor
Karen Cameron

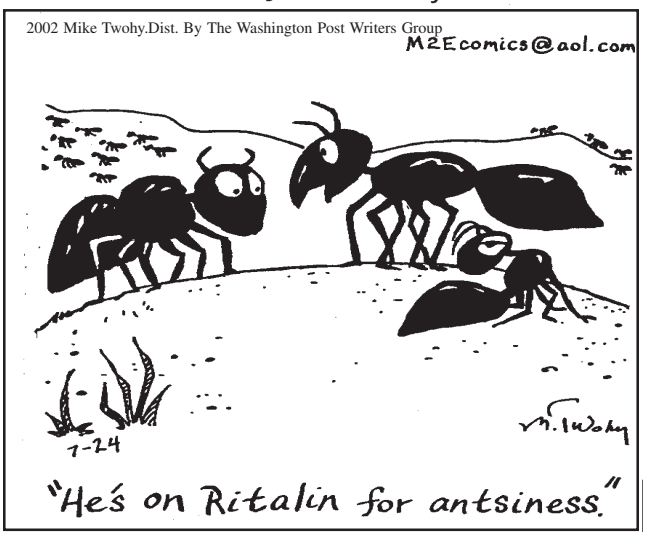
Associate Editors
Nelma Fennimore
Karen Cameron
Chris Majalca

Staff Writer
Judy Kaplan

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

You may now contact us via e-mail at:
MDDAOFRIV@AOL.COM

THAT'S LIFE By Mike Twohy



Marital Therapy (continued from page 2)

in minutes and may even need to delay orgasm. Women, however, may be put in the mood by their partner's consideration throughout the day. States Dr. Alexander Guerra, "A woman doesn't necessarily have to have an orgasm; it should be up to her. A man does not need to feel that he failed if she does not reach orgasm." What is important is that both are comfortable participating in love-making.

Communication: Feelings are emotions; they are not good or bad. Feelings may be perceived as bad or embarrassing when they were quashed or ridiculed in childhood. Only when feelings are put into action does moral judgment become applicable.

Reciprocally, expressing and sharing feelings can be a large stumbling block in a relationship. People learn early the extent to which expression of feelings is acceptable. In some homes, any expression of feelings is discouraged. Feelings that are not expressed can cause enormous discomfort and confusion years later. The effects of unrecognized and unexamined feelings can fester like an internal wound. Unfortunately, people who grow up in families where they never feel safe to share feelings or thoughts, may never feel comfortable in sharing their inner worlds. Help in expressing feelings can be derived through therapy and with practice.

Effective communication includes:

- **Speaking** about how you feel. Identify feelings and express them. Learn to ask for what you need.
- **Listening** without judging, without defensiveness, and without interrupting. If you are thinking about what your response will be, you are not effectively listening.
- **Understanding** the other person's feelings and point of view.

Communication is enhanced by a neutral, quiet and private place for your discussion. Eye contact and holding hands also help. When conflicts arise, use "I" statements, not "you" statements. For example, you might say "I feel sad when you leave without saying goodbye," instead of "You make me mad when you leave like that." Positive statements are more effective than negative ones, such as, "I miss the way you used to bring me flowers," rather than "You never bring me flowers anymore." It is important to avoid yelling, screaming, and name-calling. These counter-productive approaches only increase tensions. When one partner is very upset,taking time out may be necessary for that person to regain equilibrium before discussing an upsetting subject. Avoid bringing up the past. It is important to work on issues in the present and find mutually workable solutions.

Through marital therapy people can learn to understand themselves and their partner, as well as learn to communicate effectively and to solve problems. In maintaining an authentic, intimate relationship, we gain emotional support from our partner and feel safe in a relationship. Not all marriages can be salvaged with marital therapy, but many marriages can be made stronger and more satisfying.

Reported by Jane Trilling

Source: Tampa Bay DMDA Newsletter, August-September

A Long Arm: Teenage Depression

EVEN A SINGLE BOUT OF DEPRESSION AMONG TEENS CAN SIGNIFICANTLY IMPACT THEIR FUTURE, CURTAILING EDUCATIONAL ATTAINMENT, JOB SUCCESS, AND EARNINGS

You could say it's depressing news. Not only do adolescents experience major depression at the same rates that adults do, three quarters of depressed adolescents experience further psychiatric disorder. By age 24, half of them have had another episode of major depression. And another 25% have experienced alcohol and drug problems.

Only a quarter of those with a history of major depression between ages 14 and 19 remain free of psychiatric problems through age 23. But even they are subject to residual effects of their earlier disorder during young adulthood.They make less money.They are less likely to have graduated from college.They are more likely to have a period of unemployment.

"They show functional scars," reports psychologist Peter M. Lewisohn, Ph.D., of the Oregon Research Institute, who with colleagues is examining the long-term course and consequences of adolescent depression. "We conclude that an episode of depression in adolescents really needs to be taken seriously,"

"These are very clinically important episodes," adds psychologist Paul Rohde, Ph.D. "There are occupational and educational consequences even for those who do not experience another bout of depression."

The trouble is, the vast majority of adolescents who are depressed— around 75%, Rohde reports—do not receive systematic treatment. Their episodes are consigned to resolve just with passage of time.

Yet, some adolescents are at special risk for a protracted course of the disorder, and the studies are able to pinpoint them:

© adolescent girls who experience a great deal of conflict with their parents

© both males and females who have multiple episodes of major depression as teens

© those with family history of depression.

Providing the right kind of help early may avert the "depressive scarring" that is generated by multiple episodes. Drs. Lewisohn and Rohde champion psychoeducation rather than psychotherapy or medication.

There's no question that drugs are effective in resolving adult depression, as is cognitive behavoral therapy, although psychotherapy has been shown to be more effective in preventing relapses. "But among young people, it's another story entirely," says Dr. Rohde.

"We're trying to teach the kids better ways of coping with their depression. People can learn how to deal with their depression.

"There's an approach that says 'you have an illness and you need to take a pill" Dr. Rohde explains. "Our approach is more, 'you have problems in living.You can help yourself by dealing with those problems better."'

What they provide is essentially a form of cognitive behavioral psychotherapy, albeit groupbased, as it's less stigmatizing.There's a focus on tracking moods; increasing pleasant activities, relaxation skills and social skills; identifying thinking errors and negative thoughts and coming up with more positive and realistic thoughts;

continued on page 4 (Teenage Depression)

Teenage Depression (continued from page 3)

and increasing problem-solving skills.The teens learn a variety of skills and then personalize those that prove to be the most helpful to their particular lives.

To a large degree, depression among adolescents is the manifestation of a family disorder, Dr. Lewisohn finds.The rates of mood disturbances, particularly major depression and the mildly depressed mood state known as dysthymia, are significantly elevated among their first degree relatives.

What's more, the pattern of family aggregation of psychopathology is quite specific; teens who suffer major depression have relatives primarily with mood disorders.

"There is a familial transmission of major depression from parents to their children," stresses Dr. Rohde. "It may be genetic or it may be environmental. No one knows."

What the Oregon researchers do know is that in their survey of teens in the community, seven percent had made a suicide attempt. Most such attempts are not medically lethal. But rarely are parents aware of the attempts.

Nevertheless, insists Dr. Rohde, "suicide attempts in adolescents need to be taken seriously:" The reason:The biggest predictor of future suicide completions is past suicidal behavior.

Source: Psychology Today's Blues Buster, Aug/Sept 2001

How to Evaluate Your Psychiatrist or Other Therapist If You Have (Or Possibly Have) a Depressive Disorder

by John R. Lipsey, M.D., Assistant Professor of Psychiatry at the Johns Hopkins University School of Medicine.

1) It is impossible to get good treatment for depression if your therapist does not fully understand the differential diagnosis of depression. That is, some patients have symptoms of depression as a reaction to life circumstances; others, as a manifestation of an underlying major depressive disorder. The latter disorder is a medical illness strongly influenced by genetic factors, and it appears as a more or less stereotyped syndrome. In major depression, the patient has a profound and sustained lowering of mood and of mental and physical energy, often accompanied by self-doubt, self-criticism, and self-blame. Patients usually have changes in their sleep and appetite (in either direction). They may be irritable, their pleasure in usual activities is greatly diminished, and their hope for the future darkens. Suicidal ideas are not uncommon. Clearly, patients with this illness may find that their symptoms are worsened by environmental stressors, and at times these stressors may even provoke an episode of the illness in a predisposed person. However, environmental factors are not the major cause, and for these patients the most effective intervention is pharmacological treatment with antidepressants.

On the other hand, some patients have symptoms of depression that are fully understandable as an emotional reaction to difficult life circumstances. These depressive reactions are usually transient; respond well to positive changes in the environment; and occur most frequently in vulnerable individuals who find themselves in situations where their intentions, wishes, and desires for the future are thwarted in some way, or who have been severely disappointed or grief-stricken by some sort of loss. In general, these patients do not need pharmacological treatment, do not have strong family histories of mood disorder, and are best approached with appropriate psychotherapy.

The important issue, however, is that patients in the second category, who are demoralized, are not necessarily less depressed than patients with major depressive disorders. You simply cannot tell from the degree of a person's sadness or depression whether the person is demoralized or whether he or she has a major depression. If your therapist doesn't know this, and treats all depression as an illness, with antidepressants, or treats all depression as a response of life difficulties, with psychotherapy, you don't have a good therapist. Put another way, if your therapist only knows about one type of depression, you'd better be sure it's the one you have, or you may be hit with a hammer when you aren't a nail.

2) A good therapist will always take a detailed story of both the patient's various symptoms of mood disorder (especially, suicidal ideas) and the patient's current life circumstances. If a therapist does only one or the other, it is difficult to see how he or she will be able to reach an appropriate diagnosis and treatment.

3) A good therapist should always take a detailed family history of psychiatric disorders, because the evidence is overwhelming that major depressive disorders are strongly genetically influenced.

4) A good therapist should take a thorough medical history, looking for potential medical causes of depression. For example, several neurological disorders, endocrine disorders, and a variety of medications can cause depression, so the medical history is extremely important in planning appropriate treatment.

5) Any good therapist should be willing to speak to family members in order to get another view of the patient's symptoms and history.

6) If antidepressants are used to treat major depression, the prescribing physician should initiate thorough trials of such medication and try different antidepressants if the first ones

are not successful. Approximately 80 percent of patients with major depression should respond to one of the first three antidepressants prescribed, if these medications are given in adequate doses for about eight weeks each. Blood tests to measure levels of antidepressants are useful to assess the adequacy of the dosage.

7) Depression, from whatever cause, is usually a treatable condition. A good therapist is one who does not give up early.

8) There is little sense in seeing a therapist who doesn't basically believe what you say. Similarly, it makes little sense for the patient not to tell the truth. If the truth is not being regularly told and believed, there is obviously a mismatch between the therapist and the patient.

9) Any good therapist should be flexible in approach to diagnosis and treatment. That is, he or she should always be willing to at least consider different diagnoses and treatment approaches, and he or she should always be willing to discuss the reasons for making a particular diagnosis and proposing a particular treatment. A good therapist also is always willing to consider having the patient obtain a second opinion, especially if diagnosis is in doubt or if treatment is not progressing successfully.

10) You need to find a doctor you trust and with whom you feel comfortable, who is knowledgeable about various treatments, and is openminded to new approaches." (patient)

Note: This topic is frequently brought up by patients and prospective patients. In this article, I have outlined briefly some general rules that I believe patients might use when evaluating their own treatment. Of course, these rules are really my personal opinions, and different mental health professionals might have different views; but the above thoughts may be helpful to patients as they seek and enter treatment.

Source: The Initiative, DMDA Colorado Springs, Summer 2002

MEMBERSHIP CARDS

Membership cards are availalbe. Join us with your support for MDDA and you will receive your own card to carry in your wallet. The information on it may help you when you are unable to communicate to someone trying to help you. If you are a member and we missed you, please let us know. 909/780-3366

CDMDA Conference for 2002

Bridges to Wellness, CDMDA's 11th Annual Statewide Conference will be held at The Cathedral Hill Hotel in downtown San Francisco on October 18 & 19, 2002.

Rooms will be reasonable for the bay area ($99 a night for up to four persons to a room.) Great speakers and workshops are being planned and there will be plenty of touristy places and inexpensive establishments to eat at nearby.

The talent show and art and literary displays are always wonderful. If you have something to bring to the conference for display, you may call CDMDA at: 909/780-3366. More information will be available soon with brochures as well.

Start saving for this important event. People from all over the state will attend and there will be much sharing, caring , and learning.

Who Are You?

Sandy would like to interview members for a brief personality profile that we can publish in *The Thermometer Times.*
If you would enjoy participating in this, please call her at 909/688-0368.

Alliance Library

1215 N. Buena Vista
Suite K
San Jacinto, CA

Open 1 p.m. to 3 p.m.
Tuesday, Wednesday,
Thursday, and Friday.

654-7569
927-2546
658-5335
927-5642

The public is invited to check out books, videos, audio tapes and materials on emotional disorders, their causes and treatments. Education and knowledge are powerful tools to develop understanding and compassion.

From Florida Ave., go north on San Jacinto Ave. to Esplanade. Turn left. Turn right at Buena Vista. Continue to the end of the street, and turn into the driveway. Suite K.

Riverside Suicide Crisis Help Line
Call
(909) 686-HELP
[(909) 686-4357]
24 hr. Hotline
7 Days a Week

GOT E-Mail?

If so, join **NAMI Stigma Busters** E-mail network. Help flood stigma-builders when they do or say offensive things that create stigma.
Go to NAMI website:
http:/www.nami.org
click on **Campaign Page** then **Stigma**. Leave your name and address. Done!

National Depression Screening Day, October 11, 2002

Each year National Depression Screening Day (NDSD) teams with hospitals, clinics, mental health centers, and retirement communities nationwide to offer screening for depression/manic depression Local clinicians implement the program.

Depression is among the most common–as well as the most treatable–of mental illnesses. To date more than a quarter of a million people have recieved help and a better quality of life through these screenings.

AMI of Hemet is sponsoring a site for Depression Screening on October 11th from 10 - 5 pm at the Trinity Lutheren Church, 191 Columbia Ave., Hemet.
For more information: 909/658-1008

Emotional Problems?
Emotional Health Anonymous
Saturday Riverside Meeting

Do you suffer from DEPRESSION, ANXIETY, or other EMOTIONAL PROBLEMS not related to substance abuse?

We are not professionals. We are a group of men and women who share their experience, strength, & hope with each other that they may recover from their emotional illness and help others who still suffer from emotional problems to find a new way of life.

EVERY SATURDAY: 4:00pm - 5:00pm
AT KNOLLWOOD PSYCHIATRIC CENTER
at 5900 Brockton Ave., Room 2
For more info: 626/287-6260, San Gabriel Valley Intergroup of Emotional Health Anonymous, P.O. Box 2081, San Gabriel, CA 91778 www.flash.net/sgveha

Phone Phriends

If you need someone to talk with, you may call one of the following members at the corresponding times.

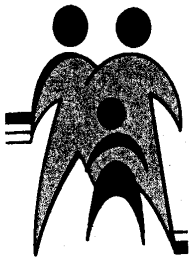
Leroy
6 a.m. to 9 p.m.
(909) 686-5047

Arnold
(909) 685-1663

Georgia Ann
6 a.m. to 9 p.m.
(909) 352-1634

Marlene and George
Before 9:30 a.m.
and from 8 p.m.
to
12 midnight
(909) 685-6241

Dawn
12 noon to 9 p.m.
909/688-1803



Family/Friends Support Groups

Riverside County Dept. of Mental Health
Offers Support groups for families and friends
of people with severe
and persistent mental illness.
These Support Groups are offered
throughout the County of Riverside.

The County also offers the
NAMI Family-to-Family Education Program
This program is a 12-week series of
educational meetings for
family members.
There is NO COST TO YOU.

For information on dates, times and location,
Please contact:

Riverside Co. Dept. of Mental Health
The Family Advocate Program
(909) 358-4987/1-800-330-4522

If you're going to be able to look back on something and laugh about it, you might as well laugh about it now.
–Marie Osmond

When it is dark enough, you can se the stars.
–Charles A. Beard

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
MDDA P.O. Box 51597 Riverside, CA 92517-2597
FAX 909/780-5758

How Patient's Rights Can Harm Treatment

Doctor Files by Elissa Ely, SPECIAL TO THE TIMES

The following is a psychiatrist's bad dream. A patient arrives at the hospital, committed by a court after he was found facing oncoming traffic on a busy road. He has not eaten or slept for days. He is convinced that a conspiracy is taking elaborate shape around him and that he is under attack. He gives his name to the registration lady as Mr. X. The registration lady shakes her head and on the admitting form she copies his real name from the emergency room face sheet. Next to that, she types: '~a.k.a. Mr. X." She has seen this before.

The necessary treatment is evident. Hospital staff need to have background information from those who know him best. Communication between family, outpatient caregivers and the hospital must be free and bi-directional. Mr. X needs to start medication, to stabilize and to be discharged to a setting where his compliance can be monitored. The problem is, without his specific permission, these elements of care violate his patient rights.

Mr. X refuses to sign his Health Care Proxy so there is no one to make medical decisions for him should he suddenly become too ill to communicate. He also refuses to sign consent forms allowing us to give him any medication. This means we will need to petition the court to force him to take antipsychotic drugs. This process takes weeks, during which he will eat only reluctantly and speak only in fragments.

Noncompliance is standard military protocol, certainly reasonable for a man "under attack." By holding him in the hospital against his will, we have proved ourselves a part of the conspiravy. So it is no suprise–just a soldier's internal consisitency–when he refuses to sign releasee forms that would let us contact anyone from his past for reliable historical details. He won't even let us tell his family he is here.

Rights are meant to be protective. During medical training, doctors supported them strongly. We believed in informed consent, confidentiality of communications, and treatment refusal. We rejected the grandfather practitioner with his last name stitched in red across one breast pocket (the first name was always "Dr."), the one who looked over half-glasses and mandated this surgery, that treatment, this medicine. We were tired of a paternalistic medical model, especially in psychiatry where the sicker the patient the fewer the explanations. We sought collaboration and choice; our patients would be our colleagues.

Psychiatric patients acquired legal rights of informed consent and refusal. They can decide which information to let doctors know, which medication to take and which treatments to refuse. They also can defend their decisions in court.

But because the pendulum is manned by human beings, it has swung too far. In cases like that of Mr. X, patient rights have begun to sabotage treatment. These same rights have lost their hero's shine and begun to look a little thuggish—riding into town with six-shooters in the name of protection, backing careglvers against the saloon wall, and standing with hands to the holster, ready to draw at the slightest opposing

Patients Rights (continued from page 7)

movement.

It is a contorted world when patients who desperately need treatment can refuse doctors access to their medical and psychiatric histories. Doctors' licenses can be revoked for forcing medications on psychotic patients, no matter how desperately they need them, without court approval (though perhaps if psychotic patients were housed in the court until their cases were heard, the process would move more rapidly). Treatment can devolve into warehousing.

It just so happens, in this particular upside-down case, that we know Mr. X. This is his fourth admission. He consistently stops medication and falls out of view after discharge. Paranoia on a grand level becomes only a matter of time. Probably, the court will let us find out what we need to know about where he has been since we last saw him and treat the life-threatening delusions we need to treat. It has let us do so before—three times.

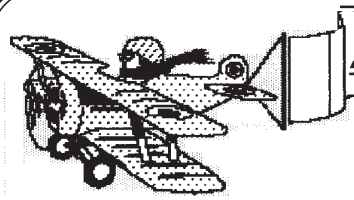
But we will need to wait until then. And, if for some reason the court rules against us, as it has done in other cases, we are at an impasse. We will be unable to discharge Mr. X because he cannot safely care for himself and unable to treat him fully because his rights have prevented it. It is a bad dream to have and a worse one to enter.

Elissa Ely is a psychiatrist at a state hospital in Massachusetts.
source unkown

FEARS

On one occasion, after splitting up into two groups to share, the question of fears suffaced. We took a few moments to list some of the things we fear most:

1. Fear of medication change
2. Fear of changing doctors
3. Fear of job insecurity
4. Fear of being alone
5. Fear of not meeting other's expectations
6. Fear of incarseration.
7. Fear of failure
8. Fear of sucess
9. Fear of partner's reactions to us
10. Fear of dissappointment
11. Fear of other illnesses
12. Fear of falling into depression



THE UPLIFTERS
(Christian emphasis) meets at
Victoria Community Church
Contact Arlie (909) 780-0379

UPLAND DMDA
FONTANA DMDA
Meet Thursday evenings
Call David or Samantha Johns
(909) 947-1307 OR
e-Mail dmjbf@aol.com

HEMET SUPPORT GROUP
"Foundations" meets every
Tuesday 7–9 pm.
Please call (909) 658-5013

TEMECULA DMDA
Mark Monroe
909/507-1365
909/926-8393

For Support People: AMI - Riverside Mental Health Administration Building, 4095 County Circle Dr. (off Hole Ave. near Magnolia) 7:30 pm,
1st & 3rd Monday each month 909/ 737-5747 (call FIRST)

Calling all interested consumers.

We are looking for consumers who are interested in sharing their personal recovery story. Living With Schizophrenia and Other Mental Illnesses *(LWSOMI)* is a recovery-education program given by trained consumer presenters for other consumers, family members, friends, professional, and lay audiences.

Individuals need not be active in mental health advocacy at this time, but they:

-"have been there" *- must be able to present professionally*
- are in recovery *- have the time to be trained, and*
- believe in treatment, with medication as the cornerstone for recovery

periodically present at 1 1/2 to 2 hour workshops, often during working hrs.

Stipends will be paid for presentations.

NAMI - - Living With Schizophrenia and Other MentaI Illnesses

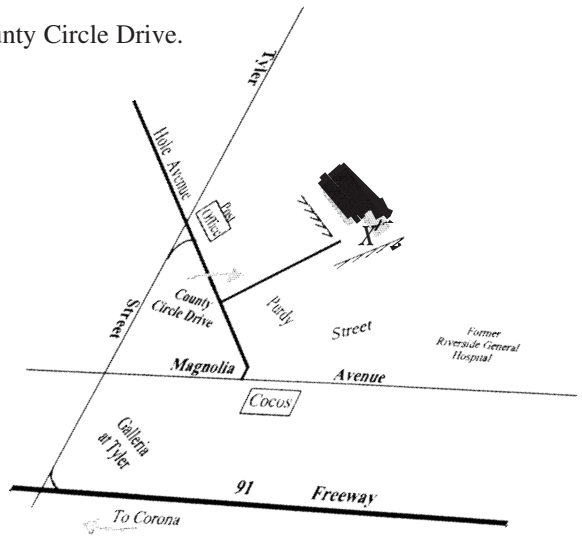
Please call for more information: Lisa Partaker, Program Coordinator
(909) 686-5484 or email: llpartaker@excite.com

A collaborative effort brought to you by:
Riv. County MH Dept. — NAMI, Western Riverside County — Jefferson Transitional Programs

MDDA of Riverside
Map Legend

= Meeting Location
= Parking

Buses 1 and 13 stop on Hole near County Circle Drive.
Bus 12 stops at Tyler and Hole



About MDDA

MDDA Of Riverside is a support group for manic-depressives and depressives who have sought or are seeking treatment for their illness. MDDA 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 Jo Ann Martin on the Saturday afternoon following the last Rap Group 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 Jo Ann or Leroy at (909) 780-3366. Our Rap Group Meetings are on the first,second, third, and fourth Saturdays of the month 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.

MEMBERSHIP INFORMATION

Individual membership for the Manic-Depressive and Depressive Association of Riverside is $15.00 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 $8.00 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, indicate below.

Mail to MDDA of Riverside, 16280 Whispering Spur, Riverside, CA 92504

DATE _____ Please Print ❒ New ❒ Renewal

NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE ____
ZIP _____

Please check one of the following:
I have: ❒ Manic-Depression (Bipolar) ❒ Depression
I am a ❒ Family Member ❒ Professional

None of the above ❒ Birth Date (Optional) : Month _____ Day _____ Year _____

Enclosed is my payment for MDDA Membership _____ $15.00 (includes newsletter).

Enclosed is my donation of $ _____ to help others receive the newsletter.

I would like a subscription to the newsletter only. ❒ $8.00 (12 issues per year).
I would like to volunteer my time and talent to help. ❒