

# The Pendulum

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Spring 2011

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**Cape County Park (North)**  
**Shelter #8**  
**June 27th • 6:00-9:00 pm**



*Bring your family and head to  
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an evening of fun and games!*

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- *Bring your own drinks*
- *Those whose last names begins with A-K:  
Bring a Dessert*
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Bring a Salad or Veggie Dish*

**Mental Health Workers, Consumers &  
Family Members Are All  
Welcome to Attend!**

## **UPCOMING EVENTS**

### **Cape Girardeau Monthly Meetings**

**Location:**

*Cape Girardeau Public Library  
O.C. Hirsch Room • 711 N. Clark  
Cape Girardeau, MO*

**May 23, 2011 • 6:30-9:00 pm**

*Support Group Meeting*

**June 27, 2011 • 6:00-9:00 pm**

*Summer Picnic in the Park  
Cape County Park*

**July 25, 2011 • 6:30-9:00 pm**

*Viewing of "Shadow Voices"*

**Please Note:**

Monthly meetings will be cancelled in  
the event of inclement weather.

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# The Volunteer Payback

By Christina Bruni



The poet Kahill Gibran is quoted: "Doubt is a pain too lonely to know that faith is his twin brother."

In times of doubt in my recovery, it was my faith that carried me through. Last year I celebrated the 20th anniversary of my first job in the workforce. How was I able to entertain going to work back in 1990? To give myself confidence, I wrote down mantras in my journal. One expression I wrote over and over was: "Action cures fear." I might not have believed this, but I felt if I wrote it down,, it would come true.

One thing I know: Working at the job you love—even if it is volunteer work—reduces the impact of your disability. And hey, it's nice to know you can afford a new Norah Jones CD without going broke.

I'm a big fan of volunteer work because it has health benefits. You get a "helper's high" that is followed by a longer period of elevated emotional well-being. And according to a study carried out at Purdue University, volunteering your time can help reduce chronic pain, lower depression, and improve your physical health, too.

Recognize that you can use your self-doubt as the catalyst for taking risks. Set a goal you know you can achieve and do one thing each day to move closer to it. The secret to success in recovery is to persist at something you desire to have. You might not have the faith that you can accomplish it, yet all you need to do is keep taking action. It might take you longer or you might have to come at it from a different angle, but it can happen. Cross the easy goals off your list and move on to the more challenging ones.

You could feel like you are all alone in what you go through. Two things that helped me cope were joining a support group and believing in a higher power.

To find a NAMI-Connection (National Alliance on Mental Illness) peer support group in your area, call the national hotline at 1-800-950-NAMI (6264). The person on the other end of the line will either be in your shoes or have been there and understand what it's like. I met some of my best friends at our weekly meetings.

Whenever I felt I couldn't go on, I let God carry me. Years ago I bought a poster that proclaimed: "You are never without a friend when you know God." Those words comforted me.

Too often, religiosity is viewed as a symptom. Providers need to understand that our spiritual beliefs can sustain and nurture us in our recovery. I realize it will sound almost delusional to say that God had a plan for my life that involved uplifting and inspiring others. While faith is not a substitute for taking your medication, it can be powerful healing in its own right. You could tune in to your higher power in a personal way. You might meditate or go for long walks in a park. You might take up journaling as I did or practice yoga.

Though I don't have a crystal ball, I can tell you one thing with certainty: The doubt will come on regularly. At times like these, place one foot in front of the other and keep on walking. You can get there from here.

SZ Magazine - Winter 2011  
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## Depression Bipolar Support Alliance of Southeast Missouri

3018 Melrose  
Cape Girardeau, MO  
573-332-0707

**Office Hours:**  
Monday - Thursday  
9:00 am - 2:00 pm  
Friday: By appointment

## ALERT

*Always check your medicine before leaving the pharmacy. Sometimes the pharmacy can give you a generic drug when you want the brand name drug. Plus you never can tell when an error is made. Save your self an extra trip back to the pharmacy by taking a little time to verify that your medicine is correct!*

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It is the manic phase of bipolar that attracts—no, demands—attention. But those who have the illness, or love someone who does, know it is depression that most disrupts and devastates lives—and dominates the course of the illness.

“Few people understand (that) depression sucks the life out of you,” says C.A., 52, of Oregon. “Desires, self-esteem, motivation, self-worth—any of those qualities that keep you going in life—disappear. Since her 2002 bipolar diagnosis, she had gone only 18 consecutive months without depression.

When P.S. of Halifax, Nova Scotia, is sad, she sometimes avoids bike riding with her seven-year-old daughter. The guilt she feels at withdrawing from her child only intensifies her depression.

“You look at the functional outcomes, such as the ability to work, family life, being an active participant in society—this is largely driven by depressive, rather than manic, symptoms,” notes Roger S. McIntyre, MD, associate professor of psychiatry and pharmacology at the University of Toronto, and head of the Mood Disorders Psychopharmacology Unit at the University Health Network in Toronto.

One reason depression is more debilitating than mania is that it lasts longer; another is that it occurs more frequently: According to a 2002 study by Lewis L. Judd and colleagues at the University of San Diego published in the *Archives of General Psychiatry*, people with bipolar I experience depression three times as often as mania. For bipolar II, the ratio of time spent in depression versus mania is a whopping 40:1.

Bipolar depression is also difficult to diagnose, and therefore to treat. Some studies suggest that as many as 50 percent of those with bipolar disorder are misdiagnosed with unipolar depression, according to Michael E. Thase, MD, professor of psychiatry at the University of Pennsylvania School of Medicine and author of several books on bipolar, depression and related topics.

It’s not surprising that misdiagnoses frequently occur. *The Diagnostic and*

# The Downside of Up

by Donna Jackel

*Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)*, doesn’t distinguish between bipolar and unipolar depression. Rather, a bipolar diagnosis is made based upon whether the person has experienced mania or hypomania.

“Bipolar depression looks very similar to major depression, with no distinct features,” says McIntyre. “That being said, people with bipolar depression more often complain of symptoms that are atypical for unipolar depression, including increased eating, sleeping, and profound reduction in energy. Moreover, people with bipolar depression also frequently complain of seasonal worsening and ‘therapeutic misadventures’ with antidepressants—that is, the depression gets worse with antidepressant therapy.”

Because bipolar and unipolar depression can “look” so similar, psychiatrists must take care to get detailed family histories—and to ask patients if they have ever experienced symptoms of mania or hypomania, says Eric D. Caine, MD, chairman of psychiatry at the University of Rochester Medical Center and an international expert on suicide prevention. Otherwise, “the tendency is to treat it as if it’s unipolar depression, with antidepressants alone, which may serve as rocket fuel for a manic episode,” he adds.

## How it feels

How does one experience bipolar depression? That depends upon whom you ask. Many people undergo distinct

periods of stability, mania, and depression. Yet other individuals can feel both depressed and manic at the same time—simultaneously feeling very sad and energized.

Holly A. Swartz, MD, associate professor of psychiatry at the University of Pittsburgh School of Medicine, says it is relatively rare for people to meet the *DSM-IV* criteria for a mixed state, which requires a major depressive episode and manic episode nearly every day for at least one week. “However, individuals meeting diagnostic criteria for either a depressive episode or a manic episode often have a few subsyndromal symptoms of the opposite pole of the disorder that co-occur with their predominant mood episode,” Swartz says. “For example, someone will meet full criteria for a depressive episode but will also have racing thoughts.”

Rapid-cycling—as defined by the *DSM-IV* diagnostic criteria—is having at least four distinct episodes of major depression, mania or hypomania, or mixed symptoms within a 12-month period. But it is possible to experience more than one rapid cycling episode a week, or “even within one day,” according to the National Institute of Mental Health.

Just because you are feeling down when you wake up and hypomanic later in the day, however, doesn’t mean you are rapid-cycling, emphasizes Joseph R. Calabrese, MD, director of the Mood Disorders Program at Case Western Reserve University in Cleveland. He says consumers often confuse mood lability (instability) with rapid-cycling. Only about 15 to 20 percent of people with bipolar experience rapid-cycling, he adds.

Jennell Anderson, 53, of The Villages, Florida, says her moods shift quickly—sometimes from one hour to the next.

“Yesterday morning, I woke up at 5:30 a.m. and by 8:00, I knew I was in a hypermanic cycle,” she says. I was running around nonstop, never stopped talking, and felt like I was running a marathon all day.” But the next morning, Anderson, who awoke early for a golf date, felt like she was “in a fog.” “I knew

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I could either get up and get going, or spiral into the depressed side of me. I went golfing!”

### Triggers

As with mania, knowing what stressors leave you vulnerable to depression can help prevent recurrences. Lack of sleep, work-related stress, and traumatic events can all be triggers. For T.L.’s husband, holidays are particularly difficult—they stir unhappy childhood memories. Vacations are also potential land mines.

“After a couple days, he becomes extremely irritable and annoying,” says T.L., who lives in Wayne, New Jersey. “He can’t relax, which is no vacation for either of us! It seems to have to do with breaking out of his work routine and structure. Even on weekends, he tends to be more symptomatic.”

Then there are the stress factors beyond one’s control—such as ill health or the death of a loved one. “The economy has greatly affected our finances and our work situations,” says Therese J. Borchard, a mother of two, popular blogger (Beyond Blue on beliefnet.com), and author of several books, including the memoir, *Beyond Blue: Surviving Depression & Anxiety and Making the Most of Bad Genes* (Hachette Book Group, 2009). “It has taken about nine months to navigate through that stress, but now that we have found a way to produce enough income, I think I will be less prone to fall into depression.”

### Keeping things steady

The severity of the illness, one’s support system, the luck—or failure—of finding effective medication, a competent doctor, and a supportive partner—all affect how successfully bipolar depression can be stabilized. Muriel Hill Rowley of Easley, South Carolina, managed to teach for 32 years, in part because of her husband’s steady encouragement, but some days it took all her inner resources to make it through the day.

“Had it not been for my work ethic, I

would have been home in bed,” Rowley says. “On many weekends, I would hole up in my apartment, not coming out again until Monday morning.”

Severe bipolar depression not only robs one of the ability to enjoy life, but also may even interfere with basic acts of self-care. C.A. lives directly across the street from a grocery store, but recalls one morning when even that short distance was too far to walk. She showered, applied some makeup, but found she couldn’t leave the house. “I stood at my bedroom window, looking across the way at the store and crying. I felt helpless and stupid.”

It is when we are in absolute despair that we most need the comfort of loved ones. The irony is this is also the time when we feel the most unlovable, are least able to return love, and tend to strain the devotion and patience of even the most steadfast caregiver.

T.L. knows her husband’s depressed when he grows quiet, turns from sweet to “snappy,” has trouble sleeping, because overly critical, and begins obsessing over trivial things, like irritating TV commercials. As soon as she observes such symptoms, T.L. asks her husband how he’s feeling and whether anything is stressing him out.

“One time, I was on the computer and he came down to the office to say good night. I was in the middle of writing an email. He gave a big sigh, stomped up the stairs, and slammed the bedroom door. I went up and calmly asked what his problem was, and he snapped something about not kissing him goodnight... as if I could read his mind. I quickly realized this was an (irrational) conversation, told him so and to get some sleep, and we could have a rational conversation the next day, which we did.”

### The darkness of despair

When the darkness doesn’t lift, despite the help of family and modern medicine, many people lose all hope. According to the National Mental Health Association, 30 to 70 percent of suicide victims suffered from major depres-

sion or bipolar disorder. And a 2000 study conducted by researchers at Johns Hopkins University found that approximately 25 to 50 percent of patients with bipolar attempt suicide at least once.

When Anderson of Florida was a 30-something mother of two, she nearly succeeded at overdosing on prescription drugs. When she awoke in the hospital and saw her ten-year-old son sitting by her bedside, she promised herself she would never try to take her life again. She has kept that vow.

A mixed state can place a patient at particularly high risk of suicide, says Caine of the University of Rochester. “In a mixed state, someone has the thinking and motor features that are much more like someone on the manic end of things,” he says. “But you can also be very suicidal then. It’s a time of impulsivity and very rapid actions. It may appear like the suicidality is sudden, but the person may have been thinking about it for a long time, and now they have the fuel to do it.”

The trick for doctors and caregivers is not to be fooled by body language—someone in a mixed state can be smiling and standing straighter, yet still be capable of suicide.

### Medical treatment

There are a limited number of mood-stabilizers that adequately treat bipolar depression and they only work in about two-thirds of patients, Calabrese says. The U.S. Food and Drug Administration has approved nine drugs to treat mania. For the depressive phase, there is just one government-approved monotherapy (an atypical antipsychotic) and one combination therapy (an antidepressant mixed with an atypical antipsychotic). The good news, says Calabrese, is that because of the success of these drugs, more pharmaceutical companies are trying to develop mood-stabilizers targeted at bipolar depression.

Of course, antidepressants are also used, off-label, to treat bipolar depression. Researchers continue to study and debate whether these drugs are helpful, harmful, or just ineffective for this pur-

pose, Experts agree that doctors should not prescribe antidepressants to anyone showing signs of mania or hypomania. A 2007 study published in the *New England Journal of Medicine* found that for people with bipolar depression who were already taking a mood-stabilizer, adding an antidepressant was no more effective than a placebo (sugar pill).

### Self-help

Having a plan in place can help prevent minor symptoms from turning into a full-blown episode, says psychologist Elizabeth Saenger, PhD, an assistant professor at Columbia University's department of psychiatry. She suggests: "Work with a mental health professional to put together a plan: 'How will I recognize when I am beginning to get depressed? How will my family?'" Saenger also recommends enlisting a trusted friend or family member who isn't afraid to tell you, "I think you should go to the doctor." And then do it.

Anderson has a rich support system—a caring husband who will play cards with her for hours to distract her from her depression, a therapist she sees every other week, and a psychiatrist she visits monthly. She also has her faith.

"God plays an important part in my life in everything I do," Anderson says. "Having that as my main support gets me by."

P.S. of Halifax says her psychiatrist is the "one constant" in her life. "I really rely on her. I respect her opinion. If she tells me to back off—that I've taken on too many projects—I might argue some, but eventually I realize she's right."

The light in what can—at times—seem like the endless darkness of depression, is that people do recover, find medications that work, and rebuild their lives. Two years ago, Borchard would have said that her depression "got in the way of everything." Not anymore.

"Today I can honestly say that my illness has made me a better spouse, mother, and worker because I've had to learn how to use an incredible amount of discipline with just about everything:

from sleeping to eating to exercising and communication, to workload and relationships," Borchard says. "I take every step of life with much more deliberation and care. If I get lazy, it could literally

cost me my life because my illness needs healthy relationships and healthy life habits."

bp - Fall 2010

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## Depression Symptoms Major Depressive Disorder

- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Difficulty concentrating
- Loss of interest or pleasure in hobbies and activities that were once enjoyed
- Difficulty sleeping
- Overeating or loss of appetite
- Persistent aches or pains, headaches, cramps or digestive problems that do not ease even with treatment
- Thoughts of suicide, suicide attempts

## Bipolar Disorder

- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Difficulty concentrating
- Loss of interest or pleasure in hobbies and activities that were once enjoyed
- May experience sleep disturbances, or oversleeping
- Overeating or loss of appetite
- Persistent aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment
- More suicide attempts than with major depressive disorder
- A profound loss of energy
- Severe depression more likely to include psychotic symptoms
- Onset of depression occurs at a younger age
- More likely to have a co-occurring mental illness, such as obsessive-compulsive disorder, panic disorder, or substance abuse
- More likely to have a family history of mania
- More episodes of depression than with unipolar depression
- Use of antidepressant—without mood-stabilizer—may cause hypomania or mania

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# Unlisted

## Exploring mental illness from a daughter's perspective

by Michelle Morra

Ministering to patients who have a mental illness is rewarding for Delaney Ruston, MD. As an objective third-party, she sees the good in every patient and always makes a point of asking if they have connection and meaning in their lives. As a doctor, compassion comes naturally to her.

It wasn't so simple as a daughter.

Richard Delaney had paranoid schizophrenia. He found that out as a young married man, even before his daughter Delaney was born. He taught English at the University of California-Berkeley. But after his daughter was born, his behavior became visibly erratic. He made scenes, had to be hospitalized on occasion, and got the family evicted five times. His wife eventually left in the middle of the night with their 11-month-old little girl.

From the time Delaney was 8 years old, her mother would drop her off for the occasional visit with Richard. Father and daughter did form a relationship, but to this day Delaney doesn't know how to characterize that bond. In the early years, she looked forward to aspects of their visits—maybe she would get an ice cream or play pinball—but the older she got, the more upsetting it was to see her dad.

"I understood that he was different and irrational. It was very painful," she says.

Yet she adapted. Sometimes he would pace and talk to himself, repeating the same things over and over. She grew accustomed to not having full conversations per se, but letting the time pass, hoping he wouldn't yell or get angry. He was never violent. The visits were not scary for Delaney, but embarrassing. Both Delaney and her mom felt she would be safe with him, that he loved his daughter.

The relationship continued into Delaney's adulthood. Richard would show up at her medical school disheveled and clearly psychotic. She had experienced the same in the schoolyard, years before. At least now, Delaney assumed, she was at the right place to get him some help.

### MyDoc Productions

Eventually the fear, frustration, and shame were too much for Delaney. Not knowing what else to do, she cut off con-

tact with her dad and got an unlisted phone number. It would be another 10 years before she saw him again.

Delaney became a doctor of internal medicine, and now works at the Pike Market Medical Clinic in Seattle, Washington, serving many homeless people. She also enjoys a second career as a documentary filmmaker for her independent company, MyDoc Productions. Her films include *If She Knew*, which explores the ethics of withholding bad news from patients; *Crisis in Control*, about psychiatric advance directives; and *Crossroads, the Intersection of Pain and Addiction*.

She learned a lot about mental illness during her medical training. Eventually, she thought that as a doctor she might be ready to reconnect with her dad.

Richard was living in supportive housing, taking medication, and was semi-supervised. It seemed a good, stable time for her to re-enter his life, and Delaney decided to document the event in a short film titled *Unlisted*.

"Hard as it was to face my guilt and come out about how I wasn't always the dutiful daughter," she says, "I knew I needed to share that story."

With his permission to bring along her camera man and sound guy, Delaney visited her dad three times. She explained to Richard that, for her, the film was about their relationship, but whenever she asked him what his thoughts were on the purpose of the film, he never gave her a straight answer. (He did, however, tell someone else on camera that Delaney was on a journey of self-discovery).

The visits went well. Richard met and played chess with his grandson, Chase. He talked to Delaney while the cameras rolled and seemed to enjoy the filming process.

What surprised her was how other people saw her dad. Members of her film crew would comment on how funny and wise Richard was. Seeing him through their eyes was an unexpected gift from making the film. But how did he feel about it? "It's hard to know Dad's emotional experience of things, to be perfectly honest." Delaney finds it hard to talk about, even

now. "He said he lived for me, and that was part of the problem. He had so much focus and love on me as his daughter... that was hard. I know he was happy (that) I was in his life, but with the psychosis and depression, it was hard to gauge happy and sad for him."

The fourth time Delaney was supposed to visit him, Richard had gone missing from his residence. She had suspected, from the tone of his phone calls, that he was off his medication. Richard never made it to that fourth camera shoot. On October 16, 2005, he jumped off the Santa Monica Pier.

### Sharing Richard's story

If Richard Delaney suffered isolation in life, he no longer does in death. *Unlisted: A Story of Schizophrenia* began as a short film that aired on PBS. Delaney later made it into a feature documentary, which premiered on PBS on October 1, 2010 and will air on public television for two years (see [unlistedfilm.com](http://unlistedfilm.com) for air dates). The one hour film won Most Compelling Documentary at Seattle's True Independent Film Festival and was featured at the national conferences of Mental Health America (MHA) and National Alliance on Mental Illness (NAMI).

Delaney is also sharing Richard's story and raising awareness as a speaker. And she frequently Skypes in at *Unlisted* screenings for audience feedback. She is pretty sure her dad would be pleased.

"I wish he could be with me on stage speaking to audiences," she says. "I don't know if he could have handled it but, gosh, it would have been a huge dream."

She has become an advocate for better services and treatments, and for better public knowledge of schizophrenia. "It's a disease that affects 1 in 100—more than HIV/AIDS—and it deserves at least a basic understanding."

Her main message is one of compassion. She gets to practice it as a doctor, but has learned that compassion doesn't just automatically filter down to her children. "It has to be taught," she now realized.

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*Continued on page 8*

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# Tips to stay on track

by Brad Peters

My first experience with the mental health world was, sadly, one that is all too common.

It was while I was at college that I befriended one of the brightest, most insightful students in the class. Quiet and almost painfully shy, Mike had been coping with schizophrenia since his middle teenage years (though I did not know it at the time.) Mike confided his struggles with the disease late in our second year of school, after a particularly stressful time for both of us. He told me about his schizophrenia almost apologetically, as if expecting me to react negatively to the news. Not knowing much about the disease at the time, I remember asking him a few general questions about his condition, and then we made a few good-natured jokes about it and got back to our studying.

What we didn't talk about was that for Mike to just function at a "normal" level required a great deal of medication. Medication that at times made him feel sick and disoriented—and that was on top of the effects of his schizophrenia.

After graduation, my core group of college friends scattered across the country. We stayed in touch for a while, but as the years wore on, we talked less and less.

My phone rang late one evening—late enough for me to know there wasn't good news on the other end of the line. Mike, who had relocated to Toronto for work, had taken his own life. His family said they had learned he had stopped taking his medication weeks earlier.

## Stick with it

Mike's story is not unfamiliar. Countless consumers and their families experience the same devastation every day. But it doesn't have to be this way. Doctors and patient groups are growing increasingly attuned and sensitive to all areas of schizophrenia treatment, from the ongoing development of medication with fewer and less severe side effects, to heightened awareness of when a patient has stopped taking their medication. It is the area of study that Peter Weiden, MD, of the National Alliance on Mental Illness (NAMI), says can actually save the lives of patients.

Research shows that more than half of people with schizophrenia don't fully follow their medication treatment plan, and the reasons are many. Some simply forget to take their medication for a day or more. Others stop taking it because they

don't believe they have schizophrenia or they're not convinced they need medication. Others forego medication because they want to avoid negative side effects or are embarrassed that they need daily treatment.

It's important for consumers to follow their treatment plans as prescribed. Studies show that missing even a day or two of medication can nearly double the risk for hospitalization. It can also increase the likelihood of depression and suicidal thoughts.

Accepting medication as a way to improve your life is your first priority. Then find ways—no matter how unconventional—to remember to keep taking it. Consider these tips to stay on track with your medication:

**Talk with your doctor.** If you have problems with your medication, contact your physician immediately. Most importantly, continue taking your medicine until you discuss the situation with the doctor. A consultation with the doctor may result in a change in dosage or new medicine altogether. Remember that your condition is unique to you, and therefore your medicinal requirements are also uniquely yours.

**Get journaling.** During times when you feel like stopping your medication, write down your feelings. Tracking the situations and circumstances of your everyday life and routine may be helpful in determining the right medication for you. Take your journal with you when you visit your doctor.

**Stay connected with others.** Stay in contact with family and friends or join a support group for others with schizophrenia. Often groups are available for patients and family members together. Interacting with others who have similar health issues and struggles can be invaluable in learning how to cope and better manage the illness—and it will remind you that you are not alone.

**Find memory aids.** The use of "reminders" can be an extremely effective tool, says Weiden. These aids can vary from pre-planning your medication use with a pill box labeled for day-to-day use, to notes or signs left in highly visible places. Use "code words" that have personal meaning to you if you want. It doesn't have to be as blatant as "Don't forget your schizophre-

nia medication at 8 a.m." Ask family members to check in and remind you to take your pills. Combining medication time with another daily activity, such as a meal, can make remembering to take your meds easier.

**Seek therapy and education.** Weiden says cognitive behavioral therapy has been shown to help people with schizophrenia gain better insight into the illness and understand why their medication is so important. He adds learning how medicines work in your body removes the impersonal aspect of medication. Once you better understand the role your medication plays in your illness and you have worked with your doctor to develop the best course of treatment, you may find it easier to comply with it.

**Don't mix medications (especially the illegal ones).** The combination of physician-prescribed medicine and the use of recreational drugs can be a huge impediment to regular treatment compliance, according to the Schizophrenia Society of Ontario. Seek help to overcome the addiction to recreational drugs. Studies have shown that people with schizophrenia who abuse drugs are less likely to stick to their treatment plan. Alcohol and drugs such as marijuana, cocaine, and amphetamines have been proven to make schizophrenia symptoms much worse, and therefore more difficult to deal with.

**Ask about long-acting medications.** You may be a candidate for long-acting injectable medications. Consult your doctor on the benefits and risks of these medications. Many of these antipsychotics are administered only once or twice a month and have been shown to increase compliance and outcomes in people with schizophrenia.

**Know the side effects.** You should always discuss all side effects with your physician. He may change the dosage or the medication in order to eliminate or reduce the side effects. He may also temporarily prescribe another medication to counteract the side effects or give practical advice to reduce the discomforts.

**Keep up with refills.** Some patients stop treatment because they run out of medi-

*Continued on page 8*

## Ask Dr. Bob

### Antipsychotics and sex

**Dear Dr. Bob:** *I have heard that some antipsychotic medications can cause sexual side effects. Can you tell me which medications cause these types of side effects, and are they more common in men or women? Is there anything I can do to counter them?*

While sexual side effects are much more common with antidepressants, antipsychotic medications can cause sexual problems in some individuals. Sexual dysfunctions include reduced sexual arousal, diminished interest in sex, impotence and reduced capacity for erections, delayed or retrograde ejaculation, amenorrhea or lack of orgasms in women and, rarely, prolonged and painful erections. Most antipsychotic drugs—with the exception of aripiprazole (Abilify)—increase the levels of prolactin in the brain and blood. An increase in this hormone in some individuals can produce side effects such as breast enlargement and secretions from the breast. This side effect is very embarrassing, especially in men.

Because it is possible to prevent, reduce, or eliminate sexual side effects, the most important step for patients to take is to frankly and explicitly describe and discuss any sexual problem that they may be having with their doctor.

Sexual problems may come from medications or, more commonly, from other reasons. Once a sexual problem is described and openly discussed, the physician can consider and decide, with the informed participation of the patient, ways for reducing or eliminating the problem.

Finally, many patients with sexual problems—whether resulting from medications, anxiety, or other causes—benefit from cognitive behavior therapy which has had remarkable success in overcoming a variety of sexual dysfunctions.

**Dear Dr. Bob:** *My daughter has schizophrenia but she refuses medication because she insists that she is normal. I've heard that individuals lack insight and are often not aware of their disability. Is lack of insight permanent and genetic? Will my daughter always refuse treatment because she is not able to understand that she has*

*a brain disorder and needs medication?*

While many patients fail to grasp the significance of their brain disorder and attempt to avoid bearing the stigma associated with schizophrenia by denying that there is anything wrong with them, their lack of insight into their illness is not deeply rooted or enduring—if psychiatrists and other mental health professionals have the tools to promote recovery. One of these tools is a person-centered and stigma-busting engagement of the patient in a collaborative relationship with his/her psychiatrist.

The starting point is an empathic inquiry into the individual's personally relevant goals and how the individual wants her life to be better than it is now. A recent study of more than 130 patients showed clearly how improvement of psychotic symptoms often facilitated insight into their illness. When a psychiatrist buys into the patient's valued goals, a light often goes on illuminating for the patient how symptoms and cognitive impairments interfere with achieving personal goals in life. Thus, when the connection is made by the patient between a medication's capacity to remove symptom obstacles and reaching their desired goals, insight, a stronger therapeutic alliance, and improved adherence to treatment often ensue.

An essential next step, however, requires psychiatrist and patient working together to develop a treatment and rehabilitation plan that will enable the patient to make slow but sure progress toward achieving goals through schooling, work, friendships, and recreational and social activities. Because medication alone cannot teach anyone the skills required for a functional life in the community, rehabilitative supports and skills training are essential for recovery and enduring insight. Patients often gain a good understanding of their illness with a recovery-oriented, rehabilitation program that doesn't "start and finish" solely with medication management.

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## Unlisted

Continued from page 6

Gradually she has started talking to her children about mental illness, "stumbling to find the right words." She and her two young children occasionally talk to some of the homeless people living in nearby Nickelsville—a "tent city" where homeless people live in tents—which Delaney says "really opens up the children's hearts."

And as *Unlisted* travels the airwaves, Delaney is wrapping up a film on global mental health, entitled *Where in the World is Mental Health?*, filmed in China, India, France and the United States.

"What's universal about the mentally ill in each of these countries, is a lack of places where they can have a connection in the community and do something meaningful," Delaney says. "Even in France, where some of the best services are available, the person I was following had to lie to try to get jobs, and still couldn't find a place where he could find meaning in his life."

So many others like Richard have died never fully knowing what they meant to their loved ones, or whether they were understood or even missed. If Delaney's message catches on, more stories will be told, more lives rendered meaningful again.

"When I made this film about my Dad, I didn't know where it would go; (I) didn't realize his intelligence, his humor, his regular guy-ness would come out. He was not a van Gogh, not a serial killer. Just a normal guy who got an awful illness."

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## Tips to stay on track

Continued from page 7

cation. To prevent an interruption in treatment, order refills before you run out.

**Avoid relapse.** If things are going well with regular use of a prescribed medicine, you will start to feel better —after all, that's the point of taking the medicine in the first place. But some people decide on their own that they no longer need their medicine. It is very important that patients understand the risk of relapse if the medication is stopped.

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When a prescribed medication causes too many side effects or fails to correct symptoms in people with schizophrenia, psychiatrists have no choice but to try another and hope for the best.

At worst, the new medication can result in even more severe side effects that can be life-threatening. At best, switching can mean a long and stressful wait to fully evaluate the new medication.

To help solve this problem, engineers and psychiatrists in Hamilton, Ontario, used electroencephalography (EEG) testing on patients who had not responded to their antipsychotic medication. The EEGs from these selected patients were then analyzed by McMaster University engineers who devised a computer algorithm (program) to determine if they would respond to clozapine. A response meant they could take clozapine; a non-response meant they could not—a much more accurate prediction than the trial-and-error method.

“Our psychiatrists, Drs. Gary Hasey and Duncan MacCrimmon (in the Department of Psychiatry and Behavioral Neurosciences at Hamilton’s McMaster University) had gathered EEG data (from patients) over the years and realized that it might contain some kind of prediction, but they had no idea how to analyze the data,” says James Reilly, PhD, a professor of electrical and computer engineering at McMaster. “So we started collaborating and I’m very pleased to say we did produce successful results.”

Clozapine can be effective in treating schizophrenia, but it also carries many possible side effects including seizures, cardiac arrhythmias, bone marrow suppression, and even life-threatening blood problems. Therefore, determining ahead of time if a patient will benefit from it is “pretty important,” says Hasey.

He notes research has already shown that EEG can help doctors make an effective diagnosis. “Just by using the brainwave measurement in the computer program, we can differentiate people with schizophrenia from people with bipolar disorders and also from healthy people.”

The study involved 23 non-responsive patients—12 men and 11 women—all

## Testing tolerance

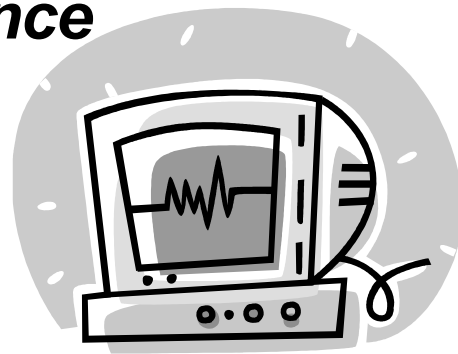
### Scientists targeting clozapine response through EEG study

By Barb Joy

of middle age. When the computer algorithm was used to predict whether or not the patient would respond to clozapine, the prediction was accurate 89 percent of the time. This result held true when it was further tested on 14 other patients.

Electrodes clamped on a person’s scalp record electrical activity produced by the firing off of neurons within the brain. Once used to diagnose tumors, strokes, and other focal brain disorders, EEGs are currently used mainly in the determination of epilepsy, coma, and brain death.

When PhD student Ahmad Khodayari-Rostamabad, of Reilly’s department, received industrial funding to develop a program to detect cracks in oil pipelines, he teamed up with Reilly and Professor Hubert de Bruin, of McMaster’s School of Biomedical Engineering. The three engineers could see the technological correlation between pipeline cracks and brainwaves; this set them on the path to discovery.



#### Results met with some skepticism

Although he says the study “shows promise,” Oakville psychiatrist Satpal Girgla, MD, questions its limitations.

“It involved a small number of patients and I don’t know if they can extrapolate the same kind of response with other medications,” he says. “It would be very helpful if we could select a patient population that would respond to a particular drug.”

Now concluded, the study has opened up a new and exciting field in the treatment of schizophrenia, Hasey says, adding it is a “very interesting preliminary report.”

He says further testing, acceptance of the EEG method as standard of care, and approval from the College of Physicians and Surgeons to erase all ethical and legal issues, are necessary before the medical community can utilize its full potential.

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## EEG and depression

The same EEG computer program used to detect response to clozapine in schizophrenia patients is currently being applied to people with unipolar depression. The program, developed by McMaster engineers and implemented by psychiatrists in the university’s Department of Psychiatry and Behavioral Sciences, is being used to detect response to three anti-depression drugs.

“The benefit (of the study) is moving toward individualized treatment,” says

psychiatrist Gary Hasey, MD. “You want to get the best effect (for each person), not just for most people.”

Started in March and funded by Wales-based Magstim Company Ltd., the study currently has 16 participants but needs 120. Recently-diagnosed patients 18 years and older who are in—or can travel to—Hamilton, Ontario, for testing are invited to participate. Call (905) 522-1155 extension 36629 for more information.

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## One size does not fit all

by Melody Moezzi



I admit it: I believe in God, angels, and miracles; exercise, antioxidants, and Omega-3s; psychiatry, therapy, mood stabilizers, and even ECT. When it comes to the pursuit of health and happiness, I refuse to choose or discriminate among the apparently divine, natural, or man-made wonders of the world. Simply put, my treatment philosophy is “whatever works.”

For me, that means, I pray and exercise and visit doctors and chow down on fish, fruits and vegetables after swallowing my standard daily handful of prescription and over-the-counter tablets and capsules. I don't consider any of these endeavors mutually exclusive. On the contrary, I've found that when I can manage to do them all at once, I feel worlds better for it.

So when I hear people talking about how there's only one way to battle bipolar disorder, or anything else for that matter, I get highly suspicious mainly because my experience has consistently taught me the exact opposite: that there's never only one way to do anything worth doing.

I know you've seen and heard the

gamut: From the organic food fanatics who are happy to smoke pot laced with God-knows-what but insist that FDA-approved pharmaceuticals are unnatural and therefore evil, to the greedy shrink who thinks you need to see her three times a week to keep your already-fairly-level head on straight. From “The World According to Tom Cruise” preaching that we ditch the scripts because God alone will cure whatever ails us, to “The World According to Narrow-Minded Physicians” preaching that we take our meds and resign ourselves to the fact that there's nothing more we can do. Well, I say to hell with all the single-source solutions. Praise the Lord and pass the ammunition already, because I'm willing to use every resource in my arsenal to get and stay well. And by ammunition, I'm referring to everything from yoga to mediation to psychotherapy to spinach. Like I said, whatever works!

Granted, what works for me may or may not work for you. There are as many ways to treat bipolar disorder as there are ways to live and thrive with it. I happen to know a good number of other successful individuals with bipolar disorder, and none of them has even close to the same formula for

health. One friend hasn't taken a mood stabilizer for years, but she will never miss a night of sleep or a doctor's appointment. Another considers walking from the couch to the refrigerator exercise and eats absolute garbage, but he prays, attends church and takes his medications just as religiously. Still another eats well, sleeps well, exercises, takes her meds, but shuns any activity that even hints at the idea of a divine or greater power. But all of them—the Sleep Zealot, the Spiritual Couch Potato and the Responsible Atheist—have managed to maintain high levels of personal and professional success despite any “rules” they appear to be breaking.

I'm not saying any one of us is right or perfect or has all the answers. Far from it. The Sleep Zealot has a pretty nasty shopping habit and debt to match; the Spiritual Couch Potato has gout and is chronically socially awkward; the Responsible Atheist boasts sky-high anxiety levels (which I suspect would drop a little if she stopped denying herself the joys of cheese and ice cream); and for all my prayer, yoga and medications, I could still stand to get more sleep and consume less saturated fat. In short, we're all high-functioning, dare I say happy, individuals, but we've all arrived here on different roads and with different baggage.

Still, we all have a least one thing in common: we've refused to entertain the idea of a one-pronged, magic-bullet solution to our unique mood disorders—or at least we've entertained it only long enough to dismiss it. We know that it'll take more than just medication or just exercise or just diet or just faith to treat any of our very unique bipolar disorders, let alone our selves. And we also know that there is always room for improvement—if only just by watching each other. I have learned some invaluable lessons from the Sleep Zealot, the Spiritual Couch Potato and the Responsible Atheist. But that doesn't mean I'm about to give up my Haagen-Dazs or stop sleeping in on Sundays any time soon.

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# 7 ways to manage depressive thoughts

by Elizabeth Saenger, PhD

Since people with bipolar disorder spend three times as many days depressed as elated, it is the lows more than the highs that cause people to seek help. When my clients are living with depression, one of the most helpful things I can do is show them how to manage their negative thoughts.

**Here are seven techniques that can help you, too, improve your mood.**

## 1. Distinguish between what you feel and what is real

Feeling depressed often means feeling hopeless and helpless. It's critical to understand that these views are symptoms of the illness, and do not reflect reality. In other words, it's the depression talking, not an objective picture of your situation. Remind yourself that the bleak outcomes you foresee for yourself are due to your mood clouding your judgement. Think back to a time when you were grounded and optimistic about your future, and tell yourself that what you thought then about your life was more accurate, because now your mood is blurring your vision.

## 2. Create alternatives to mind reading

Too often, we decide how people feel about us in the absence of evidence. If you automatically conclude that someone didn't say "hello" because she doesn't like you, rather than perhaps because she didn't see you, this is mind reading. When we are depressed, it's easy to explain a person's behavior as an expression of negative feelings about us, rather than noting the countless factors, having nothing to do with us, that influence others. It can help to write down the behavior which discouraged you in one column, your automatic interpretation of it in a second column, and multiple alternative explanations in a third column.

## 3. Ban overgeneralizations

How many times have you concluded, on the basis of a single failure, that you will always fail? Don't fall prey to overgeneralized thoughts such as "No one cares about me" and "I'm never going to be able to get a job." Instead, let



the words always, everybody, never and nobody serve as red flags that you're probably overgeneralizing.

## 4. Avoid focusing on the negative

When we concentrate on the unfortunate aspects of situations and filter out the positive—dwelling on soccer games lost, and forgetting our victories—we do ourselves a tremendous disservice. If you find yourself focusing on your limitations, envision what a friend might say to contradict your negative thoughts, or ask someone!

## 5. Break up catastrophizing

Catastrophizing involves noticing one unfavorable fact or unfortunate situation, and making it mushroom in your mind into a chain of hypothetical circumstances ending in disaster. Observed symptoms of a cold lead to an imag-

ined death from pneumonia, or a minor mistake at work results in the nightmare of getting fired. When you predict calamities, ask how probable each event is, and how likely it is they could occur together.

## 6. Create a gray continuum when you have black-or-white thinking

Black-or-white, or all-or-nothing, thinking involves inappropriately categorizing objects, situations, or people into one extreme or another. When you are depressed, it is easy to think of yourself as a total failure, or as completely worthless. Remind yourself that the world is made of shades of gray, and people who are all good or all bad are rare.

## 7. Remind yourself that thoughts and feelings are temporary

One day a client suffering from depression told me he was thinking of suicide. I empathized with him, but reminded him that depression was not a permanent condition, even though a common symptom of it was the illusion of permanency. Realizing that his state was temporary made it easier for my client to endure it.

Identifying and correcting distorted thoughts is a learned skill, just like anything else. If you "over learn" this skill—that is, learn it more thoroughly than necessary—when you are stable, you will be better able to apply it when you are stressed, depressed, and not thinking as clearly as you can.

Remember, a powerful, proven tool for reducing depression—namely, modifying your own thoughts—lies within you! With work, you can use it to help rescue yourself from depression.

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# People with schizophrenia can—and do—recover

By Xavier Amador, PhD

“Henry has schizophrenia. He will never be the same.” My brother’s doctor said it to me as if reciting a daily meditation.

“What you’ve seen this past year—his dropping out of college, (being) unable to hold a job, and his isolation from his friends and family—will only get worse in the years to come.”

Turning from my mother, he looked me squarely and added: “I am sorry, but there is no cure and this is a progressive, deteriorating disease. He will need to be on medication for the rest of his life and you will need to develop more realistic expectations about what he can and cannot do.”

I left that meeting in shock. I didn’t understand: The medications had calmed him down, he wasn’t hearing voices, and he didn’t seem paranoid. Yes, he was groggy and slow in his thinking, but he was better as far as I could see.

It was the last semester of my senior year in college and I was about to graduate with a degree in psychology. I read all I could find on schizophrenia. Ironically, I had taken a tutorial with a psychoanalyst the year before called “The Causes and Cure of Schizophrenia.” This was a time when the field was on the cusp of a major research funding commitment for schizophrenia from the National Institute of Mental Health (NIHM), and just nine years before the launch of the Decade of the Brain, a 10-year program designed to enhance public awareness of the benefits of brain research.

Psychoanalytic notions of the causes of schizophrenia (e.g., bad mothering) and talk of cures were dying out. In their place was a growing belief that schizophrenia was a disorder of the brain—a neurodevelopmental disorder like Parkinson’s disease. But the view that there was no hope for people struck with the disease was alive and well.

From the time my brother was first diagnosed in 1981 until the end of the Decade of the Brain at the turn of the millennium, something remarkable was happening: One by one, people diagnosed with schizophrenia were slowly coming out

and saying “I’m here and recovery is possible.” The consumer movement was born. It took hold and changed perceptions about schizophrenia, the focus of research, and public policy.

This likely happened for several reasons, including the partnering of family caregivers with doctors to attack stigma. It was slightly safer to talk about having schizophrenia and then, as more people spoke out, it became the subject of books, news stories and movies like *A Beautiful Mind*. The message was one of dignity and hope. The inevitable decline that my brother’s doctor predicted was not the only possible story to be told. Recovery was possible.

## What is recovery?

Among the most hopeful lessons I have learned from working with people with schizophrenia is that many can and do recover. But I was blind to my own brother’s recovery until only the last few years of his life. I didn’t see it, although he did.

What do I mean by recovery? Let me first tell you about what others have said about this vitally important concept.

In 2006, Alan S. Bellack, MD, published a review of the differing concepts of recovery in the NIMH journal *Schizophrenia Bulletin*. In this article, he contrasts the scientific community’s concepts with that of consumers and other nonprofessionals.

The scientific community, of which I am a card-carrying member, comes to this question from the medical model. The Remission in Schizophrenia Working Group, comprised of leading psychiatric experts on the disorder, defined recovery as hinging on remission—to be able to function in the community (socially and vocationally) as well as be relatively free of symptoms. They concluded that symptom remission is a necessary but not sufficient step toward recovery.

Many studies that define recovery in a number of different ways have been published. Despite their differences, they tend to agree that the definition of recovery combines improvement in symptoms with better functioning in life (e.g., relationships,

school and/or work). In his review of the concept, Bellack writes: “One notable limitation of these criteria is that they do not address the person’s subjective appraisal of functioning or the extent to which he or she is satisfied with life. This omission would allow the untenable circumstance of a person being judged recovered by a professional... yet feeling distressed by residual symptoms, stigmatized by the illness, frustrated by an inability to achieve one’s ambitions, and hopeless about the future.”

Many consumers and consumer groups offer a definition with a distinctly different emphasis. According to the Nora Jacobson, PhD, and Dianne Greenley, MSW, in an article they published *Psychiatry Services* in 2001, the essential elements of most consumer-defined recovery models involves both internal and external conditions. Internal conditions include attitudes and processes that lead to change, while the external conditions are the experiences, policies, and practices that lead to recovery.

## Lessons I have learned

When I compare consumer-oriented to scientific definitions of recovery, it is readily apparent that the former evolved from very different perspectives, histories, and goals. While scientific definitions focused on a clinical/disease model and the goal of advancing research, consumer definitions evolved from something very much like the civil rights movement. The consumer-oriented definitions of recovery had different goals (e.g., raising consciousness among consumers and their families and changing mental health policies). Rather than researchers, the target audience was consumers, family caregivers, politicians, policymakers and clinicians.

In the 1980s, I became aware of a growing group of consumers and family members who were voicing extreme dissatisfaction with a paternalistic and failing mental health system. Among these voices a continuum of views existed. At one end, the consumer movement vilified professionals and saw traditional mental health services as causing more prob-

lems than it solved, promoting hopelessness and helplessness, causing dependence, and increasing stigma. These consumers and family members identified themselves as survivors not of mental illness, but of the mental health system. I know my brother Henry and I felt that way—at least in part—for a long time.

On the other end of the spectrum, a more moderate view was expressed. Mental health professionals often failed to promote a sense of hope and optimism, did not give consumers choices, and did not see the value of actively including consumers and family members as partners in treatment. This view is more hopeful because it does not presume a failure to care, only a failure to focus efforts on the bigger picture and the subjective experience of persons with schizophrenia, and on the concerns of their loved ones. This more moderate view is the one I hold today, and I believe it was Henry's view for the last several years of his life.

### **My brother's recovery**

From a strictly scientific perspective, Henry Amador never recovered. Despite nearly 100 percent adherence to treatment, he continued to exhibit symptoms and was unable to find employment. But from Henry's perspective (and mine), he was managing the symptoms well, both with medicine and coping strategies he had learned over the years, and he had found work. The work paid nothing in dollars but much in the currency of self-respect, dignity, and meaningful activity. And for the last year of his life, Henry had a girlfriend. Mary was someone he talked to every day; they took long walks and they took turns buying each other breakfast at the local diner.

Henry, and others like him, taught me that recovery is fundamentally about finding meaningful relationships, activity, work, and reaching and maintaining goals while looking to the future with hope. It is, I believe, a far more inclusive and hopeful understanding of what recovery is.

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## **What if looks are deceiving?**

*by Jane Mountain, MD*

**Q:** My doctor says I'm "doing well," but I don't think so. Is it true that I can look better than I feel?

**A:** It can happen that your doctor is convinced you're "doing well." When you don't think so. If this is the case, it's good your doctor thinks you are doing well. That may indicate you are not as ill as you once were. However, sometimes people begin to look better when their brains are still reeling with depression, rapid cycling or mixed states. This has happened to me in the past, and even medical people I worked with didn't realize I was not feeling as well as I looked.

The crucial point here is that your doctor sees a different picture from the one you experience. The two of you are looking through different lenses. Both lenses show part of the picture, and it is essential that you help your doctor see what you are experiencing. This way, the goal of treatment becomes finding wellness, not getting almost well.

It's extremely important that your doctor understands the amount of discomfort you are experiencing, especially if you are having suicidal thoughts or difficulty getting through each day. Hopelessness, poor sleep, and lack of energy are just a few symptoms that have a profound impact on your quality of life.

Even if you are not having suicidal thoughts, rapid cycling, or mixed states, struggling through the day is not the healthy mood that's the goal of treatment. Your doctor sees improvement, and you can be glad of this, but you also don't want to main stuck in the land of "almost well" rather than that of healthy mood.

**Q:** How can I make my doctor understand that I'm feeling depressed, even though I look well?

**A:** Doctors are trained to observe carefully. But it's impossible for a doctor, even

with careful observation, to know exactly how you are feeling with depression and how much energy you're experiencing. Your goal at this point is to help your doctor see the depression you are experiencing.

Don't be discouraged if you have trouble identifying and describing your symptoms. Depression can be so overwhelming that learning how it looks and feels can take practice. My experience is that most people know when they are feeling depressed, but they can't always describe to others how they experience it. If this is happening to you, it may be helpful to tell your doctor that you feel worse than you may look.

Sometimes it's helpful to write down your feelings in a notebook for several days before your appointment, so you can be clear in getting your doctor to understand. Focus on describing feelings and scenarios, rather than distilling things down in a word. For example, instead of saying, "I'm depressed," you might say, "I couldn't stop crying yesterday even though nothing happened to cause a crying spell," or I'm not able to enjoy being with others, even though I usually like to be with people."

If your energy is low, tell your doctor and compare it to the amount of energy you have when you are feeling better. For example, "I feel tired when I get up in the morning and, by noon, it's hard for me to get through the rest of the day. When I'm feeling well, I can do the activities I plan and only feel tired at the end of the day."

Describing your sleep difficulties can help your doctor understand that you are not feeling well. Again, be specific. If you are waking up during the night, be sure to mention how long it takes to get back to sleep and how many hours of sleep you are getting compared to your normal pattern.

Once you have written down the symptoms you are feeling, don't hesitate to read them out loud to your doctor. Getting your doctor to understand your symptoms is an essential piece of meeting your wellness goals.

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# DBSA Calendar of Events

**Please Note:**

Monthly meetings will be cancelled in the event of inclement weather.

## May 2011

- **May 23rd • 6:30-9:00 pm**  
**Support Group**  
Cape Girardeau Public Library  
O.C. Hirsh Room

## June 2011

- **June 8th • 12 Noon**  
Executive Board Meeting
- **June 27th • 6:30-9:00 pm**  
Summer Picnic in the Park  
Cape County Park (North) Shelter #8

## July 2011

- **July 13th • 12 Noon**  
Executive Board Meeting
- **July 25th • 6:30-9:00 pm**  
**Support Group**  
Viewing of "Shadow Voices"  
Cape Girardeau Public Library  
O.C. Hirsh Room

## August 2011

- **August 10th • 12 Noon**  
Executive Board Meeting

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