

# The Pendulum

*We've been there. We can help.*



email: [dbsa.semo@yahoo.com](mailto:dbsa.semo@yahoo.com)

Winter 2009

## ***New Support Group formed***

A new support group for parents and caregivers who have a child with a mental illness is forming in Cape Girardeau. The group will be meeting at Southeast Hospital on December 16th, 2009.

There will be two chances to attend the group on that day. The morning group will meet from 9:00-10:00 am in room MR-105. The evening group will meet from 6:00-7:00 pm in the same location. The group will then meet on the second Wednesday of each month.

Raising a child with an emotional, behavioral, or mental disorder is the most difficult job you will ever have. Don't try to do this alone. Find other parents who have been there and understand the difficulties you are facing. They can give you information, ideas, emotional support, resources and assistance with finding your way through the system. Every effort will

be made to assure confidentiality.

For more information, contact Laura Brown at 573-579-0095. In the event of inclement weather, the support group will cancel the meeting. ■

### ***HELP WANTED:***

Part time office person needed for the DBSA of SEMO office. Hours are 12 noon to 4 p.m. Monday through Thursday. Send resume or letter of interest to:

**DBSA of SEMO**  
**P.O. Box 986**  
**Cape Girardeau, MO 63701-0986**

## ***UPCOMING EVENTS***

### ***Cape Girardeau Monthly Meetings***

***Location:***

*St. Francis Medical Center  
Assisi Room*

*I-55 & Rt. K • Cape Girardeau, MO*

**December 14, 2009 • 6:30-9:00 pm**  
**Christmas Party**

**January 25th • 7:00-9:00 pm**

**Speaker:** Jill Schmidt,  
President DBSA - SEMO

**Topic:** Our Impact on Others

**February 22nd • 7:00-9:00 pm**

**Speaker:** Mr. Scott Gibbons,  
Healthpoint Fitness Jackson

**Topic:** Exercise for Health

**Please Note:**

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



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# Liberation Education

by Stephen Pocklington

As I was entering my college campus one day in 1972, I paused curiously at the archway to read the inscription overhead. As if noticing it for the first time, I read: *“Enter That Daily Thou Mayest Grow in Knowledge, Wisdom and Love.”* It was near graduation so I had already seen that inscription perhaps a thousand times, but suddenly, that day it dawned on me how I gotten sidetracked in the pursuit of *knowledge* and was coming up woefully short on wisdom and love... and my wellbeing was suffering for it.

Similarly, today, thinking about education in relation to wellness and recovery, it seems to me we can get sidetracked learning about diagnoses, medications and treatments, and lose sight of our wellness, our wholeness, and our ever-present ability to make simple, concrete choices that move us toward whatever we want from life. Our richest educational opportunities lie in learning about all of the options and possibilities that become available when we focus on where we want to go rather than where we have been, yet many still want us to talk endlessly about symptoms and illness.

Bertrand Russell once wrote: *Almost all education has a political motive: It aims at strengthening some group... in the competition with other groups. It is this motive, in the main, which determines the subjects taught, the knowledge offered and the knowledge withheld, and also decides what mental habits the pupils are expected to acquire. Hardly anything is done to foster the inward growth of mind and spirit...*

I'm afraid that too much of what historically has passed as mental health education has been aimed at defining people by their presumed limitations, instilling a sense of dis-ability and corraling people in treatment ghettos that were socially, emotionally and spiritually barren. Dare I say, it seems to have been about learned manageability? If

system transformation is really to take us beyond those barren wastelands, beyond mere manageability, doesn't it call for a different approach to education, an approach that has as its only aim, true empowerment? We might think of this new approach broadly as Liberation Education, though you may already know of it in terms of one practical application: *Wellness Recovery Action Planning*.

In our WRAP® workshops, the focus has always been on instilling hope and shining light on the vast array of possibilities and opportunities that are still open to every human being. Each of us has already been through the school of hard-knocks and we have a wealth of knowledge and wisdom waiting to be distilled from those experiences... if only someone will facilitate the learning process with compassion, understanding and unconditional high regard.

WRAP® facilitators accept participants as experts on their own recovery, drawing everyone into a deeper, richer exploration of all that our experience has to teach. We learn from each other, as well as from our experiences. As we begin to take full advantage of life lessons, employ wellness tools that are experientially tested and proven, and give voice to our hopefulness, we create new pathways to the lives we want, whether we define those lives in terms of recovery, wellness, or joy.

The basic idea of *Liberation Education* is expressed with such clarity in Mary Ellen's simple encouragement for people to consider all perspectives and decide which ones feel right to you. The real liberation occurs when hopeful people embrace that encouragement and actually take charge of their lives by considering all perspectives and deciding for themselves which ones feel right. This is what we mean by self-determination and it's what creates a clear focus for powerful self-advocacy and informs the development of effective net-

works or support.

I am not sure anything needs to be carved in stone over the entrance to our WRAP® workshops, but I am sure that empowerment, liberation and self-determination are in the minds of all true facilitators. It is enough for us to be thinking, *Enter That You May Learn (Without Any Limits) and Grow...*

*Mental Health Recovery - Oct. 2009* ■

## 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!*

## Depression Bipolar Support Alliance of Southeast Missouri

1202 S. Sprigg  
Cape Girardeau, MO  
(Located in the Family Resource Center)  
573-334-5474

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

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# Walking the line with dual diagnosis

by Michelle Roberts

Last December, Joanne Marks found herself tangled in a web of mental illness and addiction.

Marks, 49, of Winnipeg, Manitoba, diagnosed with bipolar disorder in her 20s, had been sober for 19 years. But family stressors—an adoption that fell through—caused her to relapse.

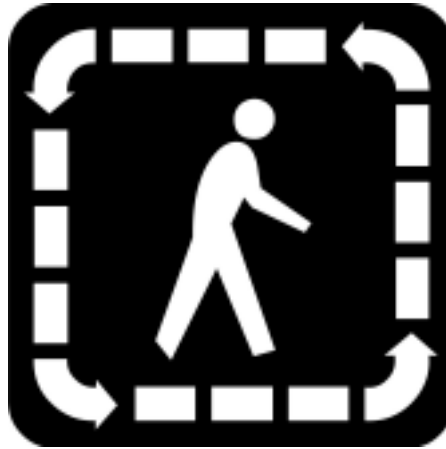
“I vaguely remember going out and buying the alcohol,” she says. “But at that point, I just needed relief from my depressive symptoms. I have an 8-year-old son I have to take care of, and I was feeling suicidal. ‘My son needs a mother,’ I told myself, and drinking was the only thing I could think of doing.”

For the next six months, Marks hid her relapse from her husband. “I drank mostly in the afternoon when my son was at school,” she recalls. “An I’d stop when he’d come home. That couple of hours I would get some relief so I could cope with the rest of the day.”

About 50 percent of people with severe mental disorders are affected by substance abuse, according to reports published in the *Journal of the American Medical Association*. The numbers are even higher for those with bipolar disorder: As many as 60 percent turn to drugs and alcohol, often to try to manage their symptoms, but they only add further pain to their lives.

“In my own personal experience, bipolar and substance abuse are very linked,” says Marks. “I never learned how to cope with my mental illness, and substance abuse was, for me, an easy way to cope. But it was an ugly cycle. It takes the emotional pain away for a little while, but in the end it would always make the depression worse. And I would end up in the hospital.”

Co-occurring disorders are also very difficult on family members, who must learn to accept that their loved one has both substance abuse and mental health problems. Some families may accept the mental health diagnosis, but not the substance abuse problem, thinking that it is a sign of bad behavior.



Despite the challenges, however, treating professionals say that it's important to remember that co-occurring disorders are a relapsing condition, and not an illness without a cure.

“There is real hope for people who have both bipolar disorder and substance abuse issues,” says Steve Lurie, executive director of the Canadian Mental Health Association (CMHA) Metro Toronto branch. “It is a challenge, for sure. But I've seen people pull themselves up out of the tangle.”

Studies dating to the early 1980s show a strong link between bipolar disorder and substance abuse problems.

The Epidemiologic Catchment Area Survey, administered from 1980 to 1984, found that people with severe mental disorders were significant risk for developing a substance use disorder during their lifetime, and that people with bipolar were especially vulnerable. This watershed American survey revealed that 60.7 percent of people with bipolar also had a substance abuse disorder (more than five times as high as the general population), compared to 47 percent of individuals with schizophrenia (more than four times as high as the general population).

Data compiled since then support these findings. The National Comorbidity Survey Replication,

archived in 2007, found that 60.3 percent of people with bipolar I and 40.4 percent of people with bipolar II reported substance use disorders in their lifetime.

Furthermore, the National Epidemiologic Survey on Alcohol and Related Conditions, published in 2005, looked at the prevalence of 12-month period, 23.6 percent reported having an alcohol disorder, while 58 percent reported one during their lifetime. As for drug use, 12.9 percent of people with bipolar I reported a problem in the past 12 months, while 37.5 reported problems during their lifetime.

According to Canada's Centre for Addiction and Mental Health (CAMH), among people who have had bipolar disorder in their lifetime, 56 percent will have a substance abuse disorder in their lifetime.

Overall, people with bipolar I tend to have more substance abuse disorders than those with bipolar II, says Keming Gao, MD, PhD, assistant professor of psychiatry and director of the Mood & Anxiety Clinic Mood Disorders Program at University Hospitals Case Medical Center at Case Western Reserve University in Cleveland.

“In my practice, I see that (patients with) rapid-cycling bipolar I have more anxiety disorders than bipolar II, which might be why they're more prone to having drug and alcohol problems,” Gao says.

Scientists have several theories as to why bipolar disorder and substance abuse appear so tightly intertwined.

“What probably makes drug abuse more attractive to bipolar patients is the self-medication theory,” says Ivan D. Montoya, MD, MPH, medical officer for the Division of Pharmacotherapies and Medical Consequences of Drug Abuse for the National Institute on Drug Abuse (NIDA). “One hypothesis is that people are trying to find something to make

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them feel good. For example, cocaine can be a way of feeling good, especially when someone with bipolar is depressed and low.

“Another hypothesis is that people with bipolar disorder simply have a genetic predisposition to both disorders.”

While “self-medication” may provide some temporary relief, Montoya says, the dangers outweigh any perceived short-term gain. Substance use can make mental health problems worse, can mimic or hide the symptoms of bipolar, can make people forget to take their medications, and can even make some medications less effective. Treatment may take longer and be more challenging.

“If somebody is addicted to drugs, they may also not be as compliant about taking their medications for bipolar disorder, which can also get them into trouble,” says Susan Weiss, PhD, chief of the science policy branch for NIDA. “Compliance is a big issue, particularly for people who are hypomanic, because they tend to like that feeling, and to get them to take medications to bring them down to level them off is not always easy to do.”

Scientists theorize that the intake

of mind-altering substances such as drugs and alcohol may actually make people with bipolar disorder and other mental illnesses feel better, at least temporarily.

Wendy Barry-Breier, 53, of Oakland, California, says she struggles with alcohol abuse and bipolar disorder on a daily basis.

“I usually drink because of depressive feelings and wanting to have some kind of relief,” says the administrative assistant for a biopharmaceutical company. “It’s very difficult when you’re bipolar and sober, because you still suffer as much as you do when you drink, if that makes any sense.”

Barry-Breier says she knows she shouldn’t drink, but contends that it is sometimes the only thing that can make her feel better, at least for a little while.

“When I’m in a deep depression, there’s no medication that can bring me out of it,” she says, “And if I drink there’s a brief reprieve. I know it only makes things worse in the long run. But even that brief reprieve from the depressive symptoms, in my darkest moments, can be tempting.”

“There are some theories, not proven, that say that the effect that

substance abuse has on the brain of people with mental disorders may compensate for some of the deficits in the brain,” says Montoya of the NIDA. “That’s still something that needs to be investigated more, but preliminary trials suggest that a compensation occurs in the brain when people abuse drugs.”

For example, Montoya says that cocaine can actually increase the levels of the neurotransmitter norepinephrine. So, during episodes of depression it can have an antidepressant effect. “That increase may help to improve the mood in people with bipolar,” he says. “Of course, there are far healthier ways to accomplish that, but that is at least part of the reason why it is so appealing to people with bipolar disorder.”

At NIDA, Montoya and his fellow scientists are also looking to find pharmacological treatments to tackle both problems at once. Research is under way to determine whether certain anticonvulsants can be used to treat bipolar disorder and, at the same time, certain kinds of substance abuse.

“People who don’t respond to lithium are often put on anticonvulsants as mood stabilizers,” says Weiss. “We’re doing a lot of research right now to see if these mood stabilizers may have effects on a variety of types of drug addiction. There may turn out to be some effective treatments for both, which would be very nice. The research is preliminary, but we’re hopeful.”

For people like Christiane Raynal, 53, of Toronto, the consequences of bipolar couple with drug and alcohol abuse have been numerous and harsh.

“For years, I had no idea what was wrong with me,” says Raynal, a part-time sales associated in a children’s store, who started drinking in the 1970s when her children were young. “I started abusing alcohol because I couldn’t cope with my behavior and my anger, which I now know was a by-product of my undiagnosed bipolar disorder.”

Raynal says her drinking cost her marriage, several jobs, and her dignity. Moreover, it has deeply impacted her relationship with her son and daughter, now adults. “Being drunk and unmedicated, I’d get mad and yell at my

kids," she says. "It was not nice I was a very bad mother."

Raynal's drinking led her to treatment seven years ago. Like many people with co-occurring disorders, it was only then that she was diagnosed with bipolar. Since that time, she has relapsed in both disorders several times.

"I am doing the best I can," Raynal says, "but I'd be lying if I said it was easy. I can't honestly tell you I'll never drink again. Every day is a test. My moods are so irregular, that sometimes the only thing that makes me feel better is drinking."

Cycling in and out of wellness is typical for people with co-occurring disorders. From a health perspective alone, having a simultaneous mental illness and a substance abuse disorder frequently leads to overall poorer functioning and a greater chance of relapse. "We often see these people in and out of hospitals and treatment programs without lasting success," Montoya says.

People with dual diagnoses also experience more episodes of psychosis. "In general, people who have bipolar and abuse drugs have more mood changes, rapid-cycling, and are ill with the symptoms of bipolar for more days of the year," Montoya says. "They are more likely to have suicide attempts."

Socially, people with mental illnesses often are susceptible to co-occurring disorders due to a "downward drift." In other words, as a consequence of their mental illness they may find themselves living in marginal neighborhoods where drug use prevails.

Having great difficulty developing social relationships, some people with co-occurring disorders find themselves more easily accepted by groups whose social activity is based on drug use. "Some may believe that an identity based on drug addiction is more acceptable than one based on mental illness," according to literature produced by the National Alliance on Mental Illness (NAMI). "Consumers with co-occurring disorders are also much more

*Continued on next page*

## SOUNDOFF!

**I've been living with** bipolar for most of my life. I began to self-medicate with drugs and alcohol when I was 15 because I felt like I was different from my friends. I quickly learned that alcohol does not mix well with this illness! Fortunately I was scared sober thanks to the shady crowd I was hanging out with. I started by attending AA and Women for Sobriety meetings. I begin each day thinking, "I'm not going to drink today," and at the end of the day I thank whatever my higher power is. It really is day by day. I have been sober since July 4, 1994.

—Name Withheld, Toronto, ON

**Overcoming substance abuse** is a battle on its own. Combined with bipolar disorder, it would seem to be almost impossible. I am not going to sugarcoat the process. I have been sober now for several years. With a dual diagnosis it has been a long and hard process, but it can be done and is a very rewarding experience. In your journey towards sobriety you will learn about yourself, others, and things around you that may in the past have been blurred by addiction. Take one day at a time, be compliant with your medications and remember to praise yourself for your accomplishments.

—Nicole McFaul, Pitt Meadows, BC

**I've been sober since 1990** and diagnosed and treated for bipolar disorder since 2002. The things that have helped me have been to learn as much about each disorder as possible, to look into all the resources available to help me live with both problems, and to find ways to help others deal with the same issues. Today I'm a psychotherapist and author specializing in addictions, mood disorders, and PTSD, which I also have.

—Jim Finley, Albuquerque, NM

**I find that nonalcoholic beer** is a great substitute for the real thing. It

tastes virtually the same as the alcoholic beers and it's excellent on hot days. (*Editor's note: Most nonalcoholic beers contain less than 0.5 percent alcohol, but even that amount may pose a risk for alcoholics.*)

—T.O.B., La Verne, CA

**Long before I was diagnosed** with bipolar II I drank to excess. It was always worse in the spring and summer. I now know that was when my mania was in full bloom. I unknowingly was using alcohol to manage my mania. Thank God I was introduced to Alcoholics Anonymous. It saved my life. I am an alcoholic and I am bipolar and I am dealing with both.

—Steven Orenstein, Overland Park, KS

**After self-medicating** for 38 years (mostly heavy marijuana use), I became honest with myself due to many physical, emotional and mental problems. I finally admitted to myself I had a problem. Not knowing what to do, I told my doctors about my condition. Then I joined a group that offers support for my recovery. But most importantly, I still take my recovery. But most importantly, I still take my medicine.

—Bruce, Red Bay, AL

**Diagnosed bipolar in 1983** but continued to drink. Psychiatrist asked: "Can you go 30 days without favorite food?" (Mexican.) Yes, of course! "Can you go 30 days without drinking?" Yes, of course! "If you can't, you may have a drinking problem." Three days later, I started drinking again. My bottom: losing my two daughters to divorce 7 years ago. I now have 7-plus years clean and sober through taking responsibility, dual diagnosis and tons of bipolar support group meetings.

—Marty Naftel, Fountain Valley, CA

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likely to be homeless or jailed," the literature states.

John Linn, 47, of San Bruno, California, says his bipolar disorder and alcohol abuse led him to a life of crime and homelessness when he was young. Living on the margins of society, he says he began to drink as a method of relieving his troubles.

"I was in so much pain," he says. "I was drinking, I lost over 100 jobs, eight careers, a wife. In my life, I've been homeless for a total of five years, living on the streets of San Francisco. I was classic bipolar I, but nobody caught it for 35 years. They pegged me as a bad kid."

An estimated 50 percent of homeless adults with serious mental illnesses have a co-occurring substance abuse disorder. Meanwhile, 16 percent of jail and prison inmates are estimated to have severe mental and substance abuse disorders. Among detainees with mental disorders, 72 percent also have a co-occurring substance abuse disorder, according to statistics compiled by NAMI.

Research has strongly shown that to recover fully, people with co-occurring disorders need treatments for both problems. Focusing on one does not ensure the other will go away. And dual diagnosis services should integrate help for each condition, assisting people in recovering from both in one setting, and at the same time.

Indeed, services for people with co-occurring disorders require different types of assistance that go beyond standard therapy or medication. They can include assertive outreach, job and housing assistance, family counseling, and even money and relationship management. Such personalized treatment is often needed long-term and can begin at whatever stage of recovery a consumer is in.

Linn, like so many others, wasn't diagnosed with bipolar until he was in an alcohol recovery program. "I had a manic episode while in there...and finally got the diagnosis after suffering from 1967 through 1993."

Since then, daily Alcoholics

Anonymous (AA) meetings, six psychiatrists, and 43 medicine combinations have finally led Linn to "some stability," he says. He's managed to stay sober, stay in a relationship, and start his own cleaning business. But Linn says that he has never been enrolled in an integrated treatment program, something he believes—and research shows—would have "made my life so much better so much sooner."

Despite significant research that supports its success, integrated treatment is still not widely available to consumers in the United States and Canada. Mental health services tend not to be well prepared to deal with patients having both afflictions. Often only one or two problems is identified. If both are recognized, the individual may bounce back and forth between services for mental illness and those for substance abuse, or they may be refused treatment by each of them. Fragmented and uncoordinated services create a gap in services for people with co-occurring disorders.

"It's a huge challenge because most mental health and addiction systems in the United States and Canada have limited capacities to provide integrated treatment for concurrent disorders, even though integrated treatment is an evidence-based practice," says Lurie of the CMHA Metro Toronto branch. "Lawmakers just haven't put much money in to build capacity. It's very underfunded in both countries when it comes to client needs."

According to NAMI, effective integrated treatment consists of "the same health professionals, working in one setting, providing appropriate treatment for both mental health and substance abuse in a coordinated fashion." The caregivers see to it that interventions are bundled together; the consumers, therefore, receive consistent treatment, with no division between mental health or substance abuse assistance. Integrated treatment also recognizes that substance abuse and traditional mental health counseling are different approaches that must be

reconciled to treat co-occurring disorders.

"That is what we know really works," Lurie points out.

Several levels of care are necessary because mentally ill patients often lack insight into the seriousness and scope of their substance abuse, Lurie adds. For that reason, people with co-occurring disorders sometimes don't do well in traditional AA or Narcotics Anonymous (NA) groups. So some mental health agencies, including the one run by Lurie, have begun special peer groups. "It's always a challenge because so many of our clients lack insight that they have a mental illness, let alone a substance abuse problem," he says. "So we start groups and say, 'here's a group of people who, like you, don't think they have a problem.' And we start from there."

Marks drank for six months, until she says, "it all came to a head."

"I just didn't like where I was going. I knew if I kept drinking I'd be back in the hospital and that really scared me. Gave it up cold turkey. I had some flips, but they were short. I found a group I really felt at home with and, after a couple months, I found a sponsor. But I do still crave it."

Now, Marks says she is using a coordinated approach, getting treatment for her mental illness at the same time as her alcoholism. She says dialectical behavior therapy, which draws on Western cognitive behavior techniques and Eastern Zen philosophies, has been helpful to her. It's helped her to become more aware of her thoughts and actions, better tolerate distress, manage her emotions, and improve her relationships. It has also helped her to stop drinking.

"I feel like I'm on the road to health again," she says. "With my illness, I will get sick again. But with the support I've got now it's not likely to get to be as severe, because now I'm not going to be drinking. I'm going to be reaching out to people and getting support to help me get through the difficult times."

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# Coming to terms with symptoms

by Steven Weisblatt, MD

One of the ongoing challenges you and your clinician will face is making sure that you are speaking the same language. Specifically, is the doctor asking questions—and are you answering them—in a way that elicits clear information and allows accurate assessment of your current symptom picture?

To make the most of the limited time available when you and your psychiatrist meet, it is critical that you know in advance what feelings to report and how to accurately describe them. In addition to reporting even mild or occasional symptoms, it is crucial that you understand the exact meaning of terms clinicians use to describe symptoms.

Accurate communication is, paradoxically, more critical the less ill a person is. Five to six times more people suffer from milder bipolar spectrum disorders than from more severe forms of the disorder that are characterized by classic and dramatic cycles of mood shift. With “soft bipolar,” there are more likely to be chronic, low-grade symptoms. While a more severely ill person may show observable symptoms to the clinician upon walking into the office, only careful and accurate dialogue will help the doctor establish an accurate diagnosis of a more subtly ill patient.

To further confuse matters, it is common for people to answer “no” when asked about having a symptom that occurs only intermittently. A person who is able to “manage” the symptom that occurs only intermittently. A person who is able to “manage” the symptom often gives a similar negative response.

As in cardiology, where you must inform the physician about any chest

pain that occurred since the last visit—whether or not you were able to “manage” the pain by lying down, for example—it is critical in psychiatry to give a complete answer. This increases the likelihood that the clinician will pick up any subtle symptoms you have.

It is vital that you observe yourself well and accurately report your observations to your clinician. This will reduce the risk of underplaying symptoms, lead to more accurate diagnoses and avoid less-than-optimal medication interventions that only make symptoms “a bit better.” By becoming more educated, you can actively promote getting treated to the point of full remission.

That requires an understanding of what a doctor means by the terms used to ask about different symptoms. For starters, here are useful definitions of two symptoms commonly reviewed during patient interviews.

**Irritability:** This can best be thought of as an *amplified* form of irritation. Irritation, an absolutely normal human experience that occurs when something upsets you, would not be considered a symptom of anything. Irritability is when you feel *easily* upset or frustrated in different environments. In common use, a person with irritability can sometimes be described as angry, “bitchy” or moody—although some people with irritability simply withdraw. Another way of thinking about irritability is to understand that while the triggering event or stimulus would indeed be annoying to most people, the frustration, anger or annoyance you feel is increased, or “amplified,” out of proportion to the context.

That disproportionate reaction may or may not be visible to someone other than yourself. Some people, especially

women, have been socialized to hide their irritability, so what they feel inside is not readily seen on the outside.

Also, in our society, calling someone “irritable” is considered a criticism. Perhaps that’s why many consumers and family members deny the presence of irritability when asked about the symptom—while readily admitting that the person with bipolar overreacts, has a low tolerance for frustration, is easily upset, has “anger problems” or that others “walk around them on eggshells.”

As well, because irritability only occurs in reaction to a stimulus (or stimuli), it is almost never present *constantly* and thus is often under-reported.

**Anxiety:** Purely defined, anxiety is a heightened state of fear or worry. Again, anxiety is an absolutely normal human experience. As a famous psychoanalyst wrote, a visit from the IRS brings out the hysteric in everybody.

Anxiety is only a symptom when it occurs out of context—that is, there is no real reason to be anxious—or the anxious feelings occur in a reasonable context but are increased out of proportion to the situation. Thus, the term “anxiety,” when used to describe a symptom, is best thought of as *amplified* anxiety.

Like irritability, amplified anxiety may not be obvious to others. Many consumers hide or don’t admit to having amplified anxiety, which complicates an accurate assessment of how they are responding to treatment.

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# Economic Outlook

## When the job market crashes, your mood doesn't have to

By Sasha Faynor

The challenge of finding a job that more than pays the rent can drag down anyone's mood. However, the uncertainty, lack of structure and financial pressures that characterize unemployment complicate the struggle to stay in remission from bipolar disorder.

I can speak from experience about that. The ongoing recession has put millions of people out of work and made it far harder to find another position, but I've been on that roller coaster for quite a while.

What with switching careers every few years, taking two yearlong maternity leaves and living in southern California's sprawl, I've had a tough time finding jobs that don't come with a lengthy commute or hefty overtime. Too much time sitting, whether in the car or at a desk, has always brought on symptoms of depression in me. And long hours spent working and driving compete with the regular sleep and exercise I require to stay in remission.

Ironically, lack of steady income has always been my biggest trigger for depression. While unemployed, I'm terrified of slipping into depression, which in the past has led to mania. I needed all my coping skills during an employment gap that spanned 2006—due in part to new medications that led to bouts of agitated depression and hysteria. As the months without income rolled on, I became so consumed by anxiety over mounting debt that I lost 10 needed pounds and began to obsess about my financial straits.

I had to play the game of parenting myself, a trick that a former therapist taught me: "Pretend you are your own parent—you wouldn't risk discouraging your child with negative talk." I exercised, got enough sleep, ate nutritiously, and kept appointments with my psychiatrist. Eventually I went back on my old, reliable medication and a month later found myself with three job offers. I took the one job feasible for the working mom

responsible for two young children, even though the salary was well below my market value as a technical writer.

Life was good again—until I got laid off in September 2008. Within days of my layoff, I had vowed to enjoy myself during this job hunt.

How? Here are 10 tried-and-true suggestions—for staving off depression and maintaining stability while unemployed.

### Lose your ego

Do not take losing your job personally. You are not your career. If you define yourself by your job or your salary, losing either will make you feel worthless. Feeling worthless can pervade your subconscious and seep out as depression.

### Stay in gratitude

Do not postpone your happiness until you get your next job. Writing a list every day of at least five simple things for which you are grateful will train you to appreciate life's mundane pleasures, such as a thoughtful phone call from a friend, a good laugh, buying a tasty pomegranate for 50 cents, or reading my article.

Focus on what you have—close friends, good health, a place to live, a sense of humor, or whatever else is true for you—and not on what you don't have. Staying upbeat will keep you projecting confidence and attract opportunities.

### Jump at exercise

Turn your new flexible schedule to advantage. Perhaps it was hard to fit exercise around your work hours; now you can pick the best time to pop in that aerobics DVD, go inline skating or otherwise get your body moving. Study after study confirms that exercise is one of the best antidepressants and stress relievers available.

Getting physical activity for at least 30 minutes a day, five to six days a week, gives you the maximum benefits from

exercise, but even taking walks to break up your day will refresh you. If you can't afford a gym membership, dancing hard to your favorite music and interval training—alternating jumping rope with calisthenics—are two cheap ways to get great cardio workouts.

### Don't project, don't panic

Stay connected to the present moment. One of the most stressful parts of unemployment is the uncertainty, the "what ifting," as in, "What if we have to move into Aunt Bessie's trailer?" Never "what if"—it will escalate into anxiety and panic and eventually immobilize you. Instead, identify an action, any action, that will help you move toward your goal. Take that action, applaud yourself for taking action, and focus on getting through one day at a time.

Anxiety comes from worrying about the future. Being completely engaged in the present moment reduces anxiety and stress.

### Use daily affirmations

Author Louise Hay recommends silently saying "I am healthy, I am wealthy," to yourself 30 times every morning. We tend to have so much negativity buried in our subconscious minds, and it's easy to succumb to that whispering defeatism. Affirmations help counteract our subliminal self-sabotage.

If you believe you are wealthy, you are. OK, perhaps not Donald Trump wealthy—but anyone can achieve spiritual wealth. Spiritual wealth is bound to keep both mania and depression at bay and keep you from relapsing.

### Volunteer

Volunteering can help you take the focus off yourself, reduce stress, and make you feel connected to a good cause. Sometimes you can even combine volunteering with your job search by offering your professional skills to a nonprofit organization. However, don't

develop a Mother Teresa complex and volunteer so much that you leave yourself no time to job-hunt.

### Be inventive

While necessity is the mother of invention, it can also be the mother of exhaustion. Shopping at five different grocery stores to save money and improvising family entertainment is time-consuming and tiring. Accept that limited funds means more work and celebrate the creativity that lack of money inspires. When I can't afford to eat out, I invite friends over. Cooking and baking with the kids keeps them entertained, and once they pass out from sugar coma, I can relax.

### Embrace the simple pleasures

Don't punish yourself for being unemployed by denying yourself time off for fun. A frugal budget might limit your entertainment options, but it can in-

crease your appreciation for simple activities such as walks on the beach, board games with the kids, and funny movies borrowed from the library. Laughter is a great stress zapper.

### Banish the negative influences

Surround yourself with positive people and positive influences. Now is not the time to hang out with Negative Uncle Ned, whose mantra is, "You should have gone to law school."

Push yourself to reach out to others. Not working outside the home can be isolating enough, so don't compound our time spent alone by avoiding friends because you're embarrassed about being unemployed. Retreating into your shell can exacerbate feelings of anxiety, panic, and stress and set your support network at a distance.

### Don't obsess

Sometimes it's hard to stop thinking about your unemployment situation, but don't let it consume you. Try to put dedicated time every day toward your job search, and then let it be.

Don't let the subject dominate your conversations, either. Let friends know your situation, brainstorm possibilities with them, then move on the other topics, like which celebrity will get the next DUI.

As for me, I just keep chipping away at my job search. Try not to brood about my stalled career and diminished income. I focus on turning my mood around by telling myself that I don't know where I will end up working, or how I will continue to pay the rent, but that faith combined with footwork can result in miracles.

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## Balancing Act

### Relax

**Stress can threaten your hard-won stability**, so it pays to learn your stress signals. "When I can't sleep, I know that I'm on overload," says Alice Domar, PhD, author of *Be Happy Without Being Perfect* (Crown, 2008) and founder of the Domar Center for Mind/Body Health in Waltham, Massachusetts. "For other people, it might be headaches or stomachaches." By developing a personal stress barometer, you'll be able to spot danger signs and head off mood swings more easily.

### Connect

**Friends are essential for health and well-being**, but you can't rely on other people to reach out to you first. "I've decided that it's silly to wait around to be invited to do things," says networking expert Robyn Henderson. "Why not be the one who does the asking? If I want to go



hiking, see a movie, go to an art gallery, or take up a new sport or hobby, then maybe someone else I know would like to join me."

### Rest

**Changes in your sleep pattern can be a sign of impending depression or mania.** The trick is to reset your body clock. The best way to do that? "Try going to bed at the same time every night and getting up at the same time," explains Steven Y. Park, MD, clinical assistant professor at New York Medical College, and author of *Sleep, Interrupted* (Jodev Press, 2008).



### Enjoy

**Small but frequent moments of positive emotion can increase your resilience** against life's challenges and make you happier, a study from the University of North Carolina at Chapel Hill reports. So even in tough times, pay attention to those "micro moments" that trigger good feelings—"whether it's the beauty outside the window or the kind things that others do," says researcher Barbara Fredrickson, PhD, a UNC professor of psychology and author of *Positivity* (Crown, 2009).

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# Mental Makeover

## Because thinking really makes it so

by Stephen Propst

### **My life is a complete mess.**

*I can't do anything right. I'm an emotional wreck. There's no cure for my illness. I'm doomed to live in a state of chaos for life. No one can help me. No one understands. I brought all of this on myself.*

Sound familiar? It does to me because that's a snapshot of the twisted thoughts and backward beliefs that consumed my mind for years. My mistaken mindset put my chances for recovery on hold for way too long.

What you think and believe affects your self-esteem, your well-being, and your recovery. In the midst of mania, thinking you are indestructible can have devastating consequences. In the depths of depression, believing that your situation will never improve only makes matters worse.

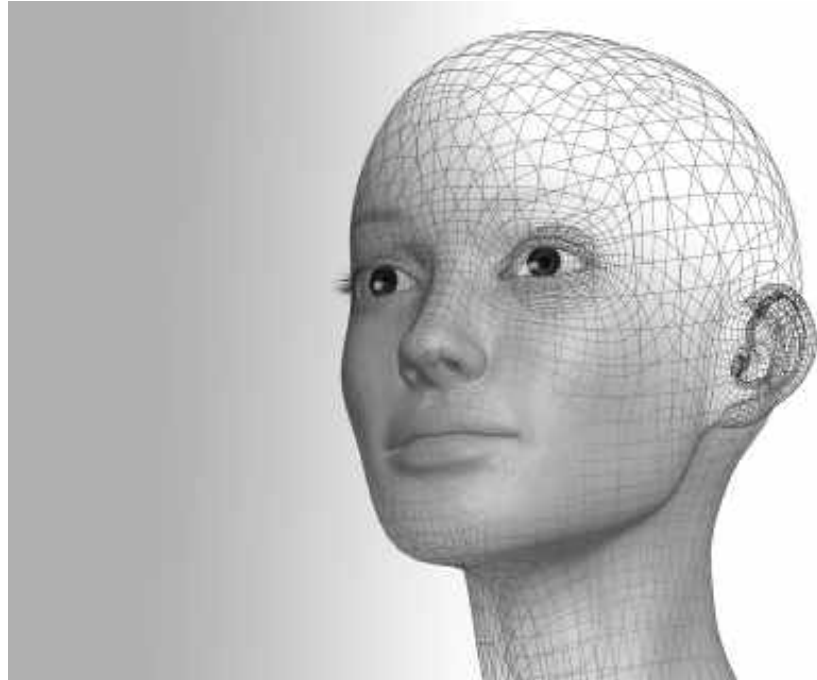
There's good news: What you think and believe can be changed...for the better. According to the principles of cognitive behavioral therapy (CBT), every act and attitude has its roots in a thought or believe, you can change your feelings, your behavior and your life.

The first step is understanding the types of thinking that hold you back and keep you from moving forward with recovery. Here are some basic cognitive behavioral concepts developed by pioneers Dr. Albert Ellis and Dr. Aaron Beck and popularized by Dr. David Burns (*Feeling Good: The New Mood Therapy* (Harper, 1999)) and others.

### **Backward Beliefs**

**Perfectionism:** We must always perform at peak and never make a mistake.

**Unfounded Fear:** We are afraid without good reason of certain people,



places, situations or scenarios.

In dealing with bipolar disorder, I have found that how I think about my situation can be more debilitating than the condition itself. So, what's the answer?

To reverse this damaging trend, you need to learn some concrete ways to untwist your thinking and turn your beliefs around for the better. You need to rethink, reprogram and regroup.

### **Rethink**

Whenever you have an unrealistic thought or an untrue belief, you have some work to do. There are three steps to take:

1. Using the categories above, identify how the thought or belief is not based in fact.
2. Revise the thought or belief to be a more accurate reflection of reality.
3. Determine what action, if any, might be taken to improve your situation.

As an example, look at this state-

ment: "I am always forgetting to take my medication." Now, go through each of the steps:

1. This is an overgeneralization. More than likely, you do not always forget to take your medicine.
2. What is more true to your situation? Probably something like this: "Although I usually take my medicine, I sometimes forget, especially on weekends when my routine changes."
3. What can you do about it? "I will purchase a pill reminder box to help keep me on track."

Here are some common thoughts or beliefs—in the form of statements—that someone living with bipolar might have. After each statement comes pointers for restating the remark in a more realistic manner, followed by the type of twisted thought or backward belief at play. After you read each example, ask yourself what actions might be taken to help ensure a positive change in mindset.

**“My mood swings are all my fault.”** Bipolar disorder is a real, organic, genetic medical condition. No one is to blame. Watch your internal dialogue, and stop pointing fingers at yourself. (Blame Game)

**“I’ll never get better.”** No one, including you, can predict the future. At one point, I could not have imagined enjoying the recovery that I do today. It was when I started to envision the best, not the worst, that I started moving more quickly toward a brighter tomorrow. (Crystal Balling)

**“I feel uneasy about going to a support group.”** Why dwell on dread and doubt? A self-limiting stance keeps you from seeking out a known solution. Logic tells you that people at a support group are well equipped to offer understanding and encouragement. The only thing you have to fear is the possibility of getting better. (Unfounded Fear)

**“Medication doesn’t work for me.”** Finding the right medication is not easy and takes time. Sometimes, a particular prescription is just not the best fit. But a failed attempt does not mean that you and your doctor can’t still find an option that works. With each successive trial, you’re one step closer to finding the solution. (Overgeneralization)

**“I’m always either in a state of major mania or deep depression.”** Start keeping a journal or a mood calendar. When you analyze the results, you’ll see that there are times of stability in your life. Even when you have bipolar, life is not so cut and dried. (Black and White Thinking)

**“I’ve made so many mistakes in dealing with my illness.”** So what? I’ll bet I have you beat! In my life, having bipolar has meant making blunders. No one is perfect. When you make a mistake, learn from it and move on. (Perfectionism)

## Reprogram

In time, you can reprogram negative thoughts. Here’s a simple technique:

Begin to replace the negative self-talk in your head by writing a more positive, realistic affirmation on an index card. Refer to it regularly whenever you find yourself embracing a convoluted thought or fostering a bad belief. Here’s an example:

“The bad thought I am having is a lie from my brain. I can’t always rely on what I’m feeling or thinking at the moment. I have to examine the facts. I have to use good reason and judgment in making decisions. I have to learn from past mistakes and be willing to make tough choices to keep my recovery moving in the right direction. Doing so will help ensure a more rewarding and fulfilling life.”

The first psychiatrist I ever visited asked me to carry around such a card and read it 50 times a day for 30 days. Initially, I thought this idea was absurd. Over the course of the month, I was astonished by how my thinking changed for the better. You can retrain your brain.

## Regroup

There have been times when my illness resulted in my thinking or saying things or developing beliefs that were extremely destructive, with devastating consequences. I had to learn to seek out and accept honest feedback from family or friends who noticed my distorted thinking.

Surround yourself with people who can profoundly and positively help you reprogram your false perceptions. Be open to their suggestions, and be willing to take action. At times when family and friends aren’t available, a support group is a wonderful place to find the help and hope you need.

Give yourself a mental makeover: Untangle your twisted thoughts and break down your bad beliefs. The more what you think and believe is aligned with genuine reality, the more balanced and healthy your life can be.

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## Carrie Fisher takes her tell-all show to Broadway

Carrie Fisher, one of Hollywood’s cultural icons and an outspoken mental health advocate, has taken her one-woman show *Wishful Drinking* to Broadway. The self-created show is directed by Tony Taccone, artistic director of the Berkeley Repertory Theatre, and is running a limited engagement at Studio 54 through January 3, 2010.

Fisher has never been shy about exposing the traumas of her less-than-perfect childhood and adult life. In this show, she lays bare her tumultuous existence with wry humor, snarky wit, and a couple of handy visuals. She is the life of her own party, giving the audience a ride through her highs and lows, and some sense of resolution as well.

A memoir based on the show, also titled *Wishful Drinking*, was published last year and is now out in paperback from Simon & Schuster.

The daughter of Debbie Reynolds and Eddie Fisher, Hollywood’s darling couple of the 1950s, Carrie Fisher grew up in the glare of publicity. Her parents were involved in a scandalous divorce when she was only 2 years old. She first performed at age 12 with her mother in a Las Vegas show.

She left high school to follow a career in film, beginning with a role in the 1975 movie *Shampoo*. A year later came her star-making role as Princess Leia in the Hollywood blockbuster *Star Wars*.

Fisher has struggled openly with alcohol, drugs and bipolar disorder for much of her life, experiences she drew on for several best-selling books before *Wishful Drinking*. Fisher’s willingness to talk about those challenges has made her one of North America’s most prominent and visible stigma-fighters and a powerful proponent of mental health.

To learn more about her Broadway show, or to purchase tickets, visit [www.round-abouttheatre.org](http://www.round-abouttheatre.org).

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## ***You've got to have friends***

*by James Waxmonsky, MD*

Children develop and polish their social skills through play, and play is how they connect to friends. Those skills and friendships are essential building blocks to healthy self esteem. A positive self image can help prevent episodes of depression, which is critically important for children with bipolar.

The key to helping your children do well socially is to provide them with support and reassurance and to be aware of their limitations. Many children with bipolar do best in one-on-one interactions of limited length. They are especially prone to getting overstimulated in large settings.

One aspect of bipolar is the lack of an internal mood thermostat, so that your child's mood is overly sensitive to outside influences. If she is thrust into the middle of a noisy birthday party with 25 other children, there is a good chance she will get overwhelmed. That doesn't mean you have to keep her home, but you will need to pay close attention to signs that she is getting overstimulated: whining, aggressive play or even social withdrawal.

For more likely success, start with smaller groups—one or two peers—and shorter time frames. If that goes well, aim gradually for longer play dates.

Some children who struggle with unstructured free play may do better in organized activities. Studies support the perception that children with bipolar tend to be artistically creative, so activities like art, acting or music lessons may be a good place to start.

The key here is to choose based on your child's abilities and desires, not yours. If your child has expressed a desire in a healthy activity, you are much better off letting him pursue his own interests. This can be particularly hard for athletic fathers who want their sons to follow in their footsteps, but you can't force children to like something.

In addition, for the significant num-



ber of children who have ADHD as well as bipolar, organized team sports can be very tough. It is not a situation suited to children with short attention spans and poor impulse control. On top of that, many children with mental illness have problems with fine motor coordination and simply are not natural athletes.

Even if children struggle in athletics, however, it is still important that they be physically active. Regular activity helps to regulate sleep and can lead to better mood stability. Some medicines for bipolar promote weight gain, so it is critically important that your child exercises. An individual sport like swimming or tennis may be a better fit.

Michael Phelps, who was treated for ADHD as a young child, is the perfect example of this. His mother put him in swimming because his high energy levels were a problem in the classroom. It was a great fit, since the sport kept him

in constant motion.

Many of my patients with bipolar or ADHD have done well with martial arts because the classes have predictable routines and emphasize self control. Plus, the chance to earn belts in advancing colors, achievable for most children willing to practice, provides frequent opportunities for success.

I consider children socially successful if they have three friends and at least one extracurricular activity per week (video games don't count). If your child is not at that level, start looking for ways to add new friends and interests. Often, if you focus on finding an activity first, your child will make friends through the activity. Thus both goals can be accomplished at the same time.

Some children can handle more friends and activities, but taking on too much poses a special risk for children with bipolar when they are having a

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manic episode. Also, overstimulation could serve as a trigger for mania.

Remember the goal is not to have your child be captain of the football team or get the lead in the school play. The goal is to have them feel good about themselves, make friends and have fun. If they can do all three, their bipolar is likely to be much improved.

*BP Magazine - Fall 2009* ■

## **Briefer form of therapy helps substance abuse**

A shorter version of what's known as "integrated group therapy" (IGT) appears better at helping people with bipolar disorder reduce substance abuse than group drug counseling, new research has found.

Researchers from the Harvard Medical School Department of Psychiatry said IGT has previously been found to be effective in reducing substance abuse, but the fact that it requires 20 sessions and highly trained therapists limits its practicality in community treatment programs.

So they compared a shorter, 12-session version of IGT, led by substance use counselors without previous cognitive behavioral training or bipolar disorder experience, to group drug counseling.

They found that people taking part in the shorter IGT program had a greater reduction in substance abuse following the sessions, and had a greater decline in risk of mood episodes during treatment.

The study, which appeared in the journal *Drug and Alcohol Dependence*, was entitled "A 'community-friendly' version of integrated group therapy for patients with bipolar disorder and substance dependence: A randomized controlled trial."

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## **Childhood ADHD impacts clinical outcome in bipolar, study finds**

People with bipolar disorder who also had attention-deficit hyperactivity disorder (ADHD) as children appear to fare worse as adults than those who didn't have ADHD, leading researchers to conclude that it may be a distinct subtype of bipolar disorder.

Swedish researchers studied people with bipolar to determine who had ADHD as a child, who still ADHD symptoms at present and who never had ADHD.

They found those who had ADHD as children had a significantly earlier onset of their first mood episode, had more frequent affective episodes (except manic episodes), and had more interpersonal violence than people without a history of ADHD. They said the differences applied whether or not the ADHD symptoms continued into adulthood.

The study, which appeared in the journal *Acta Psychiatrica Scandinavica*, was entitled "A history of childhood attention-deficit hyperactivity disorder (ADHD) impact clinical outcome in adult bipolar patients regardless of current ADHD."

*BP Magazine - Fall 2009* ■

## **Edward Kennedy a 'true champion' on mental illness**

The U.S. National Alliance on Mental Illness (NAMI) and the American Psychiatric Association (APA) said the death of U.S. Sen. Edward Kennedy is a profound loss for people with mental illnesses and other vulnerable people in America. Kennedy died Aug. 25 of brain

cancer at age 77.

In a statement, NAMI executive director Michael J. Fitzpatrick called the statesman "a true champion for individuals and families affected by serious mental illness."

The APA said that even as he was fighting for his own life, Kennedy "put patients and their care first, and fought for the 46 million Americans who are uninsured."

*BP Magazine - Fall 2009* ■

## **Red flag raised over binge eating by individuals with bipolar disorder**

Binge eating could spell big trouble for people with bipolar disorder, new research suggests.

Researchers from the University of Pisa studied binge eating and its impact on body weight, body image and self-esteem in people with bipolar.

They found that people with bipolar had a significantly higher rate of binge eating than people without bipolar, and that they had a significantly higher body mass index, larger waist circumference and higher blood sugar levels. They concluded that "the disruption of eating behavior may be a pathway to weight gain."

The study, which appeared in the journal *Psychiatry Research*, was entitled "Binge eating, weight gain and psychosocial adjustment in patients with bipolar disorder."

*BP Magazine - Fall 2009* ■



# Great Christmas Gift Habit of Positive Thinking



By Ann Smith

Christmas is a time for giving, and it is a time for kindness. While it's an important time to look outwardly and take care of loved ones and the needy, it's also a time of reflection.

It is at this time that you don't want to miss the forest for the trees. Consider one of the greatest Christmas gifts you can give - yourself. The gift of positive thinking.

## **Bah humbug! Who can be positive at a time like this?**

The economy is in turmoil. The coming year may be worse. Thousands are getting laid off, and it may have already happened to you. Your friends just lost their house. The news all around is doom and gloom. It's just not the time to be positive.

It's true. Times are tough. You may be dealing with unprecedented hardships. Things are often not fair, and you may be under real and tremendous stress.

But, times like these provide a great opportunity for you to develop the habit of positive thinking. If you can learn to do so when the going is tough, then just think how easy it will be to stay positive during good times.

Now, more than ever, is the time to observe things with the glass half full. This kind of thinking will not only help you navigate rough waters, but you can serve as a great example to others.

## **It's easier said than done**

Okay, so if you agree that now may be the time to think a bit more positively, it's easier said than done, right? You're probably thinking - it's easy for you to say, but you are not me or dealing with my stuff!

Stop already. The reality is that positive thinking is a choice, and it is an equal opportunity choice at that. All people, no matter what their circumstances, can choose to be positive.

That is the truth. It is the reality. It can be done. So stop with the excuses.

## **Okay, so what do I need to do?**

The best way to develop the habit of positive thinking is to seek help. That's right. Admit you need some help with this stuff, as life has gotten you a bit down.

For those who believe in God, pray about it. God can, and will, change you from within if you seek His help.

Simply start your day asking for His helping you become more positive in your thoughts, words and actions.

Next, make a commitment. Commit to yourself and to God that you sincerely want to learn to think with a better outlook. Sincerity is key.

While I personally believe that God's help is needed for internal changes, if you are a non-believer, then perhaps you start here.

People can only make true changes if their intent is sincere. Without that, nothing will stick.

Finally, act. Do whatever you can to catch yourself from going down the negativity path throughout the day. Try it for just one day.

If, for example, you are in heavy traffic and are thinking about what a terrible start to the day it is, halt those thoughts immediately.

Instead, go in solution mode. Ask yourself if the traffic will cause you to be late to a meeting? If so, contact the appropriate people to let them know.

Then, make yourself think about the current situation differently. Perhaps this extra time in traffic will provide you some needed quiet time.

Maybe you can further enjoy the audio book you have in the stereo. You can use this time to notice how beautiful the sky is, and stop for a second to enjoy the awe of nature.

If you are still feeling irritation coming on, then breathe deeply. And, tell yourself that you have made a commitment to be positive today, no matter what you face.

Your thoughts are your thoughts, but whatever they are, force yourself to think of the good in the situations that arise during the day. You can do it.

After this first day is over, make a quick list that evening about ways you thought more positively. You are bound to see some situations you handled better than the day before.

## **Play it again, Sam**

How did you learn to walk? Well, you crawled first, right, and then you learned to stand upright. You did it the next day, and the next, eventually learning to move across a room with more confidence and ease.

Yes, repetition works. So commit to being positive for yet another day. Stay focused on it. Course-correct yourself when need be.

Seek advice from others who have a bright outlook. Read some books if necessary. Stick with the course.

Before you know it, you will have put together a string of days in which you have thought more positive things, resulting in your mood being better and in your actions being more effective, flexible and open.

Yeah, buddy, this is great news cause you are in the process of changing. Repetitive actions will help you form a habit, and what better habit can you develop than that of positive thinking.

## **It's in the journey**

Keep in mind that real change requires patience and time. It's a journey. Be fair to yourself. If you misstep, figure out why and keep moving. If you stay committed, and sincere in your goal, you will become more positive. And, the rewards you will reap from that are limitless. So, be good to yourself. Give yourself a gift that truly will keep on giving. And, Merry Christmas.

<http://hubpages.com/hub/Great-Christmas-Gift---Habit-of-Positive-Thinking> ■

# DBSA Calendar of Events

**Please Note:**

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

## December 2009

- **December 9th • 12 Noon**  
Executive Board Meeting
- **December 14th • 6:30-9:00 pm**  
**Christmas Party**  
St. Francis Medical Center - Assisi Room
- **December 16th • 9:00 - 10:00 am and 6:00-7:00 pm**  
**Support Group for Parents & Caregivers of Children with Mental Illness**  
Southeast Missouri Hospital - Room MR-105  
Contact Laura Brown - 573-579-0095

## January 2010

- **January 13th • 12 Noon**  
Executive Board Meeting
- **January 25th • 7:00-9:00 pm**  
**Cape Girardeau Educational Meeting**  
St. Francis Medical Center - Assisi Room  
**Speaker:** Jill Schmidt, president DBSA - SEMO  
**Topic:** Our Impact on Others

## February 2010

- **February 10th • 12 Noon**  
Executive Board Meeting
- **February 22nd • 7:00-9:00 pm**  
**Cape Girardeau Educational Meeting**  
St. Francis Medical Center - Assisi Room  
**Speaker:** Mr. Scott Gibbons, Healthpoint Fitness Jackson  
**Topic:** Exercise for Health

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# The Pendulum

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St. Francis Medical Center  
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**WE NEED YOUR HELP!**

*We all know that money is tight and no one knows it better than the DBSA. You can help us to continue bringing up-to-date information and worth-while speakers to the Educational Meetings by renewing your paid membership or by donation! Effective May 1, 2006.*

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