



Mental Health Parity Legislation Introduced in U.S. Senate

On February 14, 2007 the Mental Health Parity Act of 2007 (S.558) was approved in an 18 to 3 vote in the Senate Health, Education, Labor and Pensions Committee. The new bill was officially introduced in the Senate on Feb. 12, 2007 by U.S. Senators Edward Kennedy (D-Mass.), Pete Domenici (R-N.M.) and Mike Enzi (R-Wyo.), who announced this breakthrough legislation that will ensure greater health insurance parity for persons with mental illness. The new policy would build on the landmark 1996 Mental Health Parity Act and advances the cause of stopping insurance discrimination against persons with mental disorders by closing loopholes in the existing federal law. This represents a culmination of more than a year's negotiations involving lawmakers, mental health, insurance and business organizations to craft compromise legislation.

The bill does not mandate group insurance plans to provide any mental health coverage, but it does require health insurance plans that offer mental health coverage to provide that coverage on par with financial and treatment coverage offered for other physical illnesses. The measure does include a small business exemption for companies with fewer than 50 employees, and also includes a cost exemption for all businesses.

"One in five Americans will suffer from mental illness this year. But unlike in

the past, we know today that mental illnesses are treatable – more treatable than many physical illnesses. Yet only one third of those facing mental illnesses will receive treatment," Senator Kennedy said. "The bill we introduce will begin to right these wrongs."

Senator Domenici added "This is a very special and joyous occasion, to finally be ready to tell the American people, and then the United States Senate, and then hopefully the U.S. House and the President, that we have a bill that's a winner for millions of Americans, millions of people that suffer from mental illness. Simply put, the bill will provide parity between mental health coverage and medical and surgical coverage. No longer will a more restrictive standard be applied to mental health coverage and another more lenient standard be applied to medical and surgical coverage. This a matter of fairness and I am genuinely excited that we may finally make progress to build on the 1996 law and offering this much needed help to those mentally ill and those who care for them."

The legislation would provide mental health parity for about 113 million Americans who work for employers with 50 or more employees. It would ensure that health plans do not place more restrictive conditions on mental health coverage than on medical or surgical coverage. Thus the bill would require parity for deductible, co-payments, annual and lifetime limits and the number of covered hospital days and visits and gives full parity without limiting such protections to a narrow list of diagnoses.

The 1996 law began the parity process, and helped raise greater public awareness to the plight of those with mental illnesses and the societal stigma often associated with those illnesses. Today, about 26 percent of American adults, or nearly 58 million people, suffer from a diagnosable mental disorder.

National Mental Health Facts

It is estimated that during a 1-year period, 22 to 23 percent of the U.S. adult population—or 44 million people—have diagnosable mental disorders.

The National Institute of Mental Health (NIMH) estimates that one in five children and adolescents may have a mental health disorder.

Approximately 82 million self-insured and 31 million insured employees will receive mental health parity under the new bill.

Approximately 98% of workers with employer sponsored health insurance have coverage for mental health care.

Approximately 14-20% of group health plan participants use their mental health coverage.

Information for this article was derived from an article by Klaus Marre published in "The Hill" Newspaper, from a piece on the subject in the current *American Foundation for Suicide Prevention* newsletter, and a February 12, 2007 Kennedy, Domenici, and Enzi press release.

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THIS ISSUE OF THE DBSA TAMPA BAY NEWSLETTER IS MADE POSSIBLE BY THE MEMBERS OF THIS ASSOCIATION AND BY OUTSIDE DONATIONS.

A Message From Our President

As the newly elected President, I would like to thank the new 2007 Board of Directors for their votes. Neil Bush, the very recent past chair, is going to be a hard act to follow. Neil has demonstrated four years of dedication, passion and leadership as DBSA Tampa Bay's President. I have truly admired his organizational skills and business savvy. He truly is a brilliant man.

I'd like to welcome the newly elected member to the board, Amy Gallastegui. Kitty Brogan and Neil Bush both were re-elected.

I'd like to thank Jane Trilling, Dave Cardena and Dr. L. Cooper for their dedication and hard work they have given to DBSA. I can speak for everyone when I say that we will miss you very much.

Please note the changes listed for support groups in your area.

Mark your calendars to attend the workshop series throughout the rest of the year.

I'd like to thank everyone that makes it possible for this newsletter to continue to reach DBSA members and others across our nation.

Thank You,
René Anderson
President

Mothers Day May 13th

My mother was the most beautiful woman I ever saw. All I am I owe to my mother. I attribute all my success in life to the moral, intellectual and physical education I received from her.

~ George Washington

Visit the
DBSA Tampa Bay Website:
www.dbsatampabay.org

**DEPRESSION AND BIPOLAR
SUPPORT ALLIANCE TAMPA BAY.**
P.O. Box 340572
Tampa, FL 33694
Tel: (813) 878-2906
You can e-mail us at:
info@dbsatampabay.org

THE BLANCHARD EDUCATIONAL SERIES 2007

Our lectures, seminars and workshops are held at 7:00 PM at St. Joseph's Hospital, Medical Arts Building, unless otherwise noted.
3001 W. Dr. Martin Luther King Jr Blvd
These events are free and open to the public.
There is free parking north of the building.

May 19, 2007

Parents Advocacy Training

10:00am to 3:00 pm

Family Mental Health Institute
University of South Florida, 13301 Bruce B. Downs
Lunch will be served

August, 2007

Making "AMENDS"

Medication, Exercise, Nutrition,
Discussion, Socialization

7:00 pm to 8:30 pm

Food will be served

November 23, 2007

Ask a Mental Health Professional

7:00 pm to 8:30 pm

Food will be served.

All groups & lectures may change without notice.
Please RSVP with email info@dbsatampabay.org

DBSA Tampa Bay 2007 Board Elections

The DBSA Tampa Bay Annual Meeting was held on Tuesday, March 13, 2007. The Board of Directors elected the following 2007 Executive Officers.

René Anderson	President
Neil Bush	1 st Vice President
Mary Watkins	2 nd Vice President
Carol Yaros	Treasurer
Sherri Armstron	Secretary

The next DBSA Tampa Bay Board Meeting will be Tuesday, April 24, 2007 at St. Joseph's Hospital, Medical Arts Building. Current dues-paying members are welcome to attend meetings.

DBSA Tampa Bay Support Group Changes

FMHI

Beginning Tuesday, April 3, 2007, this support group meeting on Wednesday will begin meeting at the following new location and date.

Tuesday 7:00 pm

University of South Florida
USF Department of Psychiatry and
Behavioral Medicine
3515 East Fletcher Avenue

Directions: Traveling east on Fletcher Avenue, turn right on Magnolia Drive. The Psychiatry Center is the first building on the left.

Our greatest glory is not in never
falling but in rising every time we fall.
~ Confucius

St. Josephs Hospital

Due to hospital construction, this group has been moved to the Medical Arts Building (from Conference Room C). The group will continue to meet on Wednesday at 7:00 pm.

May is Mental Health Month

Sponsored by Mental Health America, the theme for this year's observance is MIND Your Health. For more than fifty years, our country has celebrated May as Mental Health Month to raise awareness about mental illnesses and the importance of mental wellness for all.

For more information, visit
www.mentalhealthamerica.net

Bipolar Risk Factors Identified In Patients With Major Depression

By Rich Daly, *Psychiatry News* August 4, 2006, Vol 41, No 15, p 21

Worrying that other people are being unfriendly is the leading indicator of bipolar disorder among patients misdiagnosed with major depressive disorder, researchers find.

Five significant predictors of bipolar disorder (BD) risk—including comorbid anxiety and a family history of BD—were found among patients treated for major depressive disorder (MDD) though they may not have had MDD, according to a recent study.

The study of predictors of BD risk among patients treated for MDD found that the five leading predictors for BD were a belief that “people were unfriendly,” comorbid anxiety, depression diagnosis within the preceding five years, family history of BD, and past legal problems. The leading indicator—that “people were unfriendly”—was found in more than one-third of respondents who screened positive for BD.

“We were surprised by that, but it makes sense because bipolar disorder patients are often irritable and project unfriendly feelings onto those around them,” said David Kemp, M.D., one of the study investigators. He discussed the findings at a poster presentation at APA’s 2006 annual meeting in Toronto in May.

That feeling also could stem from a rejection anxiety, the investigators noted.

The study found that 100 percent of participants who endorsed all five of the predictor variables screened positive for BD on the Mood Disorders Questionnaire. The portion of the sample of people with BD screening positive dropped to 25 percent when they acknowledged having four of the predictor variables. The BD rate was 41 percent, however, when patients had three of the risk factors—likely due to the fluctuating sample size for each risk factor group. Only 2.4 percent of patients with no risk factors screened positive for BD.

The results stemmed from self-reported patient information and self-screening by 602 patients over age 18 in private practice and clinic settings who had at least one antidepressant medication failure during a current episode of MDD and had been in treatment for at least the three preceding months. Patients self-reported their demographics, family history, comorbid health

status, alcohol or drug use, legal problems, and current depression symptoms through the Centers for Epidemiological Studies-Depression (CES-D) scale. The patients then self-screened for BD by completing the Mood Disorders Questionnaire. Of the 602 study participants, 112, or 18.6%, screened positive for BD.

None of the study participants had been diagnosed with BD, OCD, schizophrenia, or schizoaffective disorder.

The study was undertaken in response to previous research that found that a substantial subset of patients who are diagnosed with unipolar major depression and do not show an adequate response to antidepressants actually had BD. Patients with unrecognized BD are misdiagnosed and incorrectly treated for an average of 10 years, the research found, which results in significant adverse personal, social, and work-related consequences.

Although 1 in 5 depression patients with one or more antidepressant medication failures screened positive for BD, there was no correlation between the number of medication failures and the likelihood that the individual had BD.

“We were thinking that more failures on antidepressants would make bipolar disorder more likely, but we didn’t find that,” Kemp told *Psychiatric News*.

Previous research has suggested that despite the introduction of new classes of antidepressants and novel approaches to

managing depression, at least 30 percent of patients with depression fail to respond adequately to antidepressant therapy, and remission rates in controlled clinical trials remain below 50 percent.

Participants in this recent study were taking an average of three antidepressants for their current episode of depression. More than 60 percent were found to be severely depressed at the time of the study, based on a CES-D score of at least 22.

Although the Mood Disorders Questionnaire BD screener is rarely administered because of time concerns, clinicians should more fully assess for BD in any patient with a depression diagnosis who endorses the risk factors identified in this study, Kemp said. He recommended routinely assessing for the risk factors as part of an initial diagnostic evaluation.

Clinicians also should talk to the patient’s family about signs of mania or hypomania. Kemp noted that clinicians who opt to use the Mood Disorders Questionnaire also should be aware that it is considered less sensitive for related conditions—such as bipolar II disorder—so it may underestimate the presence of BD.

The finding that comorbid anxiety predicts BD risk is consistent with recent findings that suggest that more than 50 percent of bipolar patients experience at least one comorbid anxiety disorder.

Funding for the study was provided by GlaxoSmithKline.

Medication and the Munchies

Antipsychotic drugs have alleviated the debilitating symptoms of thousands of patients with schizophrenia and bipolar disorder, but often at a high price. These drugs can also trigger excessive weight gain, leading to life-threatening complications such as diabetes or heart disease. Now scientists at Johns Hopkins University have uncovered the mechanism by which these drugs stimulate the appetite—a finding that could lead to new agents without the side effect of constant hunger. When clozapine, a powerful antipsychotic, was administered to mice, the animals experienced a spike of the appetite-stimulating enzyme AMPK. Blocking a receptor for histamine also

caused a boost in AMPK similar to the effects of clozapine. Histamine, well known for causing allergy symptoms, has been long suspected to play a role in weight control, but the mechanism has been unknown. By blocking histamine receptors, clozapine and other antipsychotics prevent cells from receiving the body’s signal to turn off AMPK production. As a result, AMPK builds up in the hypothalamus and continues to stimulate appetite, even when enough food has been consumed. Pharmaceutical companies may be able to screen out antipsychotic drugs with antihistamine properties and thereby avoid the side effects of weight gain.

DBSA Tampa Bay Support Group GUIDELINES

Welcome to Depression and Bipolar Support Alliance Tampa Bay. DBSA Tampa Bay brings together people with similar problems to support each other through sharing and caring, giving us all more resources to cope, even though no one has all the answers.

We share our feelings, experiences, and coping strategies. We do not recommend or prescribe medications; we only share experiences. We do not mention medications by name – we may refer to the class of medications, such as mood stabilizers, antidepressants, etc. We do not mention doctors' names during our groups.

In order for people to feel safe to participate, anything anyone reveals must be kept confidential. If an individual expresses potential harm to him/herself or to others, or the individual's behavior causes excessive discomfort to the other group members, the facilitator may have to take the issue outside of the group for consultation.

We respect each individual's choice to express their spiritual lives and, therefore, we keep such discussions to a minimum.

We care for each other by responding compassionately, not judgmentally, recognizing that each person's problem is unique. We show how we care by listening with empathy, speaking in turn and not monopolizing.

Our support groups are not therapy groups and facilitators are not therapists. Facilitators are volunteer members who have ongoing training in facilitating.

Meetings are free, however, donations are welcome to help cover the cost of our newsletter, literature, website and other services.

If you would like to become a member of DBSA Tampa Bay, membership forms are available. Remember, each support group is different and we encourage you to try other groups.

DBSA Tampa Bay WEBSITE:

www.dbsatampabay.org

The place to learn more!
Research back issues of our newsletter.
Discover documents of interest.
Link to other resources.

The Hidden Signs of Depression in Women

Most women are aware of depression's hallmarks: chronic sadness or lack of interest in activities that used to bring pleasure. These symptoms are hard to miss. But what many women, and even some doctors, may not realize is that they may have depression and not feel sadness per se, says Carlos Zarate, M.D. chief of the Mood Disorders Research Unit at the National Institute of Mental Health in Bethesda, Maryland. "Many people with depression complain of headache, stiff neck, backache, fatigue, bowel problems and changes in appetite, and in some people, those issues are the primary complaints," Dr. Zarate says. "It affects the whole body, from your immune system to your pain tolerance."

Several years ago, an international consortium of researchers analyzed data from the World Health Organization survey of nearly 26,000 people who had recently visited their primary care physicians. Of the people who met the diagnostic criteria for depression, 69 percent had reported only physical ailments to their doctors and 11 percent denied having any psychological symptoms even when asked about them. "That's what makes this issue so tricky," Dr. Zarate says. "I see lots of women who think they're just stressed out, overworked and tired, when they're actually depressed." Depression's physical side is still underappreciated by patients and doctors alike, making it one of the main reasons that half of those with the illness remain undiagnosed. What's more, when depression goes untreated, it can lead to a whole host of other serious long-term health problems.

Not everyone with depression experiences physical symptoms. But of the 12 million women who are laid low by the illness every year, about two thirds have some sort of pain, says Maurice Ohayon, M.D., professor of psychiatry at Stanford University in California. "We've found that depressed people with chronic pain have more severe fatigue, insomnia and weight gain than those who simply have low mood." Dr. Ohayon says. Moreover, their depression lasts longer.

It can be difficult to tell which came first, the depression or the pain, but most doctors now believe it can work both ways, says Madhukar Trivedi, M.D., director of the Mood Disorders Research Program and Clinic at the University of Texas Southwest-

ern Medical Center in Dallas. Although researchers are still sorting out exactly how depression causes physical symptoms, the most likely explanation has to do with altered levels of serotonin and norepinephrine, two neurotransmitters in the brain. "These same chemicals are in the fibers that go from the brain to the spinal cord, and they actually moderate pain pathways," Dr. Trivedi says. But when levels of serotonin and norepinephrine are low, as they are in people with depression, pain can be heightened.

The first step to getting better is obtaining the right diagnosis. Complaints of headaches or back pain can steer even experienced doctors away from considering depression, so you should raise the possibility if your ailments last longer than a few weeks and there's no other explanation. Proper treatment will keep you feeling healthy and happy, both emotionally and physically.

Six Long-term health risks associated with untreated depression

- **Your odds of gum disease are higher.** Depression may trigger your white blood cells into attacking healthy gum tissue, contributing to tooth loss.
- **Your chance for diabetes goes up.** Sufferers are prone to hormonal changes that cause higher levels of insulin and triglycerides.
- **Your bones may be more fragile.** Depression can speed the breakdown of bone, nearly doubling your chances of developing osteoporosis.
- **You're at increased risk for heart disease.** Depression keeps levels of stress hormones high, which raises heart rate and blood pressure.
- **You're at greater risk for pain.** People with depression are two to three times more likely to have chronic pain syndrome such as migraines or back problems.
- **You're more likely to get sick.** Depression causes an imbalance in the immune system, which ups the odds of getting infections and makes them last longer.

Excerpted from self.com article feb2007

DBSA Tampa Bay
is an all volunteer non-profit
organization.

Bipolar Manifestation

A patient's perspective...

By John Williams

Recent studies at Weill Medical College of Cornell University show that one in five people suffer from some form of depression and an undetermined number of those possibly suffer from bipolar disorder, suffering manic episodes in addition to depression.

That means that the majority of people who suffer from bipolar disorder live untreated. They live in denial of the fact that they even have a condition that can improve with treatment. A number of them self medicate with illegal drugs and alcohol to relieve their suffering, which in turn can cause more problems. They know they have extreme depression but it is countered in some cases by extreme euphoria and sometimes happy manic experiences, so they feel that they are sometimes sad or depressed but otherwise ok, as it has not caused them any major long term depression. Family, friends, and associates know they are not feeling or behaving normal but they (the bipolar person) are not aware of it and/or refuse to recognize its existence.

Sadness and excited feelings are always part of normal human emotions and usually don't continue long term, cause major issues, or psychosis. People who suffer from bipolar disorder on the other hand can be unaware of their condition. They have a difficult time in life as they tend to blame their sadness or mania on singular events, such as the holidays or loss of a job or a loved one rather than having an understanding of how the disorder affects them. Depending on the level of symptoms, seri-

ous trouble is avoided but they end up having a very intense and stressful life. If they aren't so lucky it could lead to incarceration, broken relationships, disruptive behavior, serious injuries or even suicide.

Without a diagnosis, they cannot see the big picture and are not being helped through proper treatment. With treatment begins the basic understanding of the affective disorders including bipolar disorder, which is characterized by greatly exaggerated emotional reactions and mood swings from high elation to deep depression, as well as anxiety and major depression. Many people who suffer with bipolar disorder are famous or extremely high achievers in life. They are propelled because of its extremes to the heights of creativity and success, usually not without having symptoms of the disorder affect them negatively in some way. My point from a patient's perspective is that having a better understanding of this disorder and finding treatment, in most cases, will lead to a better quality of life for the millions of individuals that it affects.

Life is a message. Listen to it.
Life is a treatment. Accept it.
Life is a foundation. Start it.
Life is education. Carry on.
Life is a belief. Trust it.
Life is love. Think about it
Life is a gift. Accept it.
Life is a work. Use it.
Life is an adventure. Dare it.

For Those of You Taking Lithium

Replacing fluids and obtaining enough dietary salt are essential for anyone taking lithium, particularly in hot weather. Heavy sweating may raise lithium levels, as may low-sodium diets. If you are on a low-sodium diet, check with your doctor regarding toxicity. Symptoms of toxicity start with increased shaking, nausea, and diarrhea. The kidneys handle lithium and sodium the same way, and losing fluids and sodium results in the kidneys retaining sodium and increased lithium levels.

Taking over-the-counter medications concurrently with lithium can be dangerous. In particular, medications such as ibuprofen (Advil, Motrin, Nuprin, etc.) and other nonsteroidal anti-inflammatory drugs (NSAIDs) such as naproxyn, may increase blood lithium levels. Always check with your doctor or pharmacist before taking any medications while on lithium. Having regular blood lithium levels checked is important to avoid toxicity.

Educational Resources

American Psychiatric Association
888-357-7924 • www.psych.org

American Psychological Association
800-964-2000 • www.apa.org

Advocacy Center
800-342-0823

www.advocacycenter.com

Child & Adolescent Bipolar Foundation
847-256-8525 • www.bpkids.org

National Alliance for the Mentally Ill
800-950-6264 • www.nami.org

National Association for the Dually Diagnosed
800-331-5362

DBSA (National)
800-826-3632

www.DBSAlliance.org

National Family Caregivers Association
301-942-6430

National Foundation for Depressive Illnesses
800-248-4344

National Institute of Mental Health
800-421-4211 • www.nimh.nih.gov

Panic Disorder Line:

800-64PANIC(7-2642)

Anxiety Disorder Line:

800-888-8-ANXIETY(26-9438)

National Mental Health Association
800-989-6642 • www.nmha.org
Confidential depression screening:
www.depression-screening.org

Obsessive-Compulsive Foundation
Ocfoundation.org

Compulsive hair pulling
StopPulling.com

Compulsive skin picking
StopPicking.com

Tourette Syndrome Association
Tsa-usa.org

We Need Your Help

We are looking for sponsorship of our quarterly newsletter.

Each issue costs our organization \$1000 and we publish 4 issues per year. If you can make any donation toward the cost of an issue or sponsor an entire issue,

Please call Neil Bush at
813-878-2906
and leave a message.

Thank You!

We look forward to hearing from you.

Extreme Irritability: Is It Childhood Bipolar Disorder? Brain's Electrical Signals Provide Clues

NIMH Press Release February 1, 2007

Results of a new study may help improve the diagnosis and treatment of two debilitating childhood mental disorders — pediatric bipolar disorder (BD) and a syndrome called severe mood dysregulation (SMD). When the brain's electrical signals were measured during mildly frustrating situations, researchers from the National Institute of Mental Health (NIMH), found a very different pattern in children with SMD, compared with children who had BD. The results indicate that different brain mechanisms may lead to irritability in children with SMD, suggesting that they may have an illness other than BD and may require different treatments.

“These aren't children with the occasional bad moods you see in most kids. They're typically very ill, with symptoms that interfere with their lives in major ways. Establishing clear diagnostic criteria is an essential step toward making sure they get the help they need,” said NIMH Director Thomas R. Insel, M.D.

Children have a comparatively low rate of BD, but the rate increases with age, to approximately 1 percent among adolescents. About 3 percent of pre-adolescent and adolescent youth are estimated to have SMD. Mood-stabilizing and antipsychotic medications are used to treat children with BD, although the data on their effectiveness are limited and several studies are underway. Since SMD was only recently defined, there are no systematic studies on its treatment, and children with SMD are often treated as if they have BD.

Defining pediatric BD is a major issue in child psychiatry, because the disorder tends to be severe in this age group and the rate of diagnosed cases is rising. Until recent years, most studies of BD were conducted in adults. Some researchers maintain that pediatric BD should be defined more broadly to include children with SMD, an assertion countered by the new finding. Results of the study were published in the February 2007 issue of the *American Journal of Psychiatry*.

The classic definition of BD includes extreme, sustained mood swings that range from over-excited, elated moods and irritability — the manic phase of the disorder — to depression. In contrast, children with SMD are extremely irritable and hyperactive, but do not have clear-cut manic episodes.

One component of irritability is the tendency to get acutely frustrated when a goal is not met. Thus, through electroencephalograms (EEGs), the researchers could observe the brain's electrical signals that occurred during frustration while children with either disorder performed simple tasks.

The new study shows that clinicians some day could use biological measurements, such as EEGs, to help make psychiatric diagnoses, in combination with clinical symptoms. Currently, clinicians diagnose mental illnesses based on symptoms alone. The difficulty of diagnosing BD in children is compounded by the frequent co-occurrence of one or more other mental disorders.

“We're approaching the day when we'll be able to use neuroscience techniques to improve psychiatric diagnoses. Pediatric BD has some of the most pressing needs in this regard, because of its severity and because of questions about how to best make the diagnosis,” said senior author Ellen Leibenluft, M.D., Chief of the Unit on Bipolar Spectrum Disorders in the Emotion and Development Branch of the NIMH Mood and Anxiety Disorders Research Program.

In this study, scientists obtained EEGs of 35 children with classic BD, 21 children with SMD, and 26 healthy children (aver-

age age 12 to 13) while they performed a task repeatedly; each time they did the task, they won or lost 10 cents. The task was frustrating because the children often lost money.

The researchers found that while both the children with BD and those with SMD became more frustrated than did healthy children performing the same task, the brain mechanisms associated with their frustration differed. Children with BD had an abnormality in the brain's P3 electrical signals, which measure ability to purposefully direct attention, but children with SMD had abnormalities in N1 signals, which occur when a stimulus grabs someone's attention. Both abnormalities suggest deficits in the brain's attention-related activity, but in different phases of that activity.

“If future research indicates that BD and SMD are two separate disorders, this could guide parents and physicians toward the right treatments,” said first author Brendan Rich, Ph.D., of the NIMH Unit on Bipolar Spectrum Disorders. “A good example is that medication prescribed for symptoms seen in SMD, such as stimulant medication, might be inappropriate for a child with classically defined bipolar disorder,” he said.

NIMH scientists Mariana Schmajuk, B.S., and Daniel Pine, M.D., also contributed to the research, as did University of Maryland scientists Koraly E. Perez-Edgar, Ph.D., (*currently at George Mason University*) and Nathan A. Fox, Ph.D.

Trust yourself. Create the kind of self that you will be happy to live with all your life. Make the most of yourself by fanning the tiny, inner sparks of possibility into flames of achievement.

~ Golda Meir

Thank you!

To all of you who have paid your dues, subscribed to our newsletter, or made donations to our organization, we truly thank you. Without this monetary support, we would not be able to provide educational materials, literature, newsletters and a website to those that need our help.

Through educating and enlightening the public, it is hoped that the stigma of mental illness will someday be eliminated.

**NEVER ADJUST OR STOP TAKING
YOUR MEDICATIONS
WITHOUT
CONSULTING YOUR DOCTOR.
TAKE YOUR MEDICATIONS
AS PRESCRIBED.**

Yale Findings Hold Promise For Stopping Progression of Bipolar Disorder

Changes in the brain that are important indicators of bipolar disorder are not prominent until young adulthood and are reduced in persons taking mood-stabilizing medications, Yale School of Medicine researchers report this month in *Biological Psychiatry*. The researchers used magnetic resonance imaging [MRI] to measure a part of the brain that regulates emotions, the ventral prefrontal cortex, that lies above the eyes. The changes in persons with bipolar disorder were not prominent until young adulthood, suggesting that the illness progresses during the teenage years. Bipolar disorder is also known as manic-depressive illness.

"The brain changes were diminished in persons with bipolar disorder who were taking mood-stabilizing medications," said Hilary Blumberg, M.D., associate professor in the Department of Psychiatry and director of Yale's Mood Disorders Research Program. "This brings hope that it may someday be possible to halt the progression of the disorder."

Blumberg added, "Research to understand bipolar disorder in youths is especially important because of their high risk for suicide."

Source: The research was conducted at Yale in collaboration with co-author John Krystal, M.D., Ravi Bansal, Andr es Martin, M.D., James Dziura, Kathleen Durkin, Laura Martin, Elizabeth Gerard, M.D., Dennis Charney, M.D., and Bradley Peterson, M.D. *Biological Psychiatry*: Published online January 20, 2006.

As seen in *Dallas DBSA* May 2006

Tai Chi may help reduce tension headaches

A California study says Tai Chi may provide significant benefits to adults suffering tension headaches. The study, conducted by the University of California, Los Angeles, found that patients who participated in a 15-week Tai Chi program reported less headache pain, increased energy, emotional well-being, social functioning and improved mental health, the university said in a release. Researchers said Tai Chi's "emphasis on relaxation, breathing and coordination may address stress, the underlying cause of the pain associated with tension headaches." The research appears in the March issue of the journal *Evidence-based Complementary and Alternative Medicine*, also known as eCAM.

Thank You to Past President Neil Bush and Newsletter Editor Jane Trilling, R.N.

From the Board of Directors, DBSA Tampa Bay.

The DBSA Tampa Bay would like to acknowledge two very special people who have given of their time and energy to the organization. We are indebted to them for all that they have done to further the knowledge and support of our cause.

Jane Trilling, R.N. has served on the Board of Directors of the DBSA Tampa Bay and has been editor of the newsletter for 10 years. She is stepping down from these two positions and we give a heartfelt thank you for an impressive job well done.

Neil Bush became involved in June 1998 as a Facilitator at St. Joseph Hospital and was appointed to the board in June 2000 as a liaison to the President. He served as President from March 2002 until March 2007. He will remain a valued board member and advisor and was elected as 1st Vice President for 2007. Neil will also continue as President of the statewide DBSA organization and Chairman of the State Mental Health Planning Council of Florida. Neil's dynamic leadership has promoted the cause of mental health locally and throughout the state to an incalculable degree. Thank you for all that you have done.

Feel free to reprint our articles or our entire newsletter.

However, please acknowledge our publication, date, author, and source.

OUR MISSION

The Depression and Bipolar Support Alliance Tampa Bay's mission is to provide education, self-help, fellowship and other direct services to people with Affective Disorders and to their relatives and friends.

This organization is a non-profit, 501(c)(3) organization operated by its members. DBSA Tampa Bay is affiliated with the national organization now called DBSA. Contributions are non-taxable as provided by law.

2007 MEMBERSHIP APPLICATION

Name _____

Address _____

City/State/Zip _____

Phone _____

How did you hear about our organization? _____

Confidentiality is very important to us. Our membership list stays within DBSA Tampa Bay only and will not be sent to any other organizations.

Please print clearly and mail to DBSA Tampa Bay, PO Box 340572, Tampa, FL 33694

MEMBERSHIP (includes newsletter)

\$20⁰⁰ Individual or Support Person

\$30⁰⁰ Family/Household

\$100⁰⁰ Individual Lifetime

NEWSLETTER

\$10⁰⁰ Newsletter only / year

\$24⁰⁰ Priority Packet / year (\$6/issue)

\$ _____ DONATION

\$ _____ TOTAL

Depression and Bipolar Support Alliance Tampa Bay SUPPORT GROUPS

PLEASE BE ON TIME

... in consideration of others. Thank you.
Times and locations may change due to circumstances beyond our control.

Carrollwood/Northdale:

Thursday 7:00 PM
Northdale Recreation Center
15550 Spring Pine Dr.
From Dale Mabry turn onto
Northdale; 2nd left onto Spring Pine.

FMHI: Tuesday 7:00 PM

University of South Florida
USF Department of Psychiatry and
Behavioral Medicine.
3515 East Fletcher Ave.
Directions: Traveling east on Fletcher
Ave, turn right on Magnolia Drive.
The Psychiatry Center is the first
building on the left.

St. Josephs Hospital:

Wednesday 7:00 PM
Grupo en Espanol y en Ingles
3001 W. Dr. Martin L. King Jr Blvd,
Tampa, Medical Arts Building.

See Our Website at:
www.dbsatampabay.org

Tampa Bay Area Crisis Center Telephone Numbers

Hernando County (352) 596-4306
Hillsborough County 211
Manatee County (941) 741-3117
Pasco County (727) 849-9988
Pinellas County 211

National Suicide Hotline:
1-800-SUICIDE

St. Petersburg: Monday 7:00 PM

Lutheran Church of the Cross
4545 Chancelor St., NE
Directions: Traveling west on 62nd Ave
N. Turn right on Bayou Grande Blvd
NE. Turn left on Shore Acres Blvd
NE. Turn right on Chancellor St NE.

James A. Haley V.A. Hospital:

Saturday 7:00 PM
13000 Bruce B. Downs., C104 West

Zephyrhills: Monday 7:00 PM

Florida Hospital (formerly EPMC)
7050 Gall Blvd. (Us Hwy 301)
Speech Therapy Room
near the Wellness Center

Children & Adolescents and their Parents & Families

Jimmie B. Keel Regional Library
2902 W. Bearss Avenue
1st and 3rd Thurs: 7:00 to 8:30 pm

Multiple Copies?

DBSA Tampa Bay members, affiliates
and supporters may order multiple
copies of our newsletter via Priority Mail
for \$24/year (4 issues). A packet holds
about 25 newsletters.

Would You Like To Reach Us?

Call 813-878-2906.
or you can also e-mail us at:
info@dbsatampabay.org.

Would you like to become a member of the DBSA Tampa Bay?

Would you like to receive our newsletter? Please
refer to the application on page 7. We also
appreciate any donations which help to defray
the cost of our services.

Thank You.

DBSA Tampa Bay

P.O. Box 340572, Tampa, FL 33694

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Michael F. Sheehan, M.D.

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May is Mental Health Month

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