

## Bipolar Disorder and Anxiety

*From a lecture given by Dr. David Sheehan, MD on October 10, 2006*

*Dr. David Sheehan is the Professor of Psychiatry and Director of Psychiatric Research at the University of South Florida Institute for Research in Psychiatry. Dr. Sheehan has written over 200 publications including the bestseller, "The Anxiety Disease".*

Bipolar disorder is more complicated than previously thought. There are now believed to be four, not two, prongs of bipolar disorder; irritability, anxiety, mania and depression. Irritability and anxiety are the most neglected aspects of the disease as they are infrequently studied and discussed. An estimated 50-60% of patients experience prominent anxiety with bipolar disorder. Many patients suffering from treatment resistant anxiety actually have undiagnosed bipolar disorder.

The neglect of the anxiety component stems from the assumption that the medications used to treat mania and depression would treat anxiety as well. It is now known that some are effective in the treatment of mania, some in depression and some in anxiety. The medications however are not interchangeable.

Medications used in the long term treatment of bipolar disorder are often not effective at treating acute mania or acute depression. Often two to three

different medications are required to control bipolar disorder. The best anti-irritability drugs for bipolar disorder are the antipsychotic medications Lithium and Depakote, but they only work in 60-65% of patients.

Medications classified as antidepressants have minimal differences and bind to similar receptors. Whereas, antipsychotic medications are lumped together in one category, but are very different from one another. They share a common dopamine thread, but bind to different receptors.

Dr. Sheehan and the USF Institute for Research in Psychiatry, along with the Southwest Medical Center at the University of Texas and the University of Cincinnati, screened 1000 patients and chose 186 patients to evaluate and compare anxiety, general anxiety disorder and panic disorder concurrent with bipolar disorder. This study produced the richest and most intact data set collected on bipolar disorder. The study, funded by Risperdal, an antipsychotic medication effective in the treatment of bipolar mania, hypothesized that Risperdal would work equally as well for anxiety as well as mania.

To the researchers' astonishment, Risperdal was no greater than the placebo. In some cases, it was even worse than the placebo. Of patients who improved or declined, the results were split evenly between Risperdal and the placebo. A new study will be

conducted in January 2007 to evaluate Depakote and Seroquel as related to bipolar disorder and anxiety.

At this time, there is no scientific data to utilize to determine which medications work best to treat the various combinations of bipolar disorder with mania, depression, anxiety and irritability. Doctors are currently working under trial and error with medications and therapy to treat bipolar disorder. Dr. Sheehan believes that bipolar disorder is probably not one disorder, but perhaps twenty to thirty different disorders with different genetic drivers. He hopes for future blood testing to determine which variant of the disorder a patient has and the appropriate treatment.

Dr. Sheehan has developed an irritability scale that measures the kinds and levels of irritability experienced. Drug companies are now using this scale to assist with the treatment of irritability and other diagnoses. He has also developed structured diagnostic interviews to categorize symptoms, using lay language, into proper disorders according to the with DSM-IV. The interview program, M.I.N.I., (Mini International NeuroPsychiatric Interview) strengthens the ability to diagnose and pinpoint disorders with increased accuracy. The interview has been translated into 43 languages covering approximately 70% of the world population.

*Reported by Jennifer Shields*

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THIS ISSUE OF THE DBSA TAMPA BAY NEWSLETTER IS MADE POSSIBLE BY A GENEROUS GRANT FROM ELI LILLY AND COMPANY

## *A Message From Our President*

I'd like to start out by saying thank you to the supporters of the DBSA newsletter.

The newsletter is a product of your continued dedication, encouragement, patience and financial contributions. I would also like to extend my sincere thanks to the new newsletter team for working hard to get the newsletter back on track in spite of their extremely busy schedules.

The DBSA 2007 National Conference: Making the Recovery Connection, is scheduled for August 10, 2007 through August 12, 2007 at the Buena Vista Palace Hotel & Spa in Orlando Florida. If you have not already registered and are interested in attending, please make your plans today. For registration form and more information please visit [www.dbsalliance.org](http://www.dbsalliance.org).

DBSA Tampa Bay hosted a facilitators training in April 2007. We had a great turn out and good food. Facilitators are the glue that holds the support groups together. If you know anyone who might be interested in becoming a support group facilitator please call 813-878-2906 or email [info@dbsatampabay.org](mailto:info@dbsatampabay.org). Our facilitators in the Tampa, St. Petersburg & Zephyrhills areas are phenomenal, and I'd like to encourage you and others around the state to keep up the wonderful work that you are doing.

Thank You,  
*René Anderson*  
President

There is only one of you in all time.

~*Martha Graham*

**Visit the  
DBSA Tampa Bay Website:  
[www.dbsatampabay.org](http://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](mailto: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.

August 25, 2007

**Making "AMENDS"**  
**Medication, Exercise, Nutrition,  
Discussion, Socialization**  
**10:00 am to 1:00 pm**  
Lunch will be served

November 2007

**Ask a Mental Health Professional**  
**7:00pm to 8:30 pm**  
Food will be served

All groups & lectures may change without notice.  
Please RSVP with email [info@dbsatampabay.org](mailto:info@dbsatampabay.org)

### **Educational Campaign Targets Depression Misconceptions**

Frustrated and concerned by misconceptions that trivialize depression as "just the blues" or dismiss it entirely as an "imaginary disease," seven prominent physician, patient, and civic nonprofit organizations in the United States have joined together to launch a public education campaign to tell Americans the truth about depression.

The Depression Is Real Coalition seeks to educate Americans that depression is a serious debilitating disease that can be fatal if left untreated and to provide hope for recovery to the nearly 19 million Americans who suffer from depression each year, says NAMI (U.S. National Alliance on Mental Illness).

The public education campaign is sponsored by the American Psychiatric Foundation (APF), the Depression and Bipolar Support Alliance (DBSA), the League of United Latin American Citizens, NAMI, the National Medical Association, Mental Health America, and the National Urban League, and is made possible through the support of Wyeth.

"Our research shows that many Americans don't realize that depression is a biologically based disease. In fact, a third of all Americans believe that mental illnesses like depression are caused by emotional or personal weaknesses, and almost that number think they are caused by old age alone," says Altha J. Stewart,

MD, president of the APF. "We believe we have a responsibility to tell the public the truth about depression – one based on scientific evidence and clinical research, not made-up "facts" or wishful thinking."

Indisputable scientific evidence shows depression to be a biologically based disease that destroys the connections between the brain cells and can affect every aspect of a person's health, says NAMI.

Sue Bergeson, president of the DBSA, says that trivializing depression as a passing mood or an imaginary illness can discourage people from seeking help – something that is dangerous because depression is the principal cause of suicide worldwide.

The campaign consists of public service announcements, advertising, and educational activities. The Web site is [www.DepressionIsReal.org](http://www.DepressionIsReal.org).

*From BP Magazine Winter 2007*

#### ***New DBSA Support Group***

Beginning in July, a new DBSA support group will be available to residents of Mid and North Pinellas County. The group will meet Tuesdays at 7:00 pm at the Sylvan Abbey United Methodist Church located at 2817 Sunset Point Road in Clearwater.

# New Depression Center Weds Research, Education, Care

*The psychiatrist who envisioned the depression treatment center hopes it will be a model for the development of other university-based centers and a catalyst for a consortium of depression centers.*

A depression specialty clinic has been added to the Depression Center at the University of Michigan. Patients will receive thorough psychiatric, neurocognitive, and sleep evaluations; consultation with a nutritionist; an addiction assessment; and an automated symptom-rating battery that enables follow-up monitoring. The consultations will take place in a single location in the new \$41-million Rachel Upjohn Building on the U-M Health System's east medical campus in Ann Arbor.

"What we are putting together is a high level of comprehensive care that will integrate all aspects of psychiatric assessment," said Melvin McInnis, M.D., director of the depression specialty clinic at the Depression Center. "At the end of the day there is a wrap-up at the attending level to put together in one large picture all the treatment needs of this one patient."

The specialty clinic is one component of the Depression Center, which merges basic and clinical research, education, and clinical care using a multidisciplinary approach to treat depression and bipolar disorder.

The first center of its kind in the nation, it is the brainchild of U-M Psychiatry Department Chair John Greden, M.D., and is modeled on the Comprehensive Cancer Centers now found in or around nearly every major U.S. city.

"If we look at the overall burden including costs, disability, and family consequences associated with depression and bipolar disorder, it's clear that our delivery system is not tailored to the problem," said Greden. "What we have is a system that typically picks up people who are depressed after they have had it for a long time. So they come to the psychiatrist when they are chronically and severely ill."

"The idea behind the comprehensive depression center is that we need to develop an approach that intervenes earlier and more effectively to prevent chronicity," Greden said. "If we are going to succeed, we know that we have to overcome stigma. Learning from what has worked in other fields of health care, I found myself

wondering why we don't have depression centers analogous to the cancer centers that were started 45 years ago when cancer had its own stigma to overcome.

"That approach brought together different disciplines and helped to change and improve the paradigm for cancer care," he noted.

In 1999 Greden proposed creation of a comprehensive depression center at U-M that would cross boundaries and involve specialists from multiple disciplines—social work, nursing, pharmacy, public health, life sciences, and kinesiology and exercise, among others—as well as physicians in many specialties.

"All these specialists are involved in various ways in the Depression Center. Part of the funding was provided by NIH [National Institutes of Health] so that our research operations would also have an interdisciplinary approach," Greden said. "Our goal is to create an integrated research, educational, clinical, and public-policy center that will enable us to find depression earlier, prevent its progression, overcome stigma, and help improve public policy

"Psychiatry is certainly the leader in this field, but if we don't approach this problem the way the cancer community did, by including people from diverse specialties, we will too often be treating the disease too late and in its most chronic period," Greden said.

The Depression Center was founded in 2001 and now makes its home in the Rachel Upjohn Building along with treatment and research personnel of the Department of Psychiatry and faculty from other schools in the university.

## Integration of Care Crucial

Past American Psychiatric Association President Michelle Riba, M.D., has the task of integrating depression care into the treatment of patients in the general medical setting. "My job within the Depression Center is to link depression care to patients who have comorbid medical

conditions, such as diabetes, cancer, and heart disease," she said.

"It is an amazing facility with the ability to transform how we provide clinical care and education and do research, and will be a prototype for the growth and development of other depression centers throughout the country," Riba said. "The center is already helping to decrease stigma about depression and bipolar disorders, and through the ability to work with many departments and faculty at the university, we will be able to mount research projects that could never have been realized."

Riba is also the zonal representative from APA to the World Psychiatric Association (WPA) and hopes to present information about the concept and utility of depression centers at future WPA meetings.

McInnis, in addition to directing the center's depression and bipolar specialty clinics, is leading an effort to understand the genetics of bipolar disorder. He and colleagues will help establish a genetic repository of individuals with and without bipolar disorder. These individuals will be followed longitudinally to identify factors that lead to—and protect against—the disorder.

Ultimately, Greden said, he hopes the depression center will serve as a model for the development of other university-based centers and as a catalyst for a consortium similar to the National Comprehensive Cancer Center Network (NCCN).

Psychiatry departments around the country are taking notice. This month, Greden and other U-M leaders will meet with department chairs from 15 institutions that are among the leaders in depression care.

"We have established some standards, and all of these institutions have met the standard," Greden said. "The metaphor is the NCCN, and our stretch goal is to have a comprehensive depression center within 300 miles of every citizen. It may take us a few decades, but we are getting started."

*From an article by Mark Moran  
April 2007 Psychiatric News*

## 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](http://www.dbsatampabay.org)

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

## Hoarding

### *A symptom of obsessive compulsive disorder*

It is not the content of a person's closets that define what psychologists would call a "problem" with collecting. It is the amount of clutter and its consequences. Although accumulating stuff can be expensive and the objects sometimes take up a good bit of space, most people do not run into trouble. They do not spend more money than they can afford, nor do they allow the stuff to take over essential living space. But the urge to hang on to things can go awry. And when it does, the consequences of this hoarding may be severe.

Although hoarders have long been subjects of fascination, it is only recently that researchers and clinicians have begun to warn that an unhealthy compulsion to stockpile may afflict more than one million people in the U.S. alone. And now a handful of neurologists, psychiatrists and psychologists have started to identify the underpinnings of the condition and have come up with a promising treatment.

People afflicted with this problem acquire and are unable to discard large numbers of items. According to Randy O. Frost, a psychologist at Smith College, what distinguishes the illness from normal collecting is the extent to which the hoarder's stuff takes over his or her living space and the impairment that is produced by the relentless collecting.

The most commonly saved items include newspapers, old clothing, bags, books, mail, notes and lists. These items can accumulate to the extent that the space is no longer available for essential activities such as cooking, sleeping and bathing.

Frost points out that the harmful consequences range from failure to pay bills (they get lost in the clutter) to injury and even death when a pile of refuse topples over.

### Collecting Data

Hoarding is explicitly mentioned in the "bible" of psychiatry, the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV), as a symptom of obsessive-compulsive personality disorder (OCD). It is also seen in a raft of other conditions, including traumatic brain injury, tic disorders such as Tourette's syndrome, mental retardation and neurodegenerative disorders. But some experts

have started to argue that hoarding should be a syndrome or entity in its own right. To begin with, hoarding can crop up in the absence of any other pathology and result in severe impairment. Some evidence also indicates that hoarding is more common than is generally recognized.

Frost and his associates surveyed public health departments and found that over a five-year period they received only 26 complaints of hoarding over 100,000 people. He believes this figure seriously underestimates the prevalence of the problem. He points out that the condition in which hoarding appears most frequently is OCD and that it afflicts 20 to 30 percent of those patients. Given that OCD occurs in about 1 to 2 percent of the world population, this would put the prevalence of OCD-related hoarding at about four per 1,000.

In addition, a study by Jen-Ping Hwang and his colleagues in the department of psychiatry at Taipei Veterans General Hospital found that 22.6 percent of hospitalized patients with dementia engaged in clinically significant hoarding, and Dan J. Stein in the department of psychiatry at the University of Stellenbosch in Cape Town, South Africa, found that patients in a geriatric psychiatry inpatient unit displayed a hoarding prevalence of 5 percent. Stephen Salloway, director of neurology and the Memory and Aging Program at Butler Hospital in Providence, R.I., estimates that about 5 percent of the dementia patients he sees exhibit clinically significant hoarding. Based on the extent of the disorder found in such sample population, Sanjaya Saxena of the University of California, San Diego, estimates that there are one million to two million hoarders in the U.S. alone. He considers hoarding a major public health problem.

One misconception about the condition is that it must arise from highly aberrant psychological processes or brain activity. In fact, similar behavior is common and highly conserved across a wide

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

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variety of species. In humans, clinically significant, compulsive gathering that results in impossible clutter appears to be on a continuum with “normal” collecting and the universal tendency to hold on to clothes, books and other items far beyond the point that they are used or needed.

Similarly, much of what is called hoarding in animals is adaptive and has a clear purpose. Animal research has focused on food hoarding, but birds and other animals also collect aluminum foil, beads and other brightly colored objects, sometimes as apart of mating behavior. Some hoarding behavior in animals, however, does not seem to be purposeful and is more like the pathological kind seen in humans – collecting as an end in itself. Normal rats are known to stockpile food seemingly for the sake of it, without regard to how much they already have, and given the choice, hamsters prefer keeping additional glass beads to food.

Animal studies have also revealed a complex set of controls on this behavior. Chemical mimics of the neurotransmitter dopamine stimulate food hoarding rats, whereas analogues of another neurotransmitter, serotonin, reduce it. Sex hormones and opiates also modulate this activity. Genetic research points to the importance of brain chemistry as well. Patients who hoard are more likely than a typical person to have close relatives with similar symptoms. Genetic analysis of hoarders with OCD and Tourette’s syndrome has linked this compulsion to a specific form, or allele, of COMT – a gene that encodes an enzyme involved in the metabolism of dopamine and other neurotransmitters.

Electrical stimulation and lesion experiments in animals suggest that the drive to amass items comes from the brain’s subcortical limbic system, made up of evolutionarily primitive structures that are involved in survival-related behaviors such as appetite, sexuality, aggression and emotional behavior. The onset of hoarding in patients with traumatic brain injury, stroke and neurodegenerative diseases has also helped pinpoint brain regions involved in this behavior. Saxena and his colleagues used brain imaging to study OCD patients with compulsive hoarding and showed they had lower metabolic ac-

tivity in their limbic system.

## Healing Hoarding

Ultimately, a thorough understanding of the neural basis for hoarding could lead to better treatment. Any such advance would be welcome because the disorder has been notoriously difficult to treat. Both clinical trials and case reports show that compulsive collecting does not respond well to either antidepressants or the psychotherapies that alleviate other OCD symptoms. Recently, however, Frost and his colleagues have developed a cognitive-behavioral treatment that addresses hoarding’s various psychological motivations.

Some hoarders have difficulty discarding things because of their indecisiveness; others because of their emotional attachment to their possessions. As Frost points out, hoarders believe that their possessions are part of them: “They can’t distinguish important from unimportant things.” Whereas most people see a 10-year-old news magazine as trash, hoarders believe it holds critical information. Still others do not discard items because they suffer executive dysfunction and other cognitive deficits that make it difficult to organize their belongings and to distinguish between items they need and those they do not.

Frost’s technique uses group therapy sessions to help patients identify the thoughts and emotions that sustain their behavior and then challenges the validity of these motivators. Patients are also encouraged to practice new patterns of behavior. They go on shopping excursions without buying anything, discard objects both in the group setting and as homework, and they learn methods for organizing their belongings. Preliminary results are promising. Patients treated in this manner begin to tolerate the anxiety associated with discarding objects and gradually reduce the extraneous junk filling up their homes. Not all the clutter has to be removed, just enough to reduce fire and health hazards.

Frost says that anyone working with these patients must remain mindful of the excruciating anxiety they go through at the mere thought – let alone act – of throwing out one of their things. A key principle is that the hoarder is the only one who should

discard possessions. Attempts, however well meant, by family members or other caregivers to tidy up by tossing stuff out will alienate the patient and increase his or her isolation and resistance to any kind of intervention. Without some change on the hoarder’s part, as soon as relatives, therapists, or camera crews leave, the newspapers, mail, and assorted odds and ends will invariably pile up once again.

*Excerpted from Scientific American Mind  
February/March 2007*

*By Walter Brown, clinical professor of psychiatry at Brown Medical School and Tufts University School of Medicine, with the help of Zsuzsa Meszaros*

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

*Twenty years from now you will be more disappointed by the things that you didn't do than by the ones you did do. So throw off the bowlines. Sail away from the safe harbor. Catch the trade winds in your sails.*

*Explore. Dream. Discover.*

*- Mark Twain*

## *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 with René Anderson  
813-878-2906  
and leave a message.**

*Thank You!*

*We look forward to hearing from you.*

# Bipolar Patients on Lithium Show Brain-Tissue Growth

By Mark Moran

Patients on lithium had significant increase in the cingulate and paralimbic regions of the brain, which regulate attention and emotion.

Lithium appears to increase gray matter in the brains of patients who use the drug, according to a report that will appear in *Biological Psychiatry* in July.

In a statement about the study released prior to publication, neuroscientists at UCLA said they have shown that lithium, long the standard treatment for bipolar disorder, increases the amount of gray matter in the brains of patients with the illness.

“Bipolar patients who were taking lithium had a striking increase in gray matter in the cingulate and paralimbic regions of the brain,” Carrie Bearden, Ph.D., a clinical neuropsychologist and assistant professor of psychiatry at UCLA said in the statement. “These regions regulate attention, motivation, and emotion, which are profoundly affected in bipolar illness.”

In this study, Bearden and colleagues at UCLA used computer analysis to analyze brain scans collected by collaborators at the University of Pittsburgh in order to determine whether bipolar patients showed changes in brain tissue and, if so, whether those changes were influenced by lithium treatment.

They employed high-resolution MRI and cortical pattern-matching methods to map gray-matter differences in 28 adults with bipolar disorder — 70 percent of whom were treated with lithium—and 28 healthy control subjects. Detailed spatial analyses of gray-matter distribution were conducted by measuring local volumes of gray matter at thousands of locations in the brain.

While the brains of lithium-treated bipolar patients did not differ from those of the control subjects in total white-matter volume, their overall gray-matter volume was significantly higher, sometimes by as much as 15 percent.

Although other studies have measured increases in the overall volume

of the brain, Bearden said, this imaging method allowed the researchers to see exactly which brain regions were affected by lithium. These new findings suggest that lithium may work by increasing the amount of gray matter in particular brain areas, which in turn suggests that existing gray matter in these regions of bipolar brains may be underused or dysfunctional.

Bearden added that there is no evidence that the increase in gray matter persists if lithium treatment is discontinued. “But it does suggest that lithium can have dramatic effects on gray matter in the brain,” she said. “This may be an important clue as to how and why it works.”

*Psychiatric News*

*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.

## Educational Resources

American Psychiatric Association  
888-357-7924 • [www.psych.org](http://www.psych.org)

American Psychological Association  
800-964-2000 • [www.apa.org](http://www.apa.org)

Advocacy Center  
800-342-0823

[www.advocacycenter.com](http://www.advocacycenter.com)

Child & Adolescent Bipolar Foundation  
847-256-8525 • [www.bpkids.org](http://www.bpkids.org)

National Alliance for the Mentally Ill  
800-950-6264 • [www.nami.org](http://www.nami.org)

National Association for the Dually Diagnosed  
800-331-5362

DBSA (National)  
800-826-3632

[www.DBSAlliance.org](http://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](http://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](http://www.nmha.org)  
Confidential depression screening:  
[www.depression-screening.org](http://www.depression-screening.org)

Obsessive-Compulsive Foundation  
[Ocfoundation.org](http://Ocfoundation.org)

Compulsive hair pulling  
[StopPulling.com](http://StopPulling.com)

Compulsive skin picking  
[StopPicking.com](http://StopPicking.com)

Tourette Syndrome Association  
[Tsa-usa.org](http://Tsa-usa.org)

## 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.

## Making a M.E.N.D.S. With Yourself

Working at St. Joseph's Hospital Psychiatric Care Center for the past eight years has provided Amy Gallestegui with the tremendous opportunity to witness different aspects of treatment that seem to help people begin to achieve a balance of wellness in their lives. She realized that offering a discharge planning group could provide the opportunity to teach patients the keys to continuing wellness. Amy came up with a title or acronym that the patients would find easy to remember, therefore enhancing the likelihood that they would continue utilizing these areas of wellness after discharge. That is when "Making a M.E.N.D.S With Yourself" was originated. Mending your life will help you achieve mental wellness. M.E.N.D.S. stands for Medication Compliance, Exercise, Nutrition, Discussing your Problems, and Socialization. She now tries to teach everyone the benefits of working on balancing these areas.

Amy will be sharing her in-depth

wellness plan on Saturday, August 25, 2007 from 10 am to 1 pm at St. Joseph's Hospital Medical Arts Building. The hands-on workshop is open to the public. Please contact DBSA Tampa Bay for additional information.

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## DBSA Launches New Online Advocacy Center

The National Depression and Bipolar Support Alliance (DBSA) has launched a new advocacy center that it says will help healthcare advocates across the country to get legislators to vote properly on the important legislation and policies concerning mental health.

The DBSA initiative includes a wide range of services, tips and informative Web pages, including information on how the legislative process works, a downloadable advocacy brochure, action alerts, current legislation, and tips on writing letters or making phone calls to legislators. Through the Web site, people can even send letters

to their elected representatives, email letters to the editor to newspapers across the country by state, identify their Congressional representatives, and research Congressional voting records.

The National DBSA says advocacy is especially important now because of the many legislative changes made to mental health services, social assistance and other areas that impact the lives of people who use the mental health system.

The new advocacy center Web site is: [www.dbsalliance.org/advocacy/AdvocateMain.html](http://www.dbsalliance.org/advocacy/AdvocateMain.html).

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*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

**Feel free to reprint our articles or our entire newsletter. However, please acknowledge our publication, date, author, and source.**

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## 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.*

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## 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)

\$20<sup>00</sup> Individual or Support Person

\$30<sup>00</sup> Family/Household

\$100<sup>00</sup> Individual Lifetime

### NEWSLETTER

\$10<sup>00</sup> Newsletter only / year

\$24<sup>00</sup> 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; 2<sup>nd</sup> 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.

## Clearwater:

Tuesday 7:00 PM  
Sylvan Abbey United Methodist Church  
2817 Sunset Point Road  
In the Rear Entrance of the Church

*See Our Website at:*  
[www.dbsatampabay.org](http://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 62<sup>nd</sup> Ave  
N. Turn right on Bayou Grande Blvd  
NE. Turn left on Shore Acres Blvd  
NE. Turn right on Chancelor 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  
**1<sup>st</sup> and 3<sup>rd</sup> 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](mailto: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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John C. Massolio, Jr.

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*Serving the Community Since 1985*