Winter 2003-04

OUTREACH

Newsletter of the
Depression and Bipolar Support Alliance

INSIDE

MISSION

The mission of the Depression and Bipolar Support Alliance (DBSA) is to improve the lives of people living with mood disorders.

Sixth Annual Consensus Conference Addresses Mood Disorders and Alcohol/Substance Abuse

Mood disorders and alcohol or substance abuse often go hand-in-hand. This is known as dual diagnosis. Studies have shown that more than half of people living with bipolar disorder have a substance abuse problem. About one quarter of people with depression also abuse drugs or alcohol. The substance of choice is usually alcohol, followed by marijuana and cocaine. Prescription drugs such as tranquilizers and sleeping medications may also be abused.

In November, DBSA held its sixth Consensus Conference. Leading researchers and clinicians from the fields of mood disorders and substance abuse met with patient advocates to examine dual diagnosis issues. Participants discussed ongoing dual diagnosis research and how to overcome barriers to effective treatment.

Facts About Dual Diagnosis

- The most important thing to understand about dual diagnosis is that the mood disorder and the alcohol/substance use are separate illnesses requiring separate treatments. Leaving one disorder untreated while treating the other is likely to make treatment less effective or ineffective.
- A person is more likely to develop a mood disorder before an alcohol or substance abuse problem. Alcohol and substances are often used to self-medicate symptoms and may be effective for a short period of time.
- A large number of people with dual diagnosis cannot or do not get the care they need because:
  - Both disorders are not diagnosed, or the disorders aren't recognized as two separate illnesses needing treatment.
  - In many communities, care for dual diagnosis is not available, or people don't have the resources to pay for it.
  - As with many illnesses, sometimes people don't stick with treatment.
- It is important that people understand the difference between taking medication and taking illegal drugs. Unlike illegal drugs, medication is safe, is taken in prescribed doses and has lasting effects. Medications are taken to manage, not mask symptoms, and can help a person work toward positive change. A person can still be "clean and sober" while taking medication.
- Talk therapy and peer assistance such as DBSA support groups can help people understand triggers that make them want to drink or use. People can also learn ways to manage stress without alcohol or drugs.

Dual Diagnosis Treatment Priorities

There are many differences among people with dual diagnosis, and treatment approaches cannot be "one size fits all". Effective treatments for dual diagnosis should:

- Address the substance use and help the person stop and stay stopped.
- Help stabilize the mood disorder symptoms.
- Motivate the person to stay with treatment.
- Help the person with family, legal, emotional, medical, and social problems.

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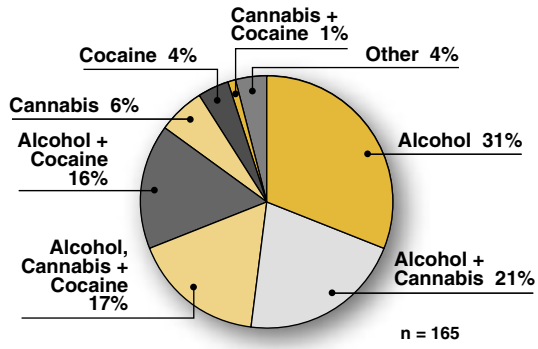
Current Patterns of Substance Use in Dual Diagnosis Bipolar



Joseph R. Calabrese, M.D.

President's Outlook

Lydia Lewis

Steps Toward Wellness

Sometimes it can be difficult to keep a positive attitude if we feel negativity in the world around us. When this happens, we need to monitor our symptoms more than ever. Ask yourself: are you prone to develop depression as the days shorten? Do you find yourself becoming manic when you see family members? Our illnesses are cyclical, and they often follow patterns. You are the best person to discover your patterns, because only you know what happens to you every day. Take a moment at the end of each day to write down a few words about how you're feeling. Share these with your health care providers.

We may have been told for so long that our symptoms were "all in our heads" that we have forgotten to listen to our bodies. In many cases, your body will give early warning signs when an episode is coming on. Pay attention to what your body is telling you: do you feel heavy, achy, energetic? Sometimes we may have felt down for such a long time that we aren't sure what to look for as a sign we're getting better. How can we work toward wellness if we've forgotten what wellness feels like?

That's why we need each other. In hard times, the people we meet in our DBSA support groups remind us that we are not alone. In stable times, we can help ourselves by reaching out and giving support to others. Talking with people who are newly diagnosed can remind us how far we've come and how important it is to stay with treatment. People who need our help can keep us going when things look dark.

We also turn to one another for knowledge. We educate each other about what to expect and how to get the most from our treatment. Our doctors can learn a lot from us, too. We are the only ones that can truly help them see our illnesses from the patient perspective.

Remember there is no right or wrong way to approach wellness. Anything that gets you out of bed and helps you get some enjoyment out of life without harming yourself or others can be part of your wellness plan. Some of these things aren't costly – taking a walk, talking with someone, or visiting the library and researching mood disorders or another subject that interests you.

You don't have to do everything all at once. Wellness is a process. Everything may not be 100% better right away, and it doesn't have to be. But if you do one thing – like picking up this newsletter and reading it, you're educating yourself and taking a step toward wellness. Even if that's the only thing you do today, you've taken one step, and sometimes the first step the hardest of all.

DBSA and Me

Cheryl Murphy DBSA Southern Nevada

"The thing that brought me to DBSA," Cheryl explains, "is that I was ready to kill myself. I was dealing with my own depression and my daughter's bipolar disorder. I was fighting with my doctors; I didn't know what was wrong. I went online looking for a group that supported parents and people who were diagnosed."

Cheryl found www.DBSAlliance.org, and with some help from DBSA staff, she formed a group that first met in July 2002. "We had a lot of setbacks," she admits, "but I wasn't about to quit – I'm too stubborn!"

DBSA Southern Nevada's biggest challenge was finding a permanent place to meet. After several changes of venue due to rules and politics beyond their control, they lost their meeting space in September 2003. A local TV station heard about their struggle and did an interview, which led to a lengthy article in the *Las Vegas Mercury*. The article got an enormous response, and by November, DBSA Southern Nevada had eight meetings throughout Las Vegas and one each in North Las Vegas and Henderson. They now hold four meetings on the same night: mood disorders, dual diagnosis, parents and adolescents. There is also a website that provides three weekly chat rooms for people who can't get to meetings.

"We are a team," Cheryl says. "It's about watching people grow and get better. Recently a man came in – he was a mess. He had lost his job – we were all worried about him. But he kept coming to meetings no matter what. Today he's sitting tall, smiling, joking, you can see the radiance in his face. It's hard to believe he's the same man. It's just amazing to watch people change. And it's all because of the support group."

Cheryl has been in 12-step recovery for more than 20 years. "I learned you have to give it away to keep it," she explains. "The rewards come when you can show someone that there is hope – there is a place for them to go and people to talk to who will understand. People need the opportunity to learn from others, so their road will be a little easier than the ones who have gone before. We help provide that opportunity."

"We reach out to others because we have been there, we care, we understand and we can help. I am so thankful to DBSA for saving my life and my daughter's life, and for giving me the opportunity to help others in their search for information and support. Together we can make a difference, one person at a time."

Letter from the Chair

William P. Ashdown

As 2004 begins, we can look back at 2003 with pride and satisfaction. DBSA touched more than three million people with our support groups, educational materials and media outreach. People who were lost now have a place to turn.

DBSA has been here to help when people needed it most – when they were afraid, ashamed or alone. We have been here for people who thought they might have a mood disorder, for those just diagnosed, and for those who were frustrated by treatment trial-and-errors. We have also been here for families, whether or not their loved ones received treatment. DBSA group members have shed light on loved ones' illnesses, and listened with compassion and understanding.

In DBSA support groups we've realized that our illnesses do not define who we are. Each of us is so much more. We all have unique talents and gifts – maybe they've been neglected or forgotten when we became ill. But they are there, waiting to be rediscovered.

Now and in the future, you can have faith that DBSA will be here for you. Faith can be the most powerful force of all, the one thing we can hang on to when our challenges seem insurmountable. When things look bleak, know that things will change. Your mood will change; your situation will change; and the treatments available will change. Embrace the change when it happens, even if it isn't what you expected. Have faith in yourself, in DBSA and in the treatments for your illness. Stick with your treatment even when you don't want to. Know that there is always hope, and that you can feel better.

Watching Washington

Congress Makes Sweeping Changes to Medicare

Legislation adding prescription drug coverage to Medicare passed Congress at the end of 2003. From 2006 to 2016, $400 billion will be spent on prescription drug coverage for people who are over 65 or have a disability. The plan also encourages private health plans to compete with Medicare. The new prescription medication program will require people to pay a monthly premium beginning in 2006. It will have a $250 deductible and a 25 percent co-payment for medication costs greater than $250, up to an initial coverage limit of $2,250. After the $2,250 limit, the person will have no benefit (other than medication discounts) until the out-of-pocket expenses are over $3,600. Beyond $3,600, 95 to 100 percent of the costs will be covered, depending on the person's income.

Critics of the legislation said its benefits were not broad enough to cover rising medication prices. Supporters said it is a good start toward providing assistance for prescription costs.

Congress will discuss other Medicare legislation in late January 2004. The Medicare Mental Health Copayment Equity Act (S. 853) would gradually reduce the mental health care co-payment from 50 to 20 percent. The Medicare Mental Health Modernization Act of 2003 (S. 646) would further improve Medicare's mental health services.

Parity Stalls for Another Year

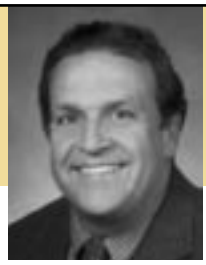
Legislation requiring insurance parity for mental illnesses (S. 486, H.R. 953) has again stalled in Congress. However, Senate Republican leaders agreed to consider the legislation early in 2004.

In the meantime, Congress has extended existing legislation through the end of 2004. It re-authorizes a current law that requires employer-provided insurance plans to make lifetime limits on mental health benefits equal to those on medical and surgical benefits. The law does not, however, require companies to provide full mental health coverage. Parity supporters, chief among them Senators Pete Domenici (R-NM) and Ted Kennedy (D-MA), secured an agreement from the Senate leadership to bring the bill to the Senate floor early next year. In the House, where Speaker Dennis Hastert (R-IL) has blocked the bill, its future is uncertain.

It is important that you voice your support of parity to Speaker Hastert (R-IL), Senate Majority Leader Bill Frist (R-TN), and your own Representatives and Senators. For help, visit www.DBSAlliance.org and click on the "Advocacy/Legislative Action Center" link, or call the U.S. Capitol Switchboard at (202) 224-3121.

DBSA 2003 Board of Directors

Scientific Advisory Board UPDATE



Dennis Charney, M.D.

A great deal of progress in mood disorder treatments has occurred in recent decades. New medications to treat mania and depression have been discovered. New psychotherapies have been developed. We have a greater understanding of the benefits of peer support. We also have new knowledge about the genetics of mood disorders.

We have come a long way from treatments like insulin shock, amphetamines and psychoanalytic theory. Today we are seeking novel treatments that are safe, effective and free of side effects. Trials to test the effectiveness of treatments such as vagus nerve stimulation and repetitive transcranial magnetic stimulation continue. There are fresh perspectives on existing treatment methods in discussion as well. We know much more about the brain today, but still have great deal to learn.

At least 3.5 million people with depression or bipolar disorder are not being treated to full wellness. Studies by Robert M. Post, M.D., estimate that at least 40 percent of people in the U.S. with bipolar disorder are not in treatment at all. It is extremely important that we all strive to educate the public with our new knowledge. If people are educated, they will be able to recognize the symptoms of depression and mania earlier and look for treatment in spite of shame or fear.

Today we can observe the formation of new brain cells in laboratory animals treated with antidepressants. We can study the genes that make people more likely to develop mood disorders in response to stress. New brain chemicals that may be related to mood disorders are being discovered. Treatment methods for imbalances in these chemicals are being developed.

Today's methods of diagnosis help us treat many people who were ineffectively treated several years ago. Thoughts, emotions and day-to-day activities affect the chemical makeup of the brain in ways we are just learning. Better approaches, both medical and psychotherapeutic, are evolving to treat these illnesses early and aggressively.

Mood disorders are the result of many different factors. Genetic vulnerability, traumatic experiences, environmental factors and chemical changes within the brain all contribute to mood disorders. With this knowledge, we can encourage families to get treatment for at-risk members, and possibly avoid future crises.

Many of the treatments being studied today are years away from clinical use. The time and effort spent in development ensures that these treatments are safe and effective. Through careful study, clinical trials, widespread education, and communication among professionals and patients, we can continue to find ways to lift depression, stabilize mania, and help future generations lead productive lives.

Celebrate 2004 with the Gift of DBSA

DBSA brings you a unique opportunity to wish friends a healthy 2004 and share your hope with those you love. Even if you missed the holidays, these timeless, all-season gifts can show someone you're thinking of them throughout the year. Your gift also helps improve the lives of people living with mood disorders.

What better way to make someone feel special than by helping others in their name? A gift donation to DBSA will help provide education and support to millions of people. It's a perfect way to celebrate any special occasion.

For a minimum $25.00 donation per gift, DBSA will send the recipient one of our signature quilt notecards announcing your thoughtful donation. The notecard will include your name and if you wish, a personalized message, but not the donation amount.

If you prefer, gift announcement notecards can be sent directly to you. You'll receive an acknowledgement of your donation for tax purposes. DBSA is a not-for-profit, 501(c)(3) Illinois corporation and all donations are deductible based on IRS regulations.

Make someone feel special by providing mood disorder education and support in their name. On behalf of those we serve, DBSA thanks you for your support.

Sixth Annual Consensus Conference

(continued from page 1)

Communication is especially important in dual diagnosis treatment. Patients need to be honest about their alcohol and substance use when talking with professionals. Professionals need to be sensitive to cultural differences among patients.

The impact of dual diagnosis is just beginning to be understood. Unfortunately, many treatment trials currently exclude people who abuse alcohol or drugs. Researchers need to develop more clinical trials that include people with dual diagnosis and gather information about their response to treatment.

In the coming months, DBSA will develop a consensus statement to summarize the conference findings. It will also call attention to the urgent need for increased research, further-reaching education and more effective treatments.

Chapter Highlights

New York Chapters Unite at Suicide Prevention Event

DBSA Rochester hosted a very successful weekend event, which included a well-attended facilitator orientation and the first state-wide chapter leader meeting. Attendees discussed forming New York State DBSA, and a member of New Jersey State DBSA shared his experience.

Featured speakers included facilitator trainer Chuck Weinstein, M.A.E, suicide prevention writer Susan Rose Blauner, and policeman and activist Eric Weaver. Participants talked about support, leadership and advocacy, and signed letters encouraging state legislators to adopt Timothy's Law, which would require insurance parity throughout New York.

Members have also been writing letters, making phone calls and contacting politicians in an effort to prevent the closing of the Canandaigua Veterans' Administration Hospital, where the event was held. Sunday morning's suicide prevention breakfast was open to the public and covered by four television stations.

For more information: Rita Cronise at (585) 924-7936 or DBSACanandaigua@aol.com.

Metro Detroit Writers Publish Words to Heal and Inspire

DBSA Metro Detroit has published an anthology of poetry and prose, *The Other Side of Darkness*, edited by Gil Saenz and Jacqueline Castine, the product of two years of writing workshop sessions. The book was created to showcase the work of support group members and to demonstrate that stability can come from suffering. More than 30 writers – some never before published, some published many times – contributed to the book, giving it a wide range of perspectives and emotions.

The book's introduction states, "The ability to sit down and write about one's experiences is a sign of detachment and of a healthy attitude. Not only is it many times therapeutic, but it also may provide important insights into a person's thoughts and feelings before, during and/or after that person experiences illness."

Copies can be obtained for $20.00 + $3.50 shipping and handling. For more information: Mary Ann Bozenski at (734) 284-5563 or lifeinbalance@mdda-metro-detroit.org.

The Road to Recovery

The Power Within

Ken Heideman
DBSA Boston, MA

"If I gave you my entire psychiatric history," Ken says, "you'd probably wonder how I could put two sentences together and function on any meaningful level. During tough times, I look back and see only the darkness, but there has been a lot of light, otherwise I wouldn't have survived."

Ken, a scientific publishing executive, was president of DBSA Boston (previously MDDA) in 1997. He began attending the support group in 1989 and subsequently served as a group facilitator, chief facilitator and board member. He began fighting depression early. At a young age, he witnessed his mother being killed by his father, who was found not guilty by reason of insanity. Later, he had a family of his own, and his first son died of a treatable illness, largely due to physician errors.

Ken tried everything to treat his depression. "Years of talk therapy, medication of every size, shape and color, moving across the country, climbing mountains, being constantly busy, trying to build a relationship with my father. All the things I accomplished were worth a lot, but they meant nothing to me at the time because I couldn't get rid of the depression. Today the outside world hasn't changed, but my internal perspective has. I'm learning to look at things differently."

Ken credits much of his turnaround to a doctor he began working with three years ago. After briefly discussing medication, to Ken's surprise, this psychopharmacologist, trained to prescribe medications, began explaining the process of finding peace of mind.

Overcoming depression, for Ken, involved a spiritual approach. By trying to control his own emotions, he found that he only allowed them to control him. When he gave up control and used that energy to follow his own creative path, he was better able to cope with the emotions and get through each day.

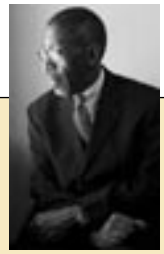
"My depression hasn't changed," he explains, "but my reaction to it has." He uses the analogy of encountering a bear in the forest: your gut reaction is to run, but you have the best chance if you lie down and act as if you're totally relaxed. Similarly, it's difficult to outrun one's own emotions. Another apt comparison is quicksand. Ken says, "the more I wiggle, the faster I sink, so I'm learning to stop wiggling."

Since he began working with this doctor, who believed in him and encouraged him, Ken has written and recorded several songs and is continuing his musical pursuits. Today he lives in the present. "I've grown a lot through my illness and have a lot to show for it, if I stay in the present. Don't regret the past," he says, "because everything you've experienced, good and bad, got you where you are now, which is on the verge of creating the kind of life you've always wanted. Have gratitude, have patience, get in touch with who you are and go for what you want now! Give yourself credit for the person you have become. The real power for all of us lies in within ourselves. Tapping into that power is exhilarating and a bit scary. But by all means, enjoy the ride!"

SAB FOCUS

Improving Cultural Understanding

Robert L. Johnson, MD, FAAP
SAB member, Professor of Pediatrics and Psychiatry
Director, Division of Adolescent and Young Adult Medicine
Interim Chair, Department of Pediatrics
UMDNJ - New Jersey Medical School



Robert L. Johnson, MD, FAAP

Culture is the behavior pattern of a racial, ethnic, religious or social group. It includes thoughts, communications, actions, customs, beliefs and values. It is the result of a person's racial/ethnic makeup, birthplace, homes and friends. Education, work and everyday life experience also influence culture.

Culture has a large impact on health care. Patients may not receive adequate care if providers do not consider their cultural needs. This is particularly true with mental health care, which relies heavily on communication. Mental health services must be sensitive to culture. Verbal and written communication must be easy to understand regardless of a person's first language or education level.

Improving Cultural Competence

If providers and patients cannot relate to one another on a cultural level, patients may be less likely to participate in treatment. They may also be less responsive. Providers must keep several key cultural differences in mind.

Communication differences: Providers must be aware of the potential for miscommunication. Culturally-linked behavior styles such as body language and eye contact may affect communication. Some cultural groups may also become anxious in the presence of "expert" providers.

Literacy differences: Educational materials must be easy to understand. This is especially important when medication directions or dosages are involved. Providers may need to make extra effort if the patient's first language is not English.

Attitude differences: Different cultures have different attitudes toward diet, exercise, smoking, drinking, body image and mental health. These differences may affect the way patients report their symptoms. They also may make patients more or less likely to stick with treatment. Providers must make an effort to understand these attitudes and make changes as needed.

Physical differences: Patients from some ethnic groups may also face special health challenges. Medication metabolism varies among ethnic groups. This may make a difference in treatment effectiveness. Some ethnic groups may also have unexpected side effects, especially from mental health medications.

What Patients and Families Can Do

If possible, patients and their families should communicate their beliefs about mental illness to providers. They should discuss previous personal or family experiences and things they have heard in the media. Patients can also let providers know the type of help they need. This may include easy-to-read materials, materials in their native language, or treatment that takes their religious beliefs into account. It's also helpful for patients to share the things they expect from treatment. This may include relief of symptoms, assistance with family difficulties, or help stopping drinking or using drugs. Having these discussions early in treatment can improve communication and make providers more aware of cultural differences.

Patients of all cultures share needs, fears and hopes. Providers have concern for patients and interest in seeing their health improve. When patients and providers work together to bridge cultural gaps, they can build a cooperative and productive treatment process.

Treating Mood Disorders with Interpersonal and Cognitive-Behavioral Psychotherapy

Psychotherapy (talk therapy) has been a useful tool to treat depression and bipolar disorder for decades. For some people, it can work well alone; for others, a combination of medication, talk therapy and peer support works best. There are many theories about what a person needs to become well and the type of psychotherapy that is most appropriate. Most psychotherapists use a combination of types, and different approaches work better for different people.

Interpersonal therapy (IPT) and cognitive-behavioral therapy (CBT) go beyond conversation, support and insight to help people change the way they relate, think and act. These therapies have been shown to yield good results when treating mood disorders.

Interpersonal therapy was originally developed to treat depression. It has since been adapted for bipolar and other disorders. It is time-limited and goal-oriented, and addresses a person's symptoms, social relationships and roles.

IPT focuses on what is happening "here and now" and attempts to help a person change, rather than just understand, his or her actions and reactions. The patient and therapist examine current relationships and relationships that have recently been lost. IPT does not focus on unconscious or subconscious motivations, wishes or dreams. It looks at conscious, outward action and social adaptation. It does not try to change the personality, but it may help teach new skills that can lessen some personality disorders.

An IPT therapist is an active supporter of the patient on the wellness journey. The therapist does not assign homework, but may encourage a person to engage in social activities.

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Ask the Doctors

Question: How do the length of sleep time and regularity of the sleep schedule affect manic and depressive episodes? Can they be triggers?

Ellen Frank, Ph.D.: Sleep loss can be a trigger for mania. However, if patients and family members keep a close watch on moods and stay on the lookout for manic symptoms, episodes can be prevented or their severity can be decreased.

Sleep loss can be preceded by disruptions in a person's social rhythms. These disruptions may be associated with serious life events, such as coping with a death in the family or spending the night caring for a very sick child. They may also be caused by less serious events like staying up much of night to watch a movie or finish housework. The stress level of the event does not necessarily indicate whether a person will become manic or how severe the mania will be.

People with bipolar disorder often have internal clocks that are easily thrown off-balance. This makes traveling across time zones or changing one's work schedule potentially risky. If a person's clock is thrown off-balance and he or she is deprived of the usual amount of sleep, this can lead to mania.

It's also important to keep in mind that different people have different needs for sleep. Find out the ideal amount of sleep that you or your loved one need(s) and try to stick to it. If you find you need much more or much less sleep than usual, this may actually be a sign of a manic or depressive episode. If this continues for more than a couple of days, call your health care professional so you can take steps to stabilize your mood before the episode becomes serious.

A regular sleep schedule helps improve the quality of your sleep and how restful it is. Keep in mind that waking up at the same time each day (even on weekends) is more important than going to bed at the same time, though you should do your best to keep both constant. If for some reason, you need to change your sleep schedule, do it gradually. Don't try to change your going to sleep time or your waking up time by more than 15 minutes per day.

Dr. Frank is Professor of Psychiatry and Psychology at the University of Pittsburgh School of Medicine, and a member of DBSA's Scientific Advisory Board.

Information in "Ask the Doctors" is not meant to take the place of a consultation with a qualified health care provider.

Interpersonal and Cognitive-Behavioral Psychotherapy *(continued from page 6)*

The IPT therapist helps the patient review his or her symptoms and relate these symptoms to one of four things. Symptoms may be the result of unresolved grief over a loss, interpersonal role disputes (conflicts with others), role transitions (changes in life status such as moving or changing jobs) or interpersonal deficits (isolation or lack of social skills). Next, the therapist and the patient work through the specific situations, one by one, to relieve symptoms and stress.

Cognitive-behavioral therapy combines cognitive therapy, which involves examining how a person's thoughts affect the emotions, and behavioral therapy, which involves changing a person's reactions to challenging situations. CBT is goal-oriented and works best when the patient takes an active role.

The cognitive aspect of CBT helps a person recognize the automatic thoughts or core beliefs that contribute to negative emotions. Next, the therapist helps the person see that some of these thoughts and beliefs are false or don't make sense. Then the person is guided to change them. Automatic thoughts may include focusing on one negative detail (an unkind person) and applying the negative quality to everything (the human race in general); perceiving things as "all good" or "all bad"; or applying labels such as "loser," "no good," or "worthless." Core beliefs may include, "I have to succeed at everything and everyone has to love me," "It's a disaster if things don't go the way I plan or expect," or "I can't change the miserable way I am."

The behavioral aspect of CBT takes place after a person has a more calm state of mind. The person can then take actions that help him or her move closer to planned goals. For example, if depression has caused someone to withdraw from life, that person may be encouraged to participate in hobbies or spend time with friends. Or a person may be gently coached, under supervision, to confront situations, things or people that cause fear or panic. Through practice, a person learns new, healthier behaviors.

With CBT, the therapist assigns homework. It may include journaling, reviewing notes or tapes of the therapy session, or trying a new approach to an old problem. There may also be exercises to make a person more aware of his or her own thoughts and actions without judging them.

The most important parts of any type of therapy are partnership, communication, collaboration and trust. When choosing a therapist, a person should feel safe and have faith in the therapist's judgment. Goals and methods should be discussed at the beginning of therapy so the patient knows what to expect and how to measure progress. Successful therapy can help a person change thoughts, beliefs, perceptions and actions for the better.

For a helpful tool in your search for a therapist, order a free copy of DBSA's *Finding a Mental Health Professional* brochure, or download it at www.DBSAlliance.org/PDF/finding.pdf.

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DBSA does not endorse or recommend the use of any specific treatment or medication. For advice about specific treatments or medications, patients should consult their health care providers.

Editor: Laura Hoofnagle

LEADERSHIP CIRCLE 2003

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DBSA acknowledges its 2003 Leadership Circle; organizations that committed a minimum of $150,000 to the association during 2003.

Support DBSA!

Just your gift alone will make a difference. Your gift alone will change a life. Contribute to DBSA by using this form, call us at (800) 826-3632 or visit our secure website at www.DBSAlliance.org. All information provided is held in strict confidence. If you have any questions, please call (800) 826-3632 or (312) 642-0049.

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