

# The Spiraling Times Newsletter

Volume I issue III

July 2009



Depression and Bipolar  
Support Alliance  
Southern Nevada

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**DBSA Southern Nevada dedicates this newsletter to all the military men and woman serving our country so we can celebrate Independence Day on July 4, 2009.**

As we all know veterans returning from combat have a high probability in developing Post Traumatic Stress Disorder, better known as PTSD.

**What is PTSD?** It is a mental disorder resulting from exposure to an extreme, traumatic stressor. PTSD has a number of unique defining features and diagnostic criteria. These criteria include:

- Exposure to a traumatic stressor
- Re-experiencing symptoms
- Avoidance and numbing symptoms
- Symptoms of increased arousal
- Duration of at least one month
- Significant distress or impairment of functioning.

To be diagnosed with PTSD, the person must have been exposed to a traumatic event in which both of the following were present:

- The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a

threat to the physical integrity of self or others; and

- The person's response to the trauma involved intense fear, helplessness, or horror.

Returning Veterans may be experiencing the effects of grieving to a deeper degree than the normal grieving most people experience.

Grief symptoms are distinct from PTSD and Depression. They include:

- Sadness
- Longing
- Missing the deceased, Non-acceptance of the death
- Feeling the death was unfair
- Anger
- Feeling stunned, dazed or shocked
- Emptiness
- Preoccupation with thoughts and images of the deceased
- Loss of enjoyment
- Difficulties in trusting others
- Social impairments
- Guilt concerning the circumstances of the death.

The existence of a distinct and intense set of grief symptoms indicates the need for clinical attention in addition to PTSD treatment

Bonds with unit members are described by many veterans as some of the closest relationships they have formed in their lives. In the Iraq conflict, young soldiers and reservists have remained with their units through training and deployment. Levels of mutual trust and respect, unit cohesiveness, and affective bonding will have been further strengthened by the experiences of deployment. While bonding and attachment to the unit may result in the some protection against subsequent development of PTSD, unresolved bereavement may be expected to be associated with increased distress over the life span unless these losses are acknowledged and grief symptoms treated on a timely basis.

Soldiers may experience overwhelming self-blame for events that are not under their control, including deaths during the chaos of firefights, accidents and failures of equipment, medical triage, and casualties from friendly fire.

If you or someone you know are experiencing any of these symptom please contact a psychiatric professional immediately.

## PTSD Information Continued

**Deaths of civilians they have developed relations with, civilian women and children are some of the most difficult to bear in addition to their comrades.**

**Along with extreme grief issues and PTSD returning Veterans have a heightened risk for developing other psychiatric disorders, including:**

- Depression
- Substance abuse
- Panic Disorder
- Obsessive-Compulsive Disorder
- Sexual dysfunction
- Eating Disorders

**Woman are more likely to**

**develop PTSD than men.**

**Treatment needs to begin As soon as possible after the trauma was experienced.**

**If you are a veteran experiencing any of these symptoms call your local VA Clinic to schedule an appointment.**

**DBSA Southern Nevada also offers a support group for anyone suffering from Post Traumatic Stress Disorder. See meeting schedule for information.**

**DBSA Southern Nevada thanks all our Veterans for their unselfish deeds in protecting our country.**

## Advocacy

There are many issues coming up for a vote this summer including the new health reform bill. There is also a bill for re-entry of prisoners to receive medications and to re-instate their Social Security Benefits so they do not relapse. Other bills on housing and other issues are important issues you need to educate yourself about and take a stand on these important bills. We have included the contact numbers for our Nevada representatives in Washington DC.

Let them know how you want them to vote. YOU can make a difference.

### IMPORTANT NUMBERS

U.S. Capitol Switchboard  
(202) 224-3121

Or go to [www.DBSAAlliance.org](http://www.DBSAAlliance.org) and click on the "Advocacy/Legislative Action Center" link.

Let Washington hear the voices of all Nevada residents concerning upcoming legislative matters that will effect you and your loved ones.

**IT ONLY TAKES ONE  
VOTE TO MAKE A  
DIFFERENCE!!!**

## Congressional Members Contact Information

### Rep. Shelley Berkley, Democrat

Washington Office:  
U.S. House of Representatives  
405 Cannon House Office Building  
Washington, D.C. 20515-2801  
Phone: (202) 225-5965  
Fax: (202) 225-3119

Main District Office:  
2340 Paseo del Prado, Ste. D106  
Las Vegas, NV 89102  
Phone: (702) 220-9823  
Fax: (702) 220-9841

### Rep. Dina Titus, Democrat

Washington Office:  
U.S. House of Representatives  
319 Cannon House Office Building  
Washington, D.C. 20515-2803  
Phone: (202) 225-3252  
Fax: (202) 225-2185

Main District Office:  
8215 S. Eastern, Suite 205  
Las Vegas, NV 89129  
Phone: (702) 387-4941  
Fax: (702) 837-0723

### Rep. Dean Heller, Republican

Washington Office:  
U.S. House of Representatives  
125 Cannon House Office Building  
Washington, D.C. 20515-2802  
Phone: (202) 225-6155  
Fax: (202) 225-5679

Las Vegas District Office:  
600 Las Vegas Blvd, Suite 680  
Las Vegas, NV 89101  
Phone: (702) 255-1651  
Fax: (702) 255-1927

## House Members Contact Information

### Senator Harry Reid, Democrat

Washington Office:  
528 Hart Senate Office Building  
Washington, D.C. 20510-2803  
Phone: (202) 224-3542  
Fax: (202) 224-7327

Main District Office:  
333 Las Vegas Blvd. S., Ste. 8016  
Las Vegas, NV 89101  
Phone: (702) 388-5020  
Fax: (702) 388-5030

### Senator John Ensign, Republican

Washington Office:  
528 Hart Senate Office Building  
Washington, D.C. 20510-2803  
Phone: (202) 224-3542  
Fax: (202) 224-7327

Main District Office:  
333 Las Vegas Blvd. S., Ste. 8016  
Las Vegas, NV 89101  
Phone: (702) 388-5020

Fax: (702) 388-5030

**Please keep this information handy so you can call your representative when an important issue comes up for a vote or for discussion.**

**Your opinion is extremely important and vital for change. Together we can make a difference in the lives affected by a mental illness.**

**Check our website regularly for advocacy**

# Bipolar Disorder and Substance Abuse

## Unfortunate Bedfellows—Written by Chris Heavey, Ph.D. & Theresa Scott, B.A.

As difficult as bipolar disorder is to live with, it is often accompanied by an additional problem: substance abuse. Mental health professionals describe the co-occurrences of mental health problems and substance abuse problems as someone having a “dual diagnosis.” Although the reasons for the high frequency of substance abuse problems remains unclear, one major study found that as many of 60% of those suffering from bipolar disorder also meet the criteria for having a substance abuse disorder at some point during their lifetime. This “co morbidity” of bipolar disorder and substance abuse is higher than for any other major mental illness. Although those suffering from depression also often have substance abuse problems, estimates from another national study suggested this occurs among approximately one quarter of those diagnosed with depression. Similarly high co morbidity of

bipolar disorder and substance abuse has been found in other cultures as well, suggesting this problem is not unique to our culture.

The reason for the frequent co-occurrence of bipolar disorder and substance abuse problems is not clear. Sr. Stephen Strakowski and his colleagues have proposed several possible explanations. First, they note that it is unlikely that bipolar disorder simply creates substance abuse problems due to the pleasure seeking that accompanies manic periods because many patients suffer from substance abuse problems before the onset of bipolar disorder. Another study found that individuals for whom substance abuse preceded the onset of bipolar illness had a significantly later age of onset than those who developed bipolar illness before developing substance abuse problems. Based on this they con-

cluded that there may be different explanations regarding the do-occurrence of these difficulties for different subgroups of individuals. **Continued page 5**

### WHAT'S NEW AT DBSA?

**DBSA Southern Nevada has a new Mission Statement, and a new logo. We will also be launching a new interactive web site by the end of July if all goes according to plan. Our new web address is:**

**[www.dbsasouthernnevada.org](http://www.dbsasouthernnevada.org)**

**We are also selling handmade ribbons representing Bipolar Disorder made and designed by our members.**

## Cognitive Behavioral Therapy—CBT

Cognitive Behavior Therapy known as CBT is a clinically and research proven breakthrough in mental health care. Hundreds of studies by research psychologists and psychiatrists make it clear why CBT has become the preferred treatment for conditions such as these . . .

- Depression and mood swings
- Shyness and social anxiety
- Panic attacks and phobias
- Obsessions and compulsions (OCD and related conditions)
- Chronic anxiety or worry
- Post-traumatic stress symptoms (PTSD and related conditions)
- Insomnia and other sleep problems
- Difficulty establishing or staying in relationships

- Insufficient self-esteem accepting or respecting yourself
- Inadequate coping skills, or ill-chosen methods of coping
- Substance abuse, co-dependency and “enabling”
- Trouble keeping feelings such as anger, sadness, fear, guilt, shame, eagerness, excitement, etc., within bounds
- Over-inhibition of feelings or expression

CBT combines two very effective kinds of psychotherapy—cognitive therapy and behavior therapy.

**Behavior therapy** helps you weaken the *connections* between troublesome situations and your habitual reactions to them. It also teaches you how to calm your mind and body, so you can feel better, think more clearly, and make better decisions.

**Cognitive therapy** teaches you how certain *thinking patterns* are causing your symptoms—by giving you a distorted picture of what’s going on in your life, and making you feel anxious, depressed or angry for no good reason, or provoking you into ill-chosen actions.

*No other type of psychotherapy has anything like this track record in outcome research.*

When combined into CBT, behavior therapy and cognitive therapy provide you with very powerful tools for stopping your symptoms and getting your life on a more satisfying track.

CBT is active therapy where your therapist takes an active part in solving your problems. He or she doesn’t settle for just nodding wisely while *you* carry the whole burden of finding the answers you came to therapy for.

**CONTINUED ON PAGE 4**

# CBT—Continued from page 3

You will receive a thorough diagnostic workup at the beginning of treatment—to make sure your needs and problems have been pinpointed as well as possible.

This crucial step—which is often skimmed or omitted altogether in traditional kinds of therapy—results in an explicit, understandable, and flexible treatment plan that accurately reflects your own individual needs.

## Structure and focused

CBT provides clear structure and focus to treatment. You will take on valuable “homework” projects to speed your progress. You may also receive take-home readings and other materials tailored to your own individual needs to help you continue to forge ahead between sessions.

## The levers of change

The two most powerful levers of constructive change (apart from medication) are these . . .

- Altering ways of thinking—a person’s thoughts, beliefs, ideas, attitudes, assumptions, mental imagery, and ways of directing his or her attention—for the better. This is the *cognitive* aspect of CBT.

- Helping a person greet the challenges and opportunities in his or her life with a clear and calm mind—and then taking actions that are likely to have desirable results. This is the *behavioral* aspect of CBT.

## CBT is usually brief

Most CBT patients are able to complete their treatment in just a few weeks or months—even for problems that traditional therapies often take years to resolve, or aren’t able to resolve at all.

Meanwhile, for people with complex problems, or who are forced to live in adverse conditions beyond their control, a longer-term treatment is also available.

## Schedule of Visits

This is determined on your individual needs, your insurance plan, and the way your own therapist prefers to work.

As a rule, however, most people can expect to begin their treatment with weekly visits. If in crisis this may go to two visits weekly.

Further on in treatment these are among the options that are often recommended. . . .

- Individual sessions every other week or monthly, combined with weekly group therapy meetings.
- Individual sessions every other week or monthly, without participation in group therapy.
- A planned break of several weeks, followed by resumption of weekly individual sessions for a period of time.
- A trial termination of therapy—with the option of resuming if the need develops. Quite often, a follow-up session or phone contact is scheduled for a future date.

In addition, most CBT practitioners subscribe to the principle of *intermittent brief psychotherapy, as and when needed*.

To find a CBT practitioner by state go to:

[www.nacbt.org](http://www.nacbt.org)

\*\*\*Please Read accompanying article—**Bipolar Disorder and Substance Abuse** written by our past Medical Advisor Dr. Chris Heavey.  
\*\*\*

## DID YOU KNOW

- |  |  |   |  |
|--|--|---|--|
| 1. 6% of Nevada residence are diagnosed with either Depression or Bipolar Disorder?                        | chance of living a normal, healthy life?   | 8. 60% of Domestic Violence victims suffer from depression?                                 | 12. That 11,000 individuals including families with children are homeless on the streets of Las Vegas daily? |
| 2. 3% of Nevada residence are diagnosed with Schizophrenia.?   | 5. That Nevada ranks 3rd in the nation for completed suicides?   | 9. 25% of Domestic Violence victims commit suicide?   | 13. That 1 out of 4 people are diagnosed with Bipolar Disorder?  |
| 1. It takes an average of 2 1/2 years to find the right combination of medications that will work for you? | 6. That Nevada ranks 3rd in Adolescent completed suicide rate in the nation?                                       | 10. That mental illness is a treatable medical illness?                                     | 14. That families raising a child diagnosed with Bipolar Disorder have a higher risk of divorce?             |
| 4. Adhering to a personal treatment plan gives you a 98%   | 7. That one out of every 4 women will have experienced at least one major episode of depression in their lifetime? | 11. That the stigma associated with mental illness attributes to people committing suicide? |  |

# Bipolar Disorder and Substance Abuse

## Continued from Page 3

For example, for individuals for whom bipolar disorder comes first, it may predispose them to become involved with substances either as a form of self-medication or as due to the pleasure-seeking aspect of manic episodes. Conversely, for the individuals for whom substance abuse comes first, the effects of substance use may sensitize the individual other risk factors for affective disorders such as bipolar disease.

Another vexing aspect of this dilemma is that past research has suggested that individuals with co morbid substance abuse and bipolar illness may have a poorer prognosis and respond less well to treatment than those suffering from only bipolar illness. On a more positive note, substance use problems typically decreased over time, even when affective symptoms persisted. These studies have limitations and therefore we should be cautious in our interpretation. Nonetheless, they point to the importance of developing effective strategies for treating co-occurring substance abuse and bipolar disorder.

Researchers have examined both pharmacological treatments and psychosocial treatments. For example, one study found that individuals with both bipolar disorder and substance abuse problems were more likely to experience antidepressant induced mania than were individuals with bipolar disorder but no substance abuse problem.

In one other recent study, clinicians compared different treatments among two groups of individuals with dual diagnosis. One group treatment involved medication management only while the second group involved medication management and cognitive behavioral treatment. Comparison of the two groups showed no significant effect on the outcome of substance abuse during treatment. However, the group receiving cognitive behavioral therapy did indicate greater improvement both in terms of medication compliance and mood related symptoms.

Generally, clinicians recognize the importance of treating both the problem of bipolar disorder and substance abuse, they are unclear on how to go about doing so in the most effective manner. Treatments that are getting the most attention at this time include cognitive behavioral therapies, and self-help programs such as Dual Recovery Support Groups. Numerous studies have shown these treatments to produce significant positive outcomes on individuals, but have shown no significant differences between the effectiveness of one treatment when compared to another.

Possibly the greatest asset of most cognitive behavioral therapies is their emphasis on giving people a sense of control over their actions by teaching them to understand the underlying motivating factors that drive them. One particular therapy is the SMART (Self-Management and Recovery Training) program, which is largely based on psychologist Albert Ellis' Rational Emotive Behavioral Therapy. Using the Rational Emotive Behavioral theory, SMART bases its treatment on the idea that "how we think and perceive life how we feel and how we act." Individuals are taught that ir-  
port substance dependency, and that countering these ir-  
rational beliefs with more rational ones improves these prob-  
lems. Individuals  
are taught to focus on and modify current beliefs, attitudes,  
personal responsibility.

*A group receiving cognitive behavioral therapy indicated greater improvement both in terms of medication compliance and mood related symptoms.*

largely determines rational beliefs sup-  
portional beliefs and re-  
sults. Individuals  
self-statements, and

searchers conducted  
vention. The out-  
proved employment

To evaluate the effectiveness of this model of treatment, re-  
a study comparing SMART therapy to a 23-step based inter-  
come shoed the group receiving the SMART program had im-  
satisfaction, life satisfaction, and medical status, as well as reduced psychiatric hospitalization. However, the  
SMART program was less effective at reducing substance abuse than the 12-step based program.

Although much remains to be learned about the complicated interaction between bipolar disorder and substance abuse, researchers have learned that the connection of these two difficulties is neither uncommon nor benign. Treatments that address both difficulties simultaneously offer the best chance of improving the diverse aspects of ones life that can be damaged by these co-occurring illnesses. Hopefully over time a greater understanding will be developed of the nature of this interconnection and how sufferers and clinicians can work together to manage and overcome these challenges.

For more information go to:

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

[www.alcoholics-anonymous.org](http://www.alcoholics-anonymous.org)

# 2009 Lecture Series Schedule, Speaker, Subject

**TUESDAY AUGUST 25, 2009**

**Suicide: The Silent Epidemic**

**Presented By**

**Lynda Tanner Delgado**

**Jason Foundation Representative**

Lynda received a Bachelor of Arts with Distinctions in Sociology from San Diego State University and a Master in Public Administration from California State University, Long Beach. Since the inception of her career in Las Vegas, she has worked with and partnered with all aspects of the community including the Clark County School District, police departments, social service agencies, Department of Child and Family Services, Department of Family Services, juvenile justice, mental health professionals, protective services, the casino industry security, and other community organizations

The Jason Foundation programs have been implemented in every high school health class of Clark County School District (the 5th largest in the nation) for the last four years. She trains all the counselors of Clark County School District annually in The Jason Foundation. It is mandatory for these counselors to go through the training. Every nurse in the Clark County School District has also been trained. In 2008, The Jason Foundation at Montevista conducted 194 presentations and trainings and touched 39,682 lives. She is dedicated to the goals and mission of The Jason Foundation .

She is P.O.S.T. certified for the Jason Foundation also. This certification includes any security or law enforcement officers training.

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**TUESDAY SEPTEMBER 29, 2009**

**The Roller Coaster Ride That Never Ends—A Parents Perspective**

**Presented By**

**Cheryl Murphy**

**Parent, Grandparent and Great Grandparent of Bipolar Children**

**President, DBSA Southern Nevada**

Cheryl has had many years of experience in raising bipolar children. She is a nationally recognized speaker on the subject. She will share her experiences, both good and bad, and tell you the secrets that can save your sanity.

Cheryl has worked within the mental health community for many years and serves on many mental health boards both locally and nationally. She has also worked in the special education field, substance abuse field and domestic violence field.

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**TUESDAY OCTOBER 20, 2009**

**Post Traumatic Stress Disorder**

**Present By**

**Larry Ashley, Ed.S., LADC, LMSW, LPC CPGC,**

Larry has been involved in the substance abuse and trauma field for over thirty years as a college professor, researcher, and therapist. He is currently Addictions Specialist and Undergraduate Coordinator in the Department of Counselor Education at the University of Nevada, Las Vegas, Director of the Problem Gambling Treatment Program, and Clinical Assistant Professor in the Departments of Psychiatry and Internal Medicine, University of Nevada School of Medicine. Due to his extensive clinical experience coupled with opportunities for local, national, and international speaking engagements, Professor Ashley is considered to be a leading expert on Post Traumatic Stress Disorder and issues related to addictions. He has a special interest on the impact of war on soldiers world wide.

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**TUESDAY NOVEMBER 17, 2009**

**HOLIDAY BLUES**

**Presented By**

**Barbara Parry, PhD.**

Dr. Parry is a regular speaker and is DBSA Southern Nevada's Medical Advisors. She has a private practice in Las Vegas.

Dr. Parry will discuss ways to avoid the holiday blues, how to start new traditions, and how to survive the family dysfunction get-together's through out the holiday season and how to de-stress during this very stressful time of year.

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**TUESDAY, DECEMBER 15, 2009**

**ADDICTIONS**

**Presented By**

**Lesley R. Dickson, MD**

**Lesley Dickson, MD, FAPM**, obtained her BA in Bacteriology from UCLA and then worked in biochemistry research for ten years before attending the University of Kentucky College of Medicine where she also completed a residency in psychiatry. She is ABPN board certified in general psychiatry, addiction psychiatry and psychosomatic illness. Following residency she was on the faculty of the University of Kentucky where she was Chief of the Consultation/Liaison Service and Residency Training Director. She has since been on the faculties of New York University and University of Nevada Medical Schools. Clinical experience has included being Chief of Inpatient Psychiatry and running dual diagnosis units for the Veterans Administration Hospitals in New York City and Las Vegas. She is now primarily in private practice and is the Las Vegas Medical Director for the Center for Behavioral Health which operates opiate substitution programs in Las Vegas and several other states. Dr. Dickson is also a psychiatrist surveyor for the Centers for Medicare and Medicaid Services.

Dr. Dickson is the Secretary/Treasure and Immediate Past President of the Nevada Psychiatric Association in addition to being State Legislative Representative and Newsletter Editor. She is an active member of the Clark County Medical Society and the Nevada State Medical Association and has served as a delegate to the last two state conventions. She has been very active in the Academy of Psychosomatic Medicine and became a Fellow in 1994. She is also the Governor appointed psychiatrist member of the Committee on Co-Occurring Disorders. Dr. Dickson was recently appointed to the IRB committee of University Medical Center.

# WEEKLY MEETING LIST

## MONDAY EVENING

**ADOLESCENT DIAG-  
NOSED  
Ages 13-17**

**6:30 PM TO 8:00 PM**

**Rawson-Neal Psychiatric  
Hospital**

**1650 Community College  
Drive  
Las Vegas, NV 89146**

**Training Room 1**

## WEDSDAY EVENING

**ADULT DIAGNOSED  
(18 & OVER)**

**6:00 PM TO 7:30 PM**

**Rawson-Neal Psychiatric  
Hospital**

**1650 Community College  
Drive  
Las Vegas, NV 89146**

**Training Room 1**

## THURSDAY EVENING

**DUAL DIAGNOSED  
Addiction and Mood Disorder**

**6:00 PM TO 7:30 PM**

**Rawson-Neal Psychiatric  
Hospital**

**1650 Community College  
Drive  
Las Vegas, NV 89146**

**Training Room 1**

## MONDAY EVENING

**PARENTS OF DIAGNOSED  
ADOLESCENTS**

**6:30 PM TO 8:00 PM**

**Rawson-Neal Psychiatric  
Hospital**

**1650 Community College  
Drive  
Las Vegas, NV 89146**

**Training Room 2**

## WEDSDAY EVENING

**PARENTS, FAMILY &  
FRIENDS**

**6:00 PM TO 7:30 PM**

**Rawson-Neal Psychiatric  
Hospital**

**1650 Community College  
Drive  
Las Vegas, NV 89146**

**Training Room 2**

## THURSDAY EVENING

**PTSD  
Post Traumatic Stress  
Disorder**

**6:00 PM TO 7:30 PM**

**Rawson-Neal Psychiatric  
Hospital**

**1650 Community College  
Drive  
Las Vegas, NV 89146**

**Training Room 2**

## DBSA SOUTHERN NEVADA

3941 Copperhead Hills St.  
Las Vegas, NV 89129

Phone: 702-818-5634  
Fax: 702-818-5834

Email:  
info@dbsasouthernnevada.org

Web Address:  
www.dbsasouthernnevada.org



Depression and Bipolar  
Support Alliance

*You Are Not Alone, We've Been There,  
We Understand, We Care, We Can Help*

*We are on the web  
www.dbsasouthernnevada.org*

# Membership—Donation Application

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Annual Dues \$15.00: ( )

Family Membership \$25.00 ( )

Professional Membership \$100.00: ( )

Donation Only \$: \_\_\_\_\_

Quarterly Newsletter \$15.00: ( )

Number of Subscriptions Ordered: \_\_\_\_\_

Total Enclosed \$: \_\_\_\_\_

**Please Make Checks Payable To:**

**DBSA Southern Nevada**

**THANK YOU FOR SUPPORTING  
DBSA SOUTHERN NEVADA**

Memberships, Subscriptions and Donations are tax deductible up to the fullest extent of the law. A receipt will be mailed to you at the address you list for tax purposes.

**Donations at meetings are greatly appreciated but not required for support group attendance.**

Your donations help support all of the free services we offer within our community.

All donations stay within our community

Professional Membership includes one year business card advertising in our Quarterly Newsletter.

**Please Mail Application and Checks To:**

**DBSA Southern Nevada  
3941 Copperhead Hills St.  
Las Vegas, NV 89129**