



# OUT OF THE FOG

The monthly newsletter of NAMI San Francisco

## Visit our New Website!

NAMI-San Francisco has proudly unveiled a new website, designed to better meet your needs on an ongoing basis.

- See information on upcoming events!
- News and pictures of past events!
- Past newsletter!
- Special announcements!
- Post messages and comments to our Blog!

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



**NAMI SF's New Address:**  
1010 Gough St.  
San Francisco, CA 94109

## Family to Family Class

**Starting September 22 in San Francisco**

NAMI-SMC is offering the Family To Family Education Class for parents, spouses, children and other family members of persons with a mental illness. Learn about facts and skills to help you and your family. There is no charge, class meets one night a week for 12 weeks.

**Call the NAMI office 415-905-6264 to register.**

**Advance registration is required, class size is limited.**

There is also a Family to Family Education Program **Teacher Training** being held in Santa Rosa August 10-12. Call Joy Seaman 707 528-1204 for information.

## Join us at the General Meeting on July 18

**The Behavioral Health Court of San Francisco** is an innovative program which diverts individuals with a serious mental illness, who come into the criminal justice system away from jail and into supportive housing, mental health services and rehabilitation

## The Monthly Meeting

3rd Wednesday of each month  
6:30 - 8:00 pm  
1010 Gough St.  
(between Eddy & Ellis)

### July 18

Members of **The Behavioral Health Court of San Francisco** Judge Mary Morgan, Jennifer Johnson, Cynthia Johns and Kathleen Connolly will tell us about the success and growth of the court over the past year.

**No Meeting in August -  
Enjoy the summer!**

### September 19

**Terrance Ketter** of the Stanford Mood Disorder Clinic, one of the foremost leaders in bipolar research, will discuss treatments for bipolar

# The Body Electric

By Ann Bauer, Reprinted from Salon.com, June 19, 2007

At the age of 3, my older son withdrew, becoming sullen and cross-eyed overnight. He stopped speaking and lost the ability to follow directions, vanishing inside a body that only rocked and swayed and arched away from human touch.

Together with my then-husband, I coaxed this little boy back: reading him poetry, drilling him with flashcards, crawling the floor in circles at his side. And when he returned to us, recovering in a way most autistic children never do, I believed the worst thing that would ever happen to us was done.

So when -- after more than a decade of progress -- my son began to regress, I didn't see it. I couldn't. I called it depression, anxiety, teenage sloth. I didn't realize the enormity of what was happening until my 18-year-old son could no longer climb a flight of stairs or tie his own shoes. Even then, it took us another year to figure out that he had a condition called autistic catatonia: a second withdrawal, even more cruel and dangerous than the first, which occurs on the far end of childhood.

About a month ago, I wrote a story about my son's misdiagnosis of schizophrenia during that yearlong period, as well as his frightening response to a couple of commonly prescribed antipsychotic medications, Abilify and Geodon. I cited a New York Times article about psychiatrists in Minnesota (where we live) receiving kickbacks for prescribing exactly those drugs and went on to report that my ex-husband and I finally took our son to Mayo Clinic, where he was correctly diagnosed and appropriately treated. I told how doctors there admitted a mute and feral young man, working in choreographed teams to figure out exactly what he needed, magically finding the person inside and bringing him back again.

What I did not report was that they used electroconvulsive therapy (or ECT) in order to do so.

I had two reasons for omitting this information. First, the point of my original essay was to bring attention to the misuse of antipsychotic drugs in children, adolescents and people of all ages along the autistic spectrum; I believed including the information about ECT (also commonly known as shock treatment) would hijack the piece, drawing attention away from the issues of overprescription and autistic catatonia.

But also, frankly, I didn't feel like going through a hailstorm of reader outrage and Frankenstein jokes. Because even after seeing the benefits of electroshock for myself, I

remained ambivalent about the treatment, protective of my son and simply raw.

So why go public now? Because after that original essay was posted, I received literally hundreds of messages (in fact, I continue to receive them, all these weeks later), from readers who had children, brothers, sisters or friends suffering from something similar. And these people were desperate for answers: How was my son cured? Did it last? And where could they go to obtain the same treatment for their son, daughter, brother, sister or friend.

I was in the process of responding individually to each of these queries when I received a letter from Max Fink, the doctor who had referred us to Mayo -- and whose book "Electroshock: Healing Mental Illness" I used to research ECT -- asking me to set the record straight. "I recognize the tremendous stigma attached to this treatment," it said. "But if you wish to help other parents of such adolescents, you should disclose the fact that, despite its stigma, electroshock is one of the most effective treatments in medicine; that it has been in use for more than 70 years; and that its benefit-to-risk ratio [for acute patients] is very favorable."

Everything he wrote is true.

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Convulsive therapy was introduced to modern medicine in 1934 by the Hungarian neuropsychiatrist Ladislas Meduna. He had observed that delusional patients who suffered spontaneous seizures often were miraculously cured and developed a theory that mental illness and epilepsy were "antagonistic" conditions: Those with the first had a deficit of neuroglia (branched cells that form the network for communication between neurons), whereas those with the second had a surfeit. By inducing seizures with an injection of Metrazol, Meduna believed he could "grow" neuroglia in the addled brain, thereby reversing disease.

Proponents of ECT no longer believe this. In fact, they can't say exactly why it works, only that it does, swiftly and consistently, in roughly 90 percent of catatonia cases, and 60-70 percent of patients with severe depression, mania and intractable psychosis. Recently, neurologists have begun recommending regular electroconvulsive therapy sessions for patients with movement disorders, such as Parkinson's, saying that it minimizes tremors and reduces the need for drugs such as L-dopa, which has notoriously negative side effects. (ECT has proved ineffective, however, when used for dysthymia, anxiety, substance abuse and personality disorders.)

The prevailing theory today is that ECT somehow repairs and sensitizes various neurotransmitter receptors, such as the ones that bind to serotonin, dopamine, glutamate and cortisol. But the truth is, no one really knows.

"Think of it like rebooting the brain," one clinician told me. "You don't know exactly why your computer isn't working, but if you shut it off and turn it back on, nine times out of 10, it'll come back online and function just fine."

This is small consolation on a chilly, blue morning in May, as I drive to Mayo before dawn and walk through the still-sleeping ward. Inside my son's room I stand at his

*Continued on page 4*

## County Mental Health

The County mental health access line  
for all consumers is

**415-255-3737**

The Mobile Crisis Unit is

**415-355-8300**

# The Wrong Place To Treat Mental Illness

Cuts in state Medicaid budgets promise to exacerbate prison warehousing of mentally ill.

*From The Washington Post by Marcia Kraft Goin, July 8, 2007*

Last month the Supreme Court rightly blocked the execution of Scott Panetti, a Texas man who was convicted of a double murder and who suffers from delusional schizophrenia. The case drew public attention to the intersection between mental illness and executions.

But what about those who are mentally ill and imprisoned but not on death row? A national conversation on this issue is urgently needed.

There is a pervasive attitude in this country that such people are getting what they deserve: After all, like Panetti, they are in jail for something.

But did you know that the Los Angeles County Jail houses the largest psychiatric population in the country? That's not justice. That's emblematic of a national emergency. Before the 1960s, people with mental illnesses were generally cared for in institutional settings, mostly state-run psychiatric facilities. Many advocates correctly saw this as "warehousing" people who could be cared for in less restrictive settings. Federal legislation and the courts powered a move toward deinstitutionalization, calling on states and counties to provide resources for social services, vocational rehabilitation and treatment services. The introduction of effective antipsychotic medications also drove the trend toward deinstitutionalization.

In the decades since, community-based services have helped many people. But the situation today constitutes a national failure.

## What's gone wrong?

Most important, the necessary community resources didn't materialize in anywhere near the level that was needed. Also, antipsychotic medications, while powerful treatments, don't work in isolation. Patients need a relationship with a psychiatrist, clinic or other stabilizing force to ensure adherence to drug regimens and achieve the best possible recovery.

Deinstitutionalization has succeeded in decreasing the overall number of hospital beds, but an unforeseen consequence has been the proportional increase in the number of people with mental illnesses housed in the criminal justice system. Worse, once imprisoned, people with mental illness are shown to have much longer incarcerations than other inmates, primarily because a prison environment and lack of treatment aggravate the

very illness that has led to their objectionable or antisocial behavior.

While no one would argue that Scott Panetti belongs on the streets, his case compels us to consider the justice system's role: Is it to mete out punishment that seeks retribution, or are there cases where real justice means effective treatment that seeks rehabilitation?

Consider again Los Angeles County: In 2002 there were 38,600 psychiatric evaluations at the inmate reception center of the Twin Towers jail. Of these, 23,190 people (60 percent) were found to be in need of mental health treatment. A reasonable person could not fail to see the correlation between decreased funding for mental health resources, the closure of hospital beds, homelessness and the criminalization of mental illnesses. Untreated and lacking access to long-term care, people with mental illnesses often end up with symptoms and behaviors that result in jail time.

Cuts in state Medicaid budgets promise to exacerbate these problems. Not only is this shift in funding a blight on our society, it also costs money -- a lot of money. Corrections officials, mental health workers, medication, amortization of buildings and time spent by police in court all cost more than treating patients appropriately in their community. This doesn't make financial sense, much less humanitarian sense.

When considering the direction of public policies that affect those with mental illnesses, politicians and other officials must be guided by the latest research.

Government-funded studies have shown in recent years that jail-diversion programs, which help people get the treatment they need, result in positive outcomes for individuals, communities and the criminal justice system. While jail diversion does generally result in lower criminal-justice costs and greater treatment costs, studies are underway to analyze the differential.

The question the court answered in the Panetti case was about one's fitness to be executed, but in many more cases, the question is about the appropriateness of incarceration at all.

Remember to donate to the

**Community Thrift Store**

This is our *best source* of income  
for the NAMI SF Chapter!!

**625 Valencia Street at 17th Street**  
**415-861-4910**



bedside, reading the form I've been handed, then take a deep breath and sign so the doctors who have assembled six-deep can take him to a surgical suite, put him under a "light" general anesthesia, attach electrodes to his temples, and shock him until he has a seizure. Under any other circumstances, this young man -- 19 years old, of normal intelligence, and legally in charge of his own medical decisions -- would not need parental consent. But here's what it means to be clinically catatonic: Though he is burly and muscular, my son's mind is spinning so fast his body has stopped functioning altogether and he cannot exert enough pressure to use a ballpoint pen. His signature at the bottom of the sheet is illegible.

After I have scrawled my name under his, I hand the paper to my ex-husband who does the same. Then we walk alongside the bed that is being wheeled with effort by two medical students into a large, bright theater. They talk excitedly as we walk: This is the first time they will observe an actual ECT treatment.

Just then, the female student glances in our direction. Her face softens. "We'll take good care of him," she says.

And I nod blindly, through stupid, angry tears.

Then my former husband and I stand against a wall while they coax our son onto a fancier gurney, one with long straps that they pull out to their full length and buckle snugly around him. We watch the anesthesiologist lean over his frozen form and slip a needle into his arm. And I remember the day of his tonsillectomy, 13 years ago, when we -- still hopeful young parents -- held him down, our hands meeting on his Winnie the Pooh gown, while someone lowered a rubber mask over his small face.

Suddenly, there is a problem. "They don't belong in here!" a voice says, and we are hustled out, into a small waiting room where I sit uncomfortably across from the man to whom I was married for 14 years. "Don't worry, it'll be all right," he says, in lieu of touching me. And again, I nod.

Twenty minutes later, the male medical student comes out to talk to us.

"Your son is fine, everything went well," he says in a bright voice. "And you should know, we got a really good seizure using the very lowest level of current."

"Is that better?" I ask. "What does that mean? Is less current safer, or a sign that he's closer to the surface than we think?"

The boy's eyes cloud and he looks suddenly bewildered. He pauses, then says, "Honestly, ma'am, I have no idea."

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By the early 1940s, electrical current had replaced chemical agents to become the standard method for convulsive therapy. Ugo Cerletti and Lucio Bini, the Italian researchers who developed the protocol for "electroshock" by experimenting on animals, were nominated for (but did not receive) a Nobel Prize in medicine.

But ECT's popularity plummeted briefly in the 1960s when drugs such as imipramine and chlorpromazine were introduced and deemed preferable by most doctors. And it dropped off again in the mid-'70s, when the film "One Flew

Over the Cuckoo's Nest" depicted electroshock as medicalized torture, used by venal healthcare workers to keep mental patients in line. Despite a series of movies and television shows that vilified the therapy -- "Law and Order" even did an episode about ECT, called "Cruel and Unusual" -- rates crept back up over the next several decades, mostly for patients with drug-resistant forms of mental illness. And by the mid-'90s (the most recent period from which statistics are available), about 100,000 people in the U.S. were being treated annually with ECT.

"One of the major reasons ECT is so controversial is because of the way it's been portrayed in the media," says Dr. Teresa Rummans, professor of psychiatry and the former medical director for ECT at Mayo Clinic. "Our challenge is to get people to consider this therapy as an option, despite the negative things they've seen in the movies. It's not a panacea. But for certain people who can't be helped any other way, it can be life changing, or life saving."

Today, even anti-ECT activists admit the therapy sometimes works in cases where nothing else has. But there is a debate raging about whether the side effects of ECT -- including memory loss and confusion -- are temporary or, in the language of the medical establishment, "persistent." Earlier this year, Harold Sackeim -- a professor of psychiatry and radiology at Columbia University -- published the results of a 25-year study in the journal *Neuropsychopharmacology*, confirming that ECT can cause permanent memory loss.

We didn't turn to this treatment until it was the only option left and our son was so lost, overwhelmed and deluded that his quality of life was entirely gone. I remind myself of this. I've read and reread the quote from novelist William Styron -- author of the visceral depression memoir "Darkness Visible" -- after he underwent ECT in 2000: "I'm writing. I don't sense any memory loss whatsoever ... I would say that my memory is somewhat better than it might have been a year ago." I remind myself that today electroconvulsive therapy is practiced not only by the Mayo Clinic but also by neurologists and psychiatrists in nearly every well-respected academic and teaching hospital in the country.

Still, I pray that this is not a terrible, irreversible mistake.

After his first treatment, my son is wheeled back to his room. I check him over, anticipating strap marks from where he strained upward during the convulsion, or burn marks on his temples. All I find is a white bandage on the crook of his arm, from where the IV needle went in. He sleeps the rest of the afternoon. When he awakens, he appears confused, but he is able to drink some water. The nurse asks him if he has a headache; he thinks for a few moments then signals "No."

Drained, my ex and I drive back to Minneapolis together. We've told no one what we'd gone to Rochester to do, in fear that some distant relative with a Scientology bent might file an injunction to stop us. Now, the weight of this sits between us and we barely speak.

Eighteen hours later, my husband drives me back to Rochester. It is 10 a.m. on a Saturday. We walk onto the unit and while we are being checked for contraband (anything with a blade, a sharp edge, or a cord), my son ambles out of his room and smiles at us. He raises a hand. "Hey, good to

see ya," he says, and walks -- not quickly, but purposefully - into the lounge where three other patients are sitting in front of the TV. "What are you watching?" we hear him ask one of the others.

My husband turns to me, eyes freakishly wide. "Holy cow," he says, grabbing my hand. "Have you ever seen him move like that?"

And, of course, I have. But it was long ago: before I met this man, before my son became depressed and discouraged, before the catatonia set in.

Later that day, we play hearts and when my son shoots the moon [taking all the heart tricks, plus the queen of spades; a move that requires careful strategy and a straight face], he gathers up all the cards and crows the single word "Yes!" out loud.

It is an eerie, wonderful sound that doesn't fade for me, even as we are riding home.

In "Flowers for Algernon," the science fiction novella written by Daniel Keyes in 1959, a retarded janitor named Charlie Gordon undergoes brain surgery and is "cured." His IQ rises from 68 to the genius range. Then the process begins to reverse and Charlie, now sober and worldly and able to read in several languages, must experience his own deterioration. In the final pages of the novel, after writing a scientific paper detailing the descent, he becomes once again a shambling, childlike man.

Bringing our son home from the hospital is something like this. After seven ECT sessions, he seems ready: still autistic -- this is a lifelong condition that no current therapy will change -- but clearheaded, affectionate, gentle and ready for real life. On the day of his arrival back home, he writes a new schedule, updates his calendar, washes his clothes. On the second day, he is a little shakier, more tentative; around dinnertime, he begins laughing joylessly, under his breath.

"I can feel the catatonia coming back," he whispers to me late in the evening. "Please, help me. Make it stop."

Day 3, he is supposed to return to work and he does, but his supervisor calls midway through the shift to say there is a problem: By the time I arrive, he is standing in place, swaying, tears streaming down his face. He cries for the next 17 hours, taking breaks only to eat, which he does in enormous quantity, telling us he's trying to erase the sadness and bad thoughts. On Day 4, he pushes through the wall of me and his father, sobbing, saying he is leaving us and leaving his life, then walks away -- a shaking, swooning mass topped with a backward baseball cap -- into a steadily graying twilight.

Together with two police officers, a paramedic, and our respective spouses, we track him down and take him back to Mayo, where they determine he needs more ECT. This time, however, the response is not so immediate: He lies in his bed, lumpen and rank-smelling, his head lolling. It is only after the third treatment that my son is resurrected again. I call and he answers the phone in his old voice, telling me he's feeling quite good now and would like to go home again soon. He remembers little of the four days between hospital stays but promises things will be different this time. Better.

That's when the psychiatrist in charge of his case calls a

*Continued on page 7*

## Bifepunox: New Schizophrenia Medication Phase III Study Results

*Reprinted from Schizophrenia.com, July 4, 2007*

In May of 2007, pharmaceutical companies Wyeth, Solvay and psychiatric research company Lundbeck reported more recent findings on bifepunox, a possible new drug for treating schizophrenia that has been in the works for some time now. New research including 6-months of data looked at stabilized adults with schizophrenia using a randomized, double-blind, placebo-controlled phase III study. (basic drug study information). Of course, with all new medications - many side effects don't become well known until many years after launch, so its impossible to say for sure what additional side effects may be caused by a new medication.

Bifepunox has been featured on this site before, and was seen as a possible new advancement in the medication treatments of schizophrenia. In 2006, phase III trails were delayed and not expected till 2008; but in a positive turn, the first 6-months of data are available now. In 2004, Schizophrenia Bulletin had these hopeful things to say about bifepunox:

Bifepunox, is a novel third-generation antipsychotic that exhibits partial agonist properties for dopamine D2 as well as serotonin 5-HT1A receptors. Bifepunox, which was developed by Solvay, has shown efficacy superior to haloperidol in Phase III clinical trials, with few side effects. The drug is effective on both positive and negative symptoms and appears to present little risk for weight-gain, cardiovascular, or extrapyramidal side effects.

In analyses of data from one Phase 3, six-month, randomized, double-blind, placebo-controlled study:

- Compared with placebo, bifepunox significantly prolonged time to deterioration over six months.
- Bifepunox patients experienced decreases in body weight and body mass index vs. placebo over six months.
- Bifepunox patients showed favorable effects on total cholesterol, triglycerides, very low-density lipoprotein and low-density lipoprotein, comparable with placebo over a six-month period.
- In these analyses, the most common side effects reported with bifepunox (incidence of greater than or equal to 5 percent and twice the placebo rate) included nausea, vomiting, dizziness, anorexia, akathisia, dyskinesia and asthenia.

"We are encouraged by these additional analyses of clinical data, which underscore bifepunox's favorable weight and lipid profile," says Earl Sands, M.D., Vice President, Research and Development at Solvay Pharmaceuticals, Inc. "Bifepunox, if approved, may be an important treatment option in the long-term management of adult patients with schizophrenia."

## Support Groups



### Family Members' Groups

#### *African American Family Support*

1st Thursdays, 5:30-7:30 pm at  
1380 Howard St., Rm 537. Call Wanda at 255-3694

#### *San Francisco Family Support Group*

Tuesdays, 5:15-6:45 p.m. at SF General Hospital, 1001 Potrero St., Room 7M30. Info: Susanne at 415-558-5900

#### *Sibling & Adult Children Network*

Call Mary Gullekson at 474-7010 for information

#### *Berkeley Sibling Support Group*

Call Carolyn Defay at (510) 644-8579

### Bilingual & Monolingual Support Groups

*Chinese Families Mental Health Alliance.* Ed Koo 352-2047

### Consumer Self-Help Groups

#### *Depression & Bipolar Support All. (formerly DMDA)*

Saturday afternoons at 1:30-3:00 and  
1st Mondays at 6:45-8:00 pm in the Saint Francis Hospital,  
900 Hyde St., 2<sup>nd</sup> Floor Conf. Room. Call 519-0171

#### *SPIRITMENDERS Community Drop-in Center*

2940 – 16<sup>th</sup> Street #B2 (415) 552-8565

#### *OASIS (Office of Self Help)*

1095 Market Street at 7<sup>th</sup>, Suite 202 (415) 575-1400

#### *RECOVERY, Inc.* for nervous ailments.

(415) 333-6454 (meets at California Pacific in SF)

#### *Consumers with Schizophrenia*

3rd Wednesday of each month, 5:30 pm  
1380 Howard St., 5th floor. Info: Susanne at 558-5900

#### *Hoarding & Cluttering Support*

2nd Monday and 4th Wednesday of each month.  
Antonio (415) 421-2926 x306

#### *Health and Wellness Action Advocacy*

1st Thursday of each month, 1-3pm. Antonio at  
(415) 421-2926, x306

*Anxiety & Panic Self Help Group:* John (650) 755-0883

*Alcoholics Anonymous:* San Fran: (415) 621-1326

Marin: (415) 499-0400 San Mateo: (650) 573-6811

*Narcotics Anonymous SF Helpline:* (415) 621-8600

NAMI-San Francisco is a self-help organization of family members, mental health consumers, friends, professionals and other interested citizens, united to provide support, education and advocacy for persons with severe mental illness. NAMI-San Francisco is a private, non-profit organization.



## NAMI-SF Support Groups

- 1) **For Caregivers and Friends Only**  
1010 Gough  
2<sup>nd</sup> Wednesday at 6:30  
Contact Vickie at 661-5208
- 2) San Francisco General Hospital  
7<sup>th</sup> Floor, Room 7 M 30  
Tuesdays, 5:15 – 6:45 p.m.  
Call Susanne Killing at 558-5900

### **DBSA meeting location change:**

**The latest word from Jo Beth Welsh, Director of Volunteer Services at St Francis Hospital, is that we will holding our DBSA SF Support Meetings at our old location ( 2nd Floor, Conference Rooms B&C ) until July 21st and then move to the Lower Level, Conference Rooms A, B and C.**

## DBSA

### **Depression and Bipolar Support Alliance of San Francisco**

*(formerly San Francisco Depressive and Manic Depressive Association)*



#### **Regular Support Group:**

every Monday at 6:45-8:15pm and  
every Saturday at 1:30-3:00pm.

#### **Young Adults Support Group:**

1st and 3rd Monday of each month at 6:45-8:15pm for 18 to 25+ year old people.  
Contact Harry at 650-430-2909 for information.

#### **Friends And Family Support Group:**

1st and 3rd Monday of each month at 6:45-8:15pm. Contact Jane at 415-519-0171 or Harry at 650-430-2909 for information.

#### **Location:**

2nd floor of St. Francis Hospital  
900 Hyde St.  
between Pine and Bush in San Francisco  
Conference rooms B, C, and D

Meetings are on a drop in basis and are open to peers, please note we do not allow observers. You do not need to be a member to attend, however memberships are \$20.00 a year and you are encouraged to join and support the organization.

meeting. We've reached a decision-making point, he says. ECT alone is effective but transient. Also, there are residual symptoms of the catatonia: tics, disordered thoughts, twilight around the edges of his mind. The best option is to continue with the ECT three times a week for the duration of his hospital stay and afterward, once or twice a week on an outpatient basis.

In addition, they'd like to try a drug that will bridge the treatments and sustain their effect.

Because our son has responded so badly to medications in the past, all four parents object. But we are told it is the only option, barring constant, lifelong ECT.

"Most people will need something to keep them well after their course of treatment," says Dr. Rummans. "Electroconvulsive therapy resets the circuits and gets things working. But I think of it the same way as when someone has electroconversion for cardiac arrhythmia: They still need medication or surgery afterward to maintain. The brain works similarly to the heart in this respect."

Here's what I know: Even given the potential risks and my distrust of its murky track record, ECT has brought my son back to life twice and I am suddenly more afraid of what will happen to him -- that inevitable Charlie Gordon-like crumbling -- if he is disconnected from the machines.

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It is Memorial Day weekend and our family urges us to get away. "You need to take a break from this," my father tells me. "Go out of town for a couple days and we'll take over at Mayo."

My husband and I throw a change of clothes into a bag,

climb onto our Triumph, and ride 12 hours through the Badlands and into the Black Hills. On the morning of the third day -- our final one -- we go to Bear Butte, the mountain just outside Sturgis, S.D., to which many Native Americans trace their spiritual roots.

We know that bikers have a reputation for desecrating this sacred place. So we are careful: touching nothing, taking nothing, leaving nothing behind.

It is a cool afternoon with clear skies but dampness that licks our cheeks and arms. We climb the rubbly laccolith through trees hung with colorful Indian tobacco ties, bits of cloth representing the six directions: north, south, east, west, above and Earth Mother. When the wind blows, they move like soundless bells.

As we near the top of Bear Butte, a storm gathers and I run ahead. I reach the wooden platform at the peak and stand in the center, watching black clouds scud like ships. Lightning cracks to the north of the mountain. Then, as if in answer, there is a flash from the south. I face east so I can watch both sides of the storm. Up here I am taller than the trees, the highest point between Rapid City and the Wyoming border, inviting one of the bolts to strike. Never has the power of electrical current seemed so clear and there is a part of me that wants to feel it, here in this hallowed place. I imagine the six directions have conspired to tell me something and I must listen, so I look toward the forked branches of light.

My husband arrives then, breathless, climbing the steps of the platform and coming toward me with his arms outstretched.

"Sit," he orders. And I do. But I keep my head up, feeling the rain on my face and watching the flickering sky.

*Out of the Fog* is published 10 times a year by NAMI-San Francisco, a non-profit organization affiliated with the National Alliance on Mental Illness, which goes by the acronym NAMI, and NAMI-California, the statewide affiliate.

#### **NAMI San Francisco**

1010 Gough St.  
San Francisco, CA 94109  
415-905-NAMI  
415-905-6264  
[www.namif.org](http://www.namif.org)  
Contact us at [namif@fsasf.org](mailto:namif@fsasf.org)

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Send newsletter additions/submissions/change requests to  
[renee.deger@yahoo.com](mailto:renee.deger@yahoo.com)



## Please Join NAMI SF

NAMI-San Francisco is moving to a system where members renew in their anniversary months, but many of you are on the calendar-year system.

Please let us count you. There is power in numbers. We need the support of families, friends, consumers, professionals and others who share our goals. Your dues help us pay for the printing of the newsletter, educational materials and mailings and the Family-to-Family Education Course, an invaluable resource for people who love someone with a mental illness.

Checks may be made out to "NAMI San Francisco"

Please mail to:

NAMI-San Francisco Treasurer  
PMB 426  
1010 Gough St.  
San Francisco, CA 94109

NAME \_\_\_\_\_

(Please Print)

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CITY \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

This is a: •New Membership •Renewal •Address change

What is your relationship to a person with a mental illness?

•self • parent • sibling • spouse • health care/professional  
Other \_\_\_\_\_

Please Check One:

- \$10 Consumer
- \$45 Individual or Family Membership
- \$100 Organization or Benefactor Membership
- \$250 or more for Patron Membership
- \$500 or more for Sustaining Membership

• I cannot join NAMI-San Francisco at this time but I would like to receive *Out of the Fog* or I am enclosing a donation of \$ \_\_\_\_\_ to help cover the cost of *Out of the Fog*.

## NAMI SAN FRANCISCO

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