Subject Two:
Subject Review & Training/Teaching Guide

Psychiatric Disorders Within A Co-Occurring Diagnosis

Subject Review Developed By:
Rhonda McKillip, LLC
Text: THE BASICS, Second Edition:
A Curriculum for Co-Occurring Psychiatric and Substance Disorders

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1

Purpose of the Subject Review & Teaching Guide

1. Cross-train staff on Co-Occurring Psychiatric and Substance Disorders using *THE BASICS, Second Edition* as the text. Training, study, or review by treatment providers of the curriculum/subjects in *THE BASICS, Second Edition* either individually or by the entire staff.
2. Provide discussion and teaching format for Universities and Colleges using *THE BASICS* as their course work text.
3. Assist professionals in Subject Review for Credentialing Exams offered by the International Certification & Reciprocity Consortium (IC&RC) and other national boards.

❖ **NOTE**: These PowerPoint presentations are **NOT** the officially endorsed "Study Guides" for the IC&RC and other National Exams recommending *THE BASICS, Second Edition* as material to be studied for their exams. *THE BASICS, Second Edition – the two volume set* – **IS** the recommended Study Guide for the credentialing exams. These Subject Reviews are overviews that I created to give professionals a way of reviewing subject material or training presentations *on THE BASICS*. These are not sufficient or intended to be the sole credentialing preparation for any credentialing, CEU, or licensing exams as they are only an overview.

2

Bibliographies/References/Resources

- *THE BASICS, Second Edition* is supported by thousands of professional research studies, references, and resources…over 1,600 of these are listed in the curriculum.
- In each of the eight subjects and six appendices there are sources/references listed within the subject text itself.
- At the end of each of the eight subjects and six appendices you will find extensive bibliographies of the references and resources.
- An enormous gratitude is extended to the treatment participants who – while being taught the psychoeducation in this curriculum – commented and shared what was helpful. They contributed through their responses (without knowing I had written the curriculum) what I needed to add, eliminate, or explain differently.
- Much appreciation to the thousands of professionals who contributed to the psychoeducation found in *THE BASICS, Second Edition* through their trainings, research studies, books, mentoring, collegial support, and sharing their vast experience and knowledge with me.

3

Putting Evidence Based Practice (EBP) into Action

1. ***PURPOSE**: THE BASICS eliminates the "gap" between the system and the professionals providing the services; between the evidence based practices and the person seeking services. THE BASICS is a compendium of materials designed to help clinicians teach the evidence based practice skills to persons with co-occurring disorders. It is designed to ensure the continuity of care.*
2. ***EBP:** Integrated System of Care; Universal Dual Diagnosis Capabilities; Principles of Empathy and Hope; Motivational Interviewing Approach; Stages of Change Model Design; Strength Based; Skill Building; Solution Focused; Neurochemistry Based Disorders of the Brain; Symptom Identification; Symptoms Management; Best Practices Curriculum Topics, i.e. Nutrition, Stress Management, Cognitive Behavioral, and much more…*

4

Scope of the SUBJECT REVIEWS & DSM-5 UPDATE INFO

1. The Subject Reviews for each of the eight subjects in *THE BASICS, Second Edition* is meant to provide bullets of the curriculum content and examples.
2. It is *not*, of course, intended to present the entire curriculum in this PowerPoint format.
3. Please refer to the actual curriculum for the complete list of the examples, explanations, and psychoeducation on all the topics in these Subject Reviews.
4. Also please take a look at the *LESSON PLANS* located on my website for detailed group lesson plans to put the curriculum into action.
5. *THE BASICS* was never written with the intention of making a diagnosis either by professionals or treatment participants. It was purposely written without sufficient information available to make a diagnosis possible. There are other forms, evaluations, and specifically trained professionals to make diagnoses.
6. Yet symptom identification and discussion is extremely important.
7. During the printing of *THE BASICS, Second Edition* the format of the *Diagnostic and statistical manual of mental disorders*, originally published by the American Psychiatric Association in1952, was the DSM-IV-TR, 2000.
8. So this was my dilemma as the author of the curriculum…

5

9. Do I publish a *Third Edition* for the sole purpose of updating the limited amount of diagnostic criteria to align with the DSM-5? Or do I find a way to update the material that would be available at no cost on my website?
10. I chose the latter…no additional cost to current owners and purchasers.
11. The limited references to the DSM on the symptoms of psychiatric disorders are primarily located in *Subject Two: Psychiatric Disorders Within A Co-Occurring Diagnosis*. This subject, of course, does not cover all of the psychiatric disorders. It includes only the ones typically found among co-occurring psychiatric and substance use orders like Depression, Anxiety, Mood Disorders, Thought Disorders, Personality Disorders, etc.
12. The limited references to the DSM on Substance Disorders are located in *Subject Three, Substance Disorders Within a Co-Occurring Diagnosis*.
13. The updates from the DSM-IV-TR to the DSM-5 (American Psychiatric Association, 2013) are located in Subject Two & Subject Three of these Reviews.
14. You will find extensive lists of symptoms from other sources on Psychiatric Disorders in APPENDIX II and Substance Disorders in APPENDIX III.
15. These Appendices are worded in everyday language and are by far the very best way for individuals to understand their symptoms or identify those they may wish to discuss further with their group or individual counselor.

6

Subject Two: APPENDIX II
THE BASICS AND SYMPTOMS OF PSYCHIATRIC DISORDERS

- Throughout Subject Two you will find coverage of the psychiatric disorders and their symptoms in a more concise form.
- At the end of Subject Two you will find a 65 page APPENDIX II.

- APPENDIX II is designed to: (1) Provide ample information for the facilitation of a group that can focus exclusively on a specific disorder like Bipolar Disorder (now found in the DSM-5 under the category of Bipolar and Related Disorders); and (2) Make available more extensive information for cross-training and individual sessions.
- I have made every effort in Subject Two Review to provide updates to the DSM-5. If you find something you feel should be added please contact me and I will make revisions. I appreciate your help and input.

7

SUBJECT TWO Psychiatric Disorders within a Co-Occurring Diagnosis

Overview of Topics

Medical Disorders of the Brain · Myths & Facts About Psychiatric Disorders · Overview, Causes, Categories, Episodes, Symptoms, Diagnosing, Similarities, Challenges, and Hope · Mood Disorders · Major Depression· Symptoms · Depression in Women, Men, and Seniors · Symptoms & Treatment for Depression · Bipolar Disorder· Symptoms &Treatment of Bipolar Disorder · Anxiety Disorders· Types, Symptoms & Treatment of Anxiety · Thought Disorders· Schizophrenia · Symptoms, Stages, Subtypes & Treatment of Schizophrenia· Personality Disorders· Types, Symptoms, Defenses, Myths & Treatment of PD· Eating Disorders · Development, Continuum, Symptoms & Treatment of Eating Disorders· Non-Helpful Thoughts · Steps to Positive Thinking…

8

Subject Two Presentation Guide
Psychiatric Disorders Within a Co-Occurring Diagnosis
Presentation Subject Guide Example Located at the Beginning of Each Subject

PRESENTATION GUIDE: SEGMENTS			
A	*Prepare*	Professionals	Goal, Objectives, and Methods
			Subject Sections
			Appendices
			Handouts
		Group	Beginning: Reading, Phrase, or Relaxation
			Introductions
			Overview of Format & Subject
B	*Present*	Subject Material	Time Frames Separate Sections
			Sections of Subject
		Appendices	Appendices Related to Specific Subject
C	*Practice*	Handouts	Subject Handouts & Discussion
		Group Closure	Group Closure & Support

9

Subject Two Goal and Objectives

Goal:

Explore mental health disorders within a co-occurring diagnosis, as well as identify how negative thinking patterns affect attitude, feelings, and behavior, and the recovery process.

Objectives for Professionals:

1. Review the basics of Psychiatric Disorders.
2. Discuss the basics about Mood Disorders, Anxiety Disorders, Thought Disorders, Personality Disorders, and Eating Disorders.
3. Identify the affects of negative thinking on mental and physical health.

10

Today's Subject and Why It's Important

- This subject will focus on the Psychiatric Disorders that commonly co-occur with Substance Disorders. The specific areas discussed will include causes, categories, episodes, symptoms, and treatment of Psychiatric Disorders, and Eating Disorders.
- This subject will also summarize the difference between typical feelings or thoughts and an actual disorder, such as the difference between common "sadness" and a Depressive Disorder or typical times of "not thinking straight" and an actual Thought Disorder.

From THE BASICS, Second Edition, Page Subject 2-1

11

Medical Disorders of the Brain

20% of the population

Location of People With Co-Occurring Disorders If Not in Treatment

- Incarcerated
- Homeless

12

Why People Do Not Receive Treatment

- Mistaken beliefs…
- Fears…
- Misperceptions…

The Reality of Seeking Treatment
…statements from people receiving treatment

- Treatment provides a "safe haven" to discuss my problems and gain a fresh perspective.
- Receiving help lets me know I am not alone.
- Therapy kept me focused on resolving my problems.
- I wish I had done this long ago. I feel so much better and my life has greatly improved.

13

Myths & Facts About Psychiatric Disorders
(Refer to the text for additional examples and explanations)

- ***Myth***: People with Psychiatric Disorders can just "pull themselves out of it if they try."
- ***Fact***: A Psychiatric Disorder is not caused by personal weakness and it can't be "cured" by personal strength. Proper treatment is needed.

- ***Myth***: People with a mental illness are often violent.
- ***Fact***: People with a mental illness are much more likely to be victims of violence than to cause it. With proper treatment, they are *no* more likely to be violent than the general population.

14

"Emotional Issues" & Psychiatric Disorders

- What is the difference?
- *Most* people experience *some* degree of impaired emotional functioning at *some* point in their life.
- A person then returns to their previous level of functioning.
- There is a big difference when a person has a diagnosable Psychiatric Disorder where symptoms last more than a couple of weeks.

15

Overview of Psychiatric Disorders

- What is mental health?
- What are mental health disorders?
- Can mental health illnesses be successfully treated?

16

Overview of Psychiatric Disorders…continued

- Causes of Psychiatric Disorders
- Categories of Psychiatric Disorders

Axis I	Axis II	Axis III	Axis IV	Axis V
Clinical disorders usually first diagnosed in infancy, childhood, or adolescence (like mood disorders, anxiety disorders, schizophrenia and other psychotic disorders, eating disorders, and substance disorders)	Personality disorders (like borderline personality disorder) and Developmental Disorders (like autistic disorder)	General Medical Condition (like hyper-thyroidism)	Psycho-Social and Environ-mental Problems (like housing or occupational problems)	Global Assessment of Functioning (GAF) Scale (ranges from 1 to 100, for example, 1-10 = danger to self and others, 51-60 = moderate symptoms, and 91-100 = superior functioning and no symptoms)

DSM-5 Update: The Multiaxial System was included in THE BASICS to let treatment participants see how symptoms are categorized. The DSM-5 has changed to a single Axis Approach. The new unified assessment facilitates global sharing of health information. However, clinicians will still take note of the same mental, physical, and social considerations…they'll just go about it differently. This material may still be presented to show a multi-dimensional view which is helpful to participants; however, Axis V should be omitted as it was found to no longer be helpful to actual participants.

17

Overview of Psychiatric Disorders…continued

- Episodes of Psychiatric Illness

Acute	Recurrent	Chronic or Persistent
One or two episodes of a psychiatric disorder during a person's lifetime.	Three or more episodes throughout a person's lifetime.	• Some symptoms are present continuously over time. • This type is usually more disabling and often requires long-term care. • Many people with chronic psychiatric illness, however, have periods when they do very well and symptoms remain under control.

18

Symptoms of Psychiatric Illness

Mild	Moderate	Severe
• Few, if any, symptoms in excess of those required to make the diagnosis. • Symptoms result in no more than minor impairment in social or occupational functioning.	Many of the symptoms that often keep the person from doing things they need to do.	• Many symptoms in excess or over those required to make the diagnosis. • The symptoms that are particularly severe are present and result in marked impairment in social or occupational functioning.

19

Diagnosing a Psychiatric Disorder

1	Symptom Identification
2	Number of Symptoms
3	Duration of Symptoms
4	Level of Symptom Severity & The Effect on Functioning
5	Ruling Out or Eliminating Other Causes

20

The *Same* Diagnosis - Similarities and Differences Among Individuals

A Different Diagnosis - Similarities and Differences Among Individuals

Similar Challenges Among Individuals in Recovery:

1. Problems
2. Diagnosis
3. Recovery

21

Hope and Recovery

1	One-half to two-thirds of people with serious and persistent psychiatric disorders achieve recovery from these disorders.
2	As many as 8 in 10 people suffering from mental illnesses can effectively return to normal, productive lives if they receive appropriate treatment – treatment that is readily available.
3	The treatment success rate is 60% for Schizophrenia, 65% for major depression, and 80% for bipolar disorder. These are hopeful results when compared to the success rate for treatments of heart disease, which ranges from 41 – 52%.

22

Types of Psychiatric Disorders
Most Often Associated With Co-Occurring Substance Disorder

MOOD DISORDERS	ANXIETY DISORDERS	THOUGHT DISORDERS	PERSONALITY DISORDERS	EATING DISORDERS

DSM-5 Update: One of the many purposes of the DSM-5 (APA; 2013) was to revise the DSM and ICD (WHO) systems into a joint goal of creating a common diagnostic and symptom criterion on a global scale. Actually, there were relatively few major changes in content as it relates to THE BASICS, Second Edition – even though there are some wording changes in the criteria to improve clarity. However, the improved wording did not change – in essence – the criterion (symptom description). The most changes are the placement of a particular disorder and perhaps the major heading. For instance:

1. Mood Disorders are now called *Depressive Disorders*.
2. Bipolar Disorders – formerly under Mood Disorders – is now located in a new section called *Bipolar and Related Disorders*.
3. Anxiety Disorders no longer include Acute Stress Disorder or Posttraumatic Stress Disorder, which are now included in the new section *Trauma- and Stressor-Related Disorders*.
4. Thought Disorders – previously the category of psychiatric disorders like Schizophrenia – is now titled *Schizophrenia Spectrum and Other Psychotic Disorders*.

23

Mood Disorders – Types of Mood Disorders

Major Depression	Persistent Depressive Disorder (Dysthymia)	Bipolar Disorder	Cyclothymia

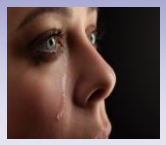
Diagnostic and statistical manual of mental disorders, Fifth Edition: DSM-5. (2013). American Psychiatric Association.

1. Major Depression is now under a new category titled *Depressive Disorders*.
2. Dysthymic is now retitled *Persistent Depressive Disorder*.
3. Bipolar Disorder is now in a new category called *Bipolar and Related Disorders*.
4. Cyclothymic is also now found in the *Bipolar and Related Disorders category.*

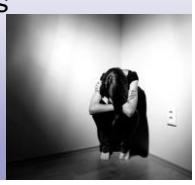
Note: I have provided this information as a way of comparing and contrasting the changes in the DSM-5 solely for the professionals. I personally will not be discussing any updates with my clients other than perhaps just being aware of calling Mood Disorders as Depressive Disorders. *The content in THE BASICS is still completely relevant for the purpose of teaching psychoeducation. Our goal is to connect with folks – not confuse them. However, the updated information will be available if you are using these guides for coursework or credentialing.*

24

Major Depression



Clinical Depression Is Different From Sadness



DSM-5 Update: Major Depression is now under a new category titled *Depressive Disorders*. There were no changes in the core criteria or symptoms of a major depression episode nor the requisite duration of at least 2 weeks. An more extensive coverage of THE BASICS ABOUT DEPRESSION is located in APPENDIX II; pages II-1 – II-5

25

Depression in Women

- Brain Chemistry Differences
- Postpartum Psychosis
- Seasonal Affective Disorder Sensitivity
- Relationship and Emotional Focus
- Menstrual Cycles
- Stress of Caring for Others

- Sex Hormones
- Physical and Sexual Abuse
- Menopause and Hormones
- Miscarriage and Infertility
- Postpartum "Baby Blues"
- Women Who Have No Children
- Postpartum Depression

An extensive coverage of THE BASICS ABOUT DEPRESSION AND WOMEN is located in APPENDIX II; pages II-5 – II-7

26

Depression in Men

- Traditional Roles of Men to be "Tough"
- Believe Emotional Pain is a Sign of Weakness
- Depression May Show Up As Anger
- Reluctant to Seek Treatment

An extensive coverage of THE BASICS ABOUT DEPRESSION AND MEN is located in APPENDIX II; page II-8

27

Depression in Seniors

- Life Events
- Medications
- Medical Problems or Illnesses

An extensive coverage of THE BASICS ABOUT DEPRESSION AND SENIORS is located in APPENDIX II; pages II-8 – II-9

28

Symptoms of Major Depression or Bipolar Disorder Depressive Episode

Physical Symptoms	Cognitive/Thinking, Emotional, and Behavioral Symptoms	Spiritual Emptiness

DSM-5 Update: Major Depression is now under a new category titled *Depressive Disorders*. Bipolar Disorder is now located under a new category of *Bipolar and Related Disorders*. In other words Depressive Disorders and Bipolar and Related Disorders are now in separate categories. The symptoms remain relatively unchanged.

29

Dysthymic Disorder
(Persistent Depressive Disorder)

Symptoms of Dysthymia
(Persistent Depressive Disorder)

Physical and Cognitive/Thinking Symptoms	Emotional, Spiritual, and Behavioral Symptoms

DSM-5 Update: The change in the DSM-5 is in the category from Dysthymia to Persistent Depressive Disorder. The symptoms have not changed.

30

Treatment for Major Depression and Dysthymic Disorder (Persistent Depressive Disorder)

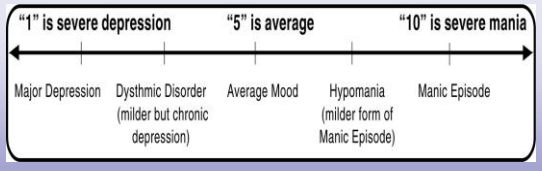
Treatments for Depression *Are* Effective

- Biological
- Psychological
- Social, Cultural, Environmental
- Spiritual
- Harm Reduction or Goal of Abstinence

31

Bipolar or Manic Depressive Disorder

- "Bi" means *two* and "polar" refers to opposite ends or *poles*.
- Bipolar Disorder is a condition involving emotions of two alternating extremes.



An extensive coverage of Bipolar Disorder is located in APPENDIX II; pages II-12 – II-17.

32

Types of Bipolar Disorder

Bipolar I Disorder

- Classic form of this illness.
- Meets the criteria for a Depressive Episodes and Manic or Hypomanic Episodes often followed by periods of average mood.

Bipolar II Disorder

- Meets the criteria for at least one episode of major depression and at least one hypomanic episode, but never a full-blown Manic Episode.

Episodes of Bipolar Disorder

- Depressive Episode Defined
- Symptoms of Depressive Episode in Bipolar Disorder

DSM-5 Update: Bipolar I requires that a person experience at least one lifetime Manic Episode as well as also experiencing Major Depressive Episodes. Bipolar II is no longer considered "milder" than Bipolar II because of the amount of time these individuals spend in depression. There is more emphasis on changes in activity and energy in addition to elevated or expansive mood.

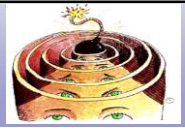
33

Subject Two: APPENDIX II
THE BASICS AND SYMPTOMS OF PSYCHIATRIC DISORDERS

TIPS TO PROFESSIONALS

The brief symptoms of Bipolar Disorder Depressive Episode can be found in this subject material on page 2-11. The extensive symptom list is located in the table SYMPTOMS OF MAJOR DEPRESSION and BIPOLAR DISORDER DEPRESSIVE EPISODE in APPENDIX II on pages II-10 – II-11. In APPENDIX II: THE BASICS AND SYMPTOMS OF PSYCHIATRIC DISORDERS you will also find a much more extensive coverage, beginning on page II-12 of: (1) The Basics About Bipolar Disorder, (2) Symptoms of a Depressive Episode (referred to above), (3) Symptoms of Manic Episode, and (4) Symptoms of Mixed Episode. APPENDIX II is designed to: (1) Provide ample information for the facilitation of a group that focus exclusively on Bipolar Disorder, and (2) Make available more extensive information for cross-training and individual sessions.

Example of expanding the curriculum using APPENDIX II



34

Manic Episode Defined

1	Euphoric	high or elevated mood with a sense of being in love with the world or "one" with the world
2	Dysphoric	high or elevated mood but in a different sense of being agitated, destructive, full of rage, anxious, paranoid, and panic-stricken

- Symptoms of Manic Episode

Physical, Cognitive/Thinking and Emotional Symptoms	Behavioral Symptoms

DSM-5 Update: No significant changes in the symptoms of Manic Episode.

35

Mixed Episode Defined

- Symptoms of Mixed Episode

Physical, Symptoms	Cognitive/Thinking and Perception Symptoms	Emotional and Behavioral Symptoms

DSM-5 Update on Mixed Episode: Rather than requiring that the individual simultaneously meet full criteria for both manic and major depressive episodes… Mixed Episode was removed. It has been replaced by *"with mixed features."* This term can now be applied to mania or hypomania when depressive symptoms are present or to episodes of depression (major depression or bipolar disorder when mania or hypomania are present.)

36

Hypomanic Episode Defined

- Symptoms of Hypomanic Episode

Physical, Symptoms	Cognitive/Thinking and Perception Symptoms	Emotional Symptoms	Behavioral Symptoms

DSM-5 Update: Hypomania is now found in the *Bipolar and Related Disorders category.* No significant changes in the symptoms of Hypomania are in the DSM-5.

Cyclothymic Disorder Defined

- Symptoms of Cyclothymic Disorder

Physical Symptoms	Emotional Symptoms	Behavioral Symptoms

DSM-5 Update: Cyclothymic is now found in the *Bipolar and Related Disorders category.* No significant changes in the symptoms of Cyclothymic Disorder.

37

Reluctance to Seek Treatment or Not Wanting Help

Treatment of Bipolar Disorder

- Education
- Mood Stability
- Medication
- Family & Social Support
- Reasonable Activity Level
- Stress Reduction
- Harm Reduction or Goal of Abstinence
- Balanced Lifestyle
- Restoration of Social Function
- Follow-up

38

Anxiety Disorders

- Feeling Anxious Versus an Anxiety Disorder
- When Anxiety Becomes Excessive
- Anxiety Disorders Aren't Just a Case of "Nerves"
- The Frequency of Anxiety Disorders

An extensive coverage of Anxiety Disorders is located in APPENDIX II; pages II-20 – II-37.

39

Types of Anxiety Disorders

Generalized Anxiety Disorder	Acute Stress Disorder & Posttraumatic Stress Disorder
Panic Disorder & Panic Attacks	Obsessive-Compulsive Disorder
Specific Phobia	Adjustment Disorders with Anxious Features
Social Anxiety Disorder or Social Phobia	Anxiety Disorder Due to a General Medical Condition
Agoraphobia	Substance Induced Anxiety Disorder

DSM-5 Update: The chapter on Anxiety Disorders no longer includes Obsessive-Compulsive Disorder which is now included in the "*Obsessive-Compulsive and Related Disorders*" section. Acute Stress Disorder & Posttraumatic Stress Disorder are now located in the "*Trauma- and Stressor-Related*" section. The DSM-5 states that the sequential order of these chapters reflects the close relationships among these disorders. In my professional opinion I would continue to teach the psychoeducational content as it is – since the new categories in the DSM-5 are not necessarily relevant to the actual treatment process.

40

TIPS TO PROFESSIONALS

In APPENDIX II: THE BASICS AND SYMPTOMS OF PSYCHIATRIC DISORDERS you will find a much more extensive coverage, on pages II-20 – II-37, of: (1) The Basics About Anxiety Disorders, (2) The Basics About Generalized Anxiety Disorder, (3) Symptoms of Generalized Anxiety Disorder, (4) The Basics About Panic Disorder and Panic Attacks, (5) Symptoms of Panic Disorders and Panic Attacks, (6) The Basics About Phobic Disorders, (7) Symptoms of Specific Phobia, (8) Symptoms of Social Phobia, (9) Symptoms of Agoraphobia, (10) The Basics About Posttraumatic Stress Disorder (PTSD), (11) Symptoms of Posttraumatic Stress Disorder (PTSD), (12) The Basics About Obsessive-Compulsive Disorder (OCD), and (13) Symptoms of Obsessive-Compulsive Disorder (OCD).

APPENDIX II is designed to: (1) Provide ample information for the facilitation of a group or groups that focus exclusively on Anxiety Disorders, and (2) Make available more extensive information for cross-training and individual sessions.

Example of expanding the curriculum using APPENDIX II

41

Similarities Among Anxiety Disorders

1	Symptoms range from mild uneasiness to intense fear and affects all areas of functioning such as: physical symptoms like a racing heart, cognitive symptoms like difficulty in concentrating, emotional symptoms like irritability, and behavioral symptoms like the tendency to cling to others for reassurance.
2	Anxiousness is present *most of the time* to one degree or another typically without a specific reason.
3	Symptoms of an Anxiety Disorder may be so uncomfortable a person may try to avoid them by stopping some or all routine, everyday activities.
4	Occasional bouts of anxiety may be so intense they may actually terrify and disable a person.
5	Symptoms are often more severe than what would be expected in response to a particular stressor or situation.

42

Generalized Anxiety Disorder (GAD)

Symptoms of GAD

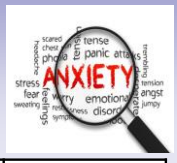
Physical and Cognitive/Thinking Symptoms	Emotional Symptoms	Behavioral Symptoms

Treatment of Generalized Anxiety Disorder

DSM-5 Update: There are no changes in the diagnostic criteria for GAD.

43

Panic Disorder and Panic Attacks



- Panic Attacks
- Symptoms of Panic Attacks

Physical Symptoms	Cognitive/Thinking Distortions	Emotional Symptoms

- Treatment of Panic Disorder and Panic Attacks

DSM-5 Update: The essential features for Panic Disorder remain unchanged. There are no changes in the diagnostic criteria for Panic Attacks.

44

Phobias

- *Specific Phobia*
- Symptoms of Specific Phobia

Physical Symptoms	Cognitive/Thinking Symptoms

DSM-5 Update: There are no changes in the diagnostic criteria for Specific Phobia.

45

Phobias…continued

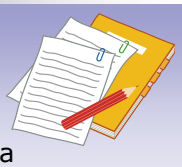
- *Social Phobia*
- Symptoms of Social Phobia

Physical and Cognitive/Thinking Symptoms	Emotional Symptoms	Behavioral Symptoms

DSM-5 Update: Social Phobia was renamed Social Anxiety Disorder, however, there are no changes in the diagnostic criteria.

46

Phobias…continued



- *Agoraphobia*
- Symptoms of Agoraphobia

Cognitive/Thinking and Emotional Symptoms	Behavioral Symptoms

DSM-5 Update: Panic Disorder and Agoraphobia have been unlinked and are coded as two separate diagnoses. This change recognizes that a substantial number of individuals with Agoraphobia do not experience Panic Attacks.

47

Treatment of Phobias often includes..

- Cognitive-behavioral Therapy
- Desensitization
- Exposure Therapy
- Anxiety Reducing Techniques

48

Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD)

Traumatic events outside the range of usual human experience can include:

survivors of accidents, rape, physical and sexual abuse, and other crimes.	rescue workers involved in the aftermath of disasters like the terrorist attacks of 911 in New York City	survivors of natural disasters such as earthquakes, tornados, floods, or hurricanes
military troops who served in combat like Vietnam and Gulf War	immigrants fleeing violence in their countries like Vietnam, Kosovar, Cuba, or Haiti	survivors of man-made disasters such as the Oklahoma City bombing

DSM-5 Update: Acute Stress Disorder and PTSD which were both formerly found in Anxiety Disorders are now located under a new category of *Trauma- and Stressor-Related Disorders.*

49

Acute Stress Disorder and Posttraumatic Stress Disorder (PTDS)…continued

Symptoms Posttraumatic Stress Disorder (PTSD)

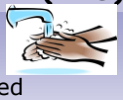
Physical Symptoms	Cognitive/Thinking and Emotional Symptoms	Behavioral Symptoms

Treatment of Posttraumatic Stress Disorder

DSM-5 Update: The change in the symptoms for Acute Stress Disorder and PTSD is the requirement that the person be explicit as to whether the traumatic events were experienced directly, witnessed, or experienced indirectly like hearing about the trauma.

50

Obsessive-Compulsive Disorder (OCD)



- The Difference Between Common Concerns and OCD
- Obsessions and Compulsions Defined

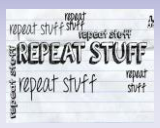
	Obsessions		Compulsions
1	Obsessions are persistent, disturbing thoughts that cause great anxiety.	1	Compulsions are the acting out of obsessions.
2	A person realizes these thoughts are not reasonable yet feels unable to stop them even though they try to resist them.	2	To get rid of the unwanted obsessive thoughts a person will engage in repetitive behaviors or thoughts to reduce their anxiety.
3	For example: A person has a preoccupation or obsession about germs that causes them great anxiety.	3	For example: The person may compulsively and repeatedly wash their hands in an attempt to avoid contamination and reduce anxiety.

DSM-5 Update: OCD is now in the category "*Obsessive-Compulsive and Related Disorders.*" Related disorders include Obsessive-Compulsive Disorder; Body Dysmorphic Disorder; Hoarding Disorder; Hair-Pulling Disorder; Excoriation (skin picking) Disorder

51

Obsessive-Compulsive Disorder (OCD)…continued

Symptoms of Obsessive-Compulsive Disorder



Cognitive/Thinking and Emotional Symptoms	Behavioral Symptoms

Treatment of Obsessive-Compulsive Disorder

DSM-5 Update: Symptoms of OCD were refined, however, there was no significant changes made in the DSM-5.

52

Anxiety Disorder Due to a General Medical Condition

- Definition
- Some medical conditions that can cause significant anxiety and physiological stimulation include:

Significant Use of Caffeine	Hypoglycemia	Lack of Sleep
Allergies	Hyperthyroidism	Premenstrual Syndrome

DSM-5 Update: Remained unchanged in the revisions.

53

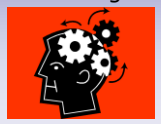
Treatment of Anxiety Disorders

Education	Family Therapy and Support
Cognitive-Behavioral Therapy	Support & Self-Help Groups
Psychotherapy	Medication
Exposure Therapy	Relaxation Techniques
Stress Management & Balanced Living	Harm Reduction or Goal of Abstinence

54

Thought Disorders

- Not "Thinking Straight" Versus a Thought Disorder
- Schizophrenia
- Violence and Schizophrenia
- Symptoms of Schizophrenia



Cognitive/ Thinking & Positive Symptoms	Cognitive/ Thinking & Negative Symptoms	Behavioral Symptoms & Functional Difficulties

DSM-5 Update: Thought Disorders are now located in "*Schizophrenia Spectrum and Other Psychotic Disorders.*" The primary change in the diagnostic criteria was the number of symptoms required for a diagnosis. There is more extensive coverage of Schizophrenia located in Appendix II; pages II-37 – II-45.

55

Stages of Schizophrenia

Acute Phase	Stabilization Phase	Stable Phase

Subtypes of Schizophrenia

- Paranoid Schizophrenia
- Disorganized Schizophrenia
- Catatonic Schizophrenia
- Undifferentiated Type
- Residual Schizophrenia

Types of Schizophrenia

Schizophreniform Disorder	Schizoaffective Disorder

DSM-5 Update: The Subtypes of Schizophrenia have been removed and replaced with a dimensional approach to rating severity called "*Schizophrenia Spectrum and Other Psychotic Disorders.*"

56

Treatment of Schizophrenia

Therapy & Metal Health Services	Multiple Family Group Therapy (MFGT)	Medication Compliance
Group Therapy	Psychosocial Treatment	Stress Reduction
Family Education, Involvement, Support & Therapy	Self-Help Groups	Harm Reduction or Goal of Abstinence

57

Personality Disorders

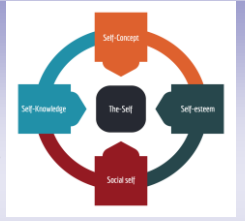
- Personality Defined
- Temperament

	Temperament Type	Basic Motive	Desires	Wants	Positive Qualities	Not-So-Positive Qualities
1	Guardian or Traditionalist	Desire for Peace	Order, Silence, Moderation, Friendliness	to belong, be useful, responsible, givers	accepting, controlled, dependable, easy-going	directionless, doubtful, passive, permissive,
2	Artisan or Hedonist	Desire for Popularity	Status, Action, Freedom, Being Loved, Approval	not tied down, freedom, enjoy today	competitive, eager, popular, inspiring	disorganized, excitable, reacting, restless,
3	Idealist	Desire for Perfection	Accomplishment, Intimacy, Accuracy, Improvement	have a goal, have integrity, to be genuine	authentic, creative, considerate, nurturing	confused, critical, too sensitive, self-righteous
4	Rationalist	Desire for Power	Control, Energy, Greatness, Influence, Privilege	be seen as competent, to learn as much as possible	ambitious, capable, confident, leader, direct	aggressive, always right, demanding, headstrong, bossy

An extensive coverage of Personality Disorders is located in APPENDIX II; pages II-45 – II-57.

58

Personality Disorders continued



- Personality Patterns and traits
- Character Defined
- Appreciating Differences Among People Begins with *Self*-Knowledge
- Personality *Problems* and Character Defects
- Personality *Problems* Versus Personality *Disorders*
- Personality Disorders Defined

59

Diagnosing a Personality Disorder

(refer to THE BASICS for complete explanations of this topic)

1. Cognition problems or difficulties in the ways of perceiving and interpreting self, other people, and events.
2. Affectivity difficulties such as expressing emotions with the correct range, intensity, adaptability or openness to change, duration, and appropriateness to situations.
3. Difficulties in interpersonal functioning and in relationships with others.
4. Impulse control problems or inability to control impulses (acting before thinking).

DSM-5 Update: Diagnostic Criteria remained unchanged.

60

Personality Disorders and Culture

Personality Disorder Clusters A, B, C

	Cluster	Personality Disorder	Individuals Often Appear….
1	A	Paranoid, Schizoid, Schizotypal	unusual or eccentric
2	B	Antisocial, Borderline, Histrionic, Narcissistic	dramatic, emotional, or changeable
3	C	Avoidant, Dependent, Obsessive-Compulsive	anxious or fearful

The DSM-5 increased the focus on culture and gender throughout. More attention to how culture and gender can influence and be influenced by psychological illness. Manual includes tools for performing a cultural formulation interview.

61

Types of Personality Disorders & Related Behavioral Patterns

	PD	Behavioral Patterns
1	Paranoid Cluster A	Pattern of not trusting and being suspicious of others, and interpreting the motives of others as damaging, spiteful, malicious, or possessing intense ill will toward the person.
2	Schizoid Cluster A	Pattern of detachment or not wanting and avoiding social relationships, and not feeling or expressing emotions much or having a restricted range of emotional expression.
3	Schizotypal Cluster A	A pattern of being severely uncomfortable in close relationships, having cognitive or perceptual distortions, and unusual, eccentric, or odd behavior.
4	Antisocial Cluster B	Pattern of disregard and disrespect for, and violation of the rights of others.
5	Borderline Cluster B	Pattern of having very unstable relationships, self-image, feelings, and impulsive and reckless behavior.
6	Histrionic Cluster B	Pattern of being excessively emotional and attention-seeking.
7	Narcissistic Cluster B	Pattern of grandiosity or feeling very self-important, need for admiration, and having little feeling or empathy for others.
8	Avoidant Cluster C	Pattern of being socially inhibited, feeling inadequate, and being extremely sensitive to criticism or negative evaluation.
9	Dependent Cluster C	Pattern of having an excessive need to be take care of by other people, which results in being very submissive and clinging.
10	Obsessive-Compulsive Cluster C	Pattern of preoccupation with needing order, perfection, and control in one's life. The symptoms of obsessions and compulsions that are found in Obsessive-Compulsive Disorder (OCD) are *not* found in Obsessive-Compulsive *Personality* Disorder.

Severity of Symptoms

62

Cluster B Personality Disorders

Symptoms of Cluster B Personality Disorders

Antisocial Personality Disorder Symptoms

Social Behavioral	Interpersonal Behavioral	Emotional

Borderline Personality Disorder Symptoms

Behavioral	Emotional	Cognitive/Thinking and Perception

Histrionic Personality Disorder Symptoms

Behavioral Symptoms	Emotional Symptoms

Narcissistic Personality Disorder Symptoms

Cognitive/Thinking and Perception	Behavioral and Emotional

DSM-5 Update: Personality Disorders and their symptoms remained unchanged.

63

World View of Cluster B Personality Disorders

	Personality Disorder	Basic Belief	World Views
1	Antisocial Personality Disorder	People are there to be taken.	1. I have to look out after myself; if people can't take care of themselves that's their problem. 2. We live in a jungle and the strong person is the one who survives; people will get me if I don't get them first. 3. I have been unfairly treated and am entitled to get my fair share by whatever means I can.
2	Borderline Personality Disorder	Other people must satisfy my needs.	1. I can't cope on my own; I need to keep those important to me immediately available or I will fall apart. 2. Tug of war: I need others - no I don't need others. 3. My feelings change rapidly; I don't understand how; my emotions confuse me.
3	Histrionic Personality Disorder	I need to impress.	1. If I don't keep others engaged in me, they won't like me. 2. It is awful to be ignored; people will pay attention only if I act in extreme ways. 3. If I entertain people, they will not notice my weaknesses.
4	Narcissistic Personality Disorder	I am special.	1. I am special and other people should recognize how special I am. 2. I don't have to be bound by the rules that apply to other people; I am entitled to special treatment and privileges. 3. It is very important to get recognition, praise, and admiration.

64

Cluster B Personality Disorders…continued

- Symptoms Can Lead to Reluctance in Seeking Treatment
- Defenses Protect People from the Unbearable

1	Acting Out	3	Denial & Clinging
2	Avoidance & Distancing	4	Projection

- Motivations to Change Vary From Person to Person

65

Myths & Facts About Personality Disorders

Myth: *All personality disorders are untreatable.*

Facts:

1. With the best possible treatment over a period of time there is evidence to show that people with Personality Disorders can improve considerably.
2. The issue is one of ensuring that good treatment is provided, and that this treatment goes on long enough for the person to benefit from it.
3. There is a lot of unpredictability in the difficulties and problems that people with a Personality Disorder experience.
4. What may be useful to one person may be of no help to another.
5. Individualizing treatment for each person is important *and* necessary.

Myth: *People with personality disorders are deliberately difficult.*

Facts:

In fact the opposite is often true – they want life to go better for them – but the *symptoms* make it difficult to change the patterns of thinking, feeling, and behaviors that are causing problems in the first place.

66

Treatment Works!

Treatment of Personality Disorders

Education	Psychosocial Therapy	Support & Self-Help Groups
Psychotherapy	Group Therapy	Stress Management
Cognitive Behavioral Therapy	Family Therapy	Harm Reduction or Goal of Abstinence
Dialectical Behavior Therapy (DBT)		

67

Eating Disorders

- Myth and Fact of Body Image in Our Society

Myth: *The "Ideal" Body Image*	• *The influence of this image can even be seen in one of the historically most popular toys – the Barbie Doll.* • *If her dimensions were translated to real life, she would be 38-21-32, 6 feet 6 inches tall, and she most certainly would be clinically anorexic, or more than 15 percent below her ideal body weight.*
Fact: The Real World Body Image	The average American woman is 5'4" weighs about 140 lbs., and wears a size 14 dress.

DSM-5 Update: Eating Disorders are now located under the category of *"Feeding and Eating Disorders."* A more extensive coverage on Eating Disorders is located in APPENDIX II: pages II-58 – II-66.

68

Eating Disorders…continued

- Typical Weight Concerns Versus an Eating Disorder
- The Development of an Eating Disorder
- Definitions and Descriptions of Eating Disorders

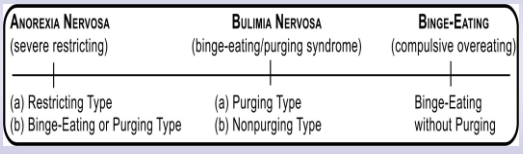
Binge-Eating Disorder	Bulimia Nervosa	Anorexia Nervosa

- Reluctance to Seek Treatment

DSM-5 Update: These disorders are now located in "*Feeding and Eating Disorders*." Diagnostic Criteria remained relatively unchanged with the exception of the minimum average of frequency of symptoms weekly.

69

Continuum of Eating Disorders



70

Symptoms of Eating Disorders

Symptoms of Anorexia Nervosa

Physical Symptoms	Cognitive/Thinking, Perception, and Emotional Symptoms	Behavioral Symptoms

Symptoms of Bulimia Nervosa

Behavioral Symptoms

Symptoms of Binge-Eating

Behavioral Symptoms

The Importance of Treatment

DSM-5 Update: The only criterion change to Binge-Eating Disorder and Bulimia Nervosa was in the required minimum frequency in order to determine a diagnosis. With Anorexia Nervosa only one change was made – the requirement for amenorrhea was eliminated.

71

Treatment of Eating Disorders

- Education
- Psychotherapy
- Cognitive-Behavioral Therapy
- Family Therapy
- Support From Friends
- Twelve Step Self-Help Groups
- Harm Reduction or Working Toward Abstinence

72

Changing Negative Thinking to Positive Thinking

- Definition
- A Little Story About Positive "Self-Talk"
- Negative Thoughts Adversely Affect Physical and Mental Health
- Positive Thoughts Contribute to Good Physical and Mental Health
- *But*…Always be Sincere With Thoughts and Feelings
- Co-Occurring Disorders and Negative Thinking Patterns

73

Negative Thinking – Defenses and Habits

- Negative Thinking As Defenses
- Negative Thinking Patterns Become Habits

- Optimism and Pessimism – A Little Story About Twins

74

Changing Non-Helpful Patterns and Habits

(a few examples are listed here, refer to THE BASICS for additional examples and explanations)

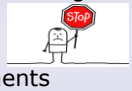
Negative Self-Talk Messages	Action Taken in Place of Defense	Positive Self-Talk Messages
"I can't believe she did that! I hate her and she'll be sorry some day. I'll make sure she is!"	Acknowledging Feelings	"I feel hurt. I wonder why I'm taking her attitude and her behavior so personally."
"This is terrible! This is horrible! I can't stand this! This is killing me!"	Developing Personal Insight	"I must be taking this situation too seriously. It's obviously not the end of the world."
"I'm such an idiot; I can't believe I'm so stupid."	Tolerance of Self	"Oops. I made a mistake; I'll be more conscientious next time."
"Oh great! She's mad; what did I do now?"	Tolerance of Others	"She must be having a bad day. Maybe I can help, or maybe I can just let her have a bad day."

75

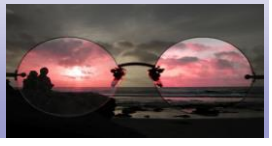
Steps to Positive Thinking

(Refer to THE BASICS for explanations and examples of each step)

- Identify Negative Thinking Patterns
- Bring Negative Self-Talk Out In the Open
- Check The Evidence for Negative Thoughts
- Say "No" or "Stop" to Negative Thoughts



- Review Progress & Accomplishments
- Focus Less on the Negative & More on the Positive – One Thought at a Time
- Be Surrounded With Positives



76

Practice Increases The Strength of Positive Thinking

Make Positive Statements to Others

77

Table of Contents
SUBJECT TWO: APPENDIX II

- APPENDIX II Purpose: Cross-trains and expands Subject Two material much more extensively than in the subject itself providing ample information to answer questions.
- Allows flexibility in meeting the needs of a particular group. For example, if the group is comprised primarily of people with Major Depression, the facilitator may choose to very briefly cover Thought Disorders and give a more expanded coverage of Major Depression.

Major Depression

Table: The Basics About Major Depression

- Prevalence
- Men & Women
- Risk Factors
- Causes
- Onset
- Course
- Symptom Severity
- Episodes of Depression
- Co-Occurring Disorders

Table: The Basics About Depression and Women

- Brain Chemistry
- Seasonal Affective Disorders
- Menstrual Cycles
- Sex Hormones
- Menopause & Hormones
- Postpartum "Baby Blues"
- Postpartum Depression

78

Depression Continued

Table: The Basics About Depression and Women continued

- Postpartum Psychosis
- Relationship & Emotional Focus or Orientation
- Stress of Caring For Others
- Physical & Sexual Abuse
- Miscarriage & Infertility
- Women Who Have No Children

Table: The Basics About Depression and Men

Text is too lengthy to include in this PowerPoint. Refer to page APPENDIX II-8

Table: The Basics About Depression and Seniors

- Classic Symptoms of Depression Are Often Mistaken For Aging
- Lack of Understanding a Psychiatric Illness
- Reluctant to Seek Treatment
- Untreated Depression Worsens *All* Existing Medical Conditions
- Clues to Depression in Seniors
- Importance of a Professional Consultation
- Depression Is a Primary Medical Illness That Requires Treatment

79

Depression Continued

Table: Symptoms of Major Depression and Bipolar Disorder Depressive Episode

• Physical • Cognitive/Thinking • Emotional & Behavioral • Spiritual Emptiness

Bipolar Disorders

Table: The Basics About Bipolar Disorder

- Prevalence
- Men & Women
- Risk Factors
- Causes
- Onset
- Course
- Cycles of Depression & Mania
- Symptom Severity
- Co-Occurring Disorders

Table: Symptoms of Manic Episode in Bipolar Disorder

• Physical & Emotional • Cognitive/Thinking & Perception • Behavioral

Table: Symptoms of Mixed Episodes of Bipolar Disorder

- Physical
- Cognitive/Thinking & Perception Symptoms
- Emotional & Spiritual Symptoms
- Behavioral Symptoms

80

Anxiety Disorders

Table: The Basics About Anxiety Disorders

• Prevalence • Risk Factors • Causes • Co-Occurring Disorders

Generalized Anxiety Disorder

Table: The Basics About Generalized Anxiety Disorder (GAD)

- Prevalence
- Men & Women
- Risk Factors
- Onset
- Course
- Symptom Severity
- Diagnosis

Table: Symptoms of Generalized Anxiety Disorder (GAD)

• Physical • Cognitive/Thinking • Emotional & Behavioral

81

Panic Disorder and Panic Attacks

Table: The Basics About Panic Disorder and Panic Attacks

- Prevalence
- Men & Women
- Risk Factors
- Onset
- Course
- Types of Panic Attacks & Triggers
- Frequency
- Symptom Severity & Diagnosis
- Co-Occurring Disorders

Table: The Symptoms of Panic Disorder and Panic Attacks

• Physical • Cognitive/Thinking • Emotional • Behavioral

Phobic Disorders: Specific Phobia, Social Phobia, and Agoraphobia

The Basics About Phobic Disorders

- Prevalence
- Men & Women
- Risk Factors
- Onset
- Course
- Symptom Severity

82

Phobic Disorders: Specific Phobia, Social Phobia, and Agoraphobia continued

Table: Symptoms of *Specific* Phobia

• Physical • Cognitive/Thinking • Emotional • Behavioral

Table: Symptoms of *Social* Phobia

• Physical & Cognitive/Thinking • Emotional Symptoms • Behavioral Symptoms

Table: Symptoms of *Agoraphobia*

• Cognitive/Thinking & Emotional Symptoms • Behavioral Symptoms

Posttraumatic Stress Disorder

Table: The Basics About Posttraumatic Stress Disorder (PTSD)

- Prevalence
- Men & Women
- Risk Factors
- Onset
- Frequency & Course
- Symptom Severity

83

Posttraumatic Stress Disorder continued

Table: Symptoms of Posttraumatic Stress Disorder (PTSD)

• Physical & Cognitive/Thinking • Emotional Symptoms • Behavioral Symptoms

Obsessive-Compulsive Disorder

Table: The Basics About Obsessive-Compulsive Disorder (OCD)

- Prevalence
- Onset
- Men & Women
- Risk Factors
- Course
- Symptom Severity

Table: The Symptoms of Obsessive-Compulsive Disorder (OCD)

• Cognitive/Thinking & Emotional • Behavioral • Different Types of OCD

84

Schizophrenia

Table: The Basics About Schizophrenia

- Prevalence
- Men & Women
- Risk Factors
- Causes
- Brain Chemistry
- Onset
- Categories of Symptoms
- Course
- Symptom Severity
- Co-Occurring Disorders

Table: Symptoms of Schizophrenia

- Positive Symptoms
- Negative Symptoms
- Functional Difficulties
- Physical & Behavioral Symptoms

Table: Differentiating Between Illusions, Delusions, and Hallucinations

- Illusions
- Delusions
- Hallucinations

85

Cluster B Personality Disorders: Antisocial, Borderline, Histrionic, & Narcissistic Personality Disorders

Table: The Basics About Cluster B Personality Disorders (PD)

- Prevalence
- Onset
- Men & Women
- Course
- Risk Factors & Causes
- Symptom Severity
- Symptom & Diagnosis
- Co-Occurring Disorders

Table: The Symptoms of *Antisocial* Personality Disorder (Cluster B)

- Behavioral
- Emotional & Cognitive/Thinking
- Social & Vocational

Table: The Symptoms of *Borderline* Personality Disorder (Cluster B)

- Behavioral
- Emotional
- Cognitive/Thinking & Perception

Table: The Symptoms of *Histrionic* Personality Disorder (Cluster B)

- Behavioral
- Cognitive/Thinking, Emotional & Physical

Table: The Symptoms of *Narcissistic* Personality Disorder (Cluster B)

- Cognitive/Thinking & Perception
- Behavioral & Emotional

86

Eating Disorders: Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating

Table: The Basics About Eating Disorders

- Prevalence
- Men & Women
- Risk
- Types of Anorexia Nervosa & Bulimia Nervosa
- Causes
- Onset
- Course
- Symptom Severity
- Co-Occurring Disorders

Table: Symptoms of Anorexia Nervosa

- Physical Symptoms
- Cognitive/Thinking & Behavioral Symptoms

Table: Symptoms of Binge-Eating and Bulimia Nervosa

- Physical & Emotional Symptoms
- Cognitive/Thinking & Behavioral Symptoms

87

Subject Two Handouts

Worksheet Handouts

1. Changing Thinking Can Change Attitudes
2. Challenge Negative Thinking: Let the Light Shine In!

Inspirational Handouts

1. We are in charge of our attitudes…
2. "Today"

88

Example of an Inspirational Handout

Today

Outside my window, a new day I see,
and only **I** can determine what kind
of day it will be.
It can be busy and sunny, laughing
and gay, or boring and cold, unhappy
and gray.
My own state of mind is the
determining key, for I am the only
person I let myself be.
I can be thoughtful and do all I can to
help, or be selfish and think just of
myself.

I can enjoy what I do and make
it seem fun, or gripe and
complain and make it hard on
someone.
I can be patient with those who
may not understand or belittle
and hurt them as much as I
can.
But I have faith in myself,
and believe what I say, and I
personally intend to make the
best of each day.

Author: *by Jan LaValley*

89

THE END: Subject Two Review and Training/Teaching Guide

- I am deeply honored to have worked with hundreds upon hundreds of the millions of individuals who have struggled and continue to struggle with Co-Occurring Psychiatric and Substance Disorders.
- Their courage and strength in pushing ahead toward health, in spite of seemingly insurmountable obstacles, is nothing short of amazing.

- I am sometimes asked why this is the *Second Edition*.
- The first printing (250 pages) was distributed without charge to agencies to receive feedback from treatment participants – many of which I sat in or taught across the country without them knowing I was connected to the curriculum in any way.
- When we listen and ask – treatment and therapy participants will tell us what is working, what is not helpful, and what they need.
- Thank you for your input which is the heart of this curriculum.

90