Subject Review & Training/Teaching Guide Developed By: Rhonda McKillip M.Ed., LMHC, MAC, CCDCIII, CDP
Sources & References Are Located Within the Text for Each Subject – With Extensive Bibliographies at the End of Each Subject
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Purpose of the Subject Review & Teaching Guide
1. Cross-over 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 and Study 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. 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.

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• Permission Is Granted to Use this Study Guide for the Purpose of Training on THE BASICS, Second Edition as material to be studied for their exams. 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.

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...

Subject Two: Psychiatric Disorders Within A Co-Occurring Diagnosis

Subject Review & Training/Teaching Guide

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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Purpose of the Subject Review & Teaching Guide

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 subject areas 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.

Subject Review Revision August 2020

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Purpose of the Subject Review & Teaching Guide
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 in Folders 1 & 2 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.
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 in 1952, was the DSM-IV-TR, 2000.
8. So this was my dilemma as the author of the curriculum...

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.

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

| A | Prepare | Professionals | Goal, Objectives, and Methods |
|   |         | Subject Sections | Appendices |
|   |         | Handouts | 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 | Handouts | Subject Handouts & Discussion |
| C | Practice | Handouts | Group Closure | Group Closure & Support |

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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...
“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.

Overview of Psychiatric Disorders

- What is mental health?
- What are mental health disorders?
- Can mental health illnesses be successfully treated?
Symptoms of Psychiatric Illness

<table>
<thead>
<tr>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Few, if any, symptoms in excess of those required to make the diagnosis.</td>
<td>Many of the symptoms that often keep the person from doing things they need to do.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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

Hope and Recovery

1. One-half to two-thirds of people with serious and persistent psychiatric disorders achieve recovery from these disorders. (Bleuler, cited in Deegan, 2002; Bleuler, cited in Deegan, 2002; Davol, cited in Deegan, 2002; Cappi, cited in Deegan, 2002; Harding et al., cited in Deegan, 2002; Huber, 1980, cited in Deegan, 2002; Oesper, cited in Deegan, 2002; Tsuang et al., cited in Deegan, 2002)
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. (American Psychiatric Association APA, 1987)
3. In fact, the treatment success rate is 60% for Schizophrenia, 65% for major depression, and 80% for bipolar disorder. (National Mental Health Advisory Council, cited in National Alliance for the Mentally Ill [NAMI], 2001). These are hopeful results when compared to the success rate for treatments of heart disease, which ranges from 41 – 52%. (National Alliance for the Mentally Ill [NAMI], 2001)
Types of Psychiatric Disorders

Most Often Associated With Co-Occurring Substance Disorder

<table>
<thead>
<tr>
<th>Mood Disorders</th>
<th>Anxiety Disorders</th>
<th>Thought Disorders</th>
<th>Personality Disorders</th>
<th>Eating Disorders</th>
</tr>
</thead>
</table>

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 where to actually place a disorder and what the major heading should be. 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.

Mood Disorders – Types of Mood Disorders

<table>
<thead>
<tr>
<th>Major Depression</th>
<th>Persistent Depressive Disorder (Dysthymia)</th>
<th>Bipolar Disorder</th>
<th>Cyclothymia</th>
</tr>
</thead>
</table>


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 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.

Major Depression

Clinical Depression Is Different From Sadness

Mood Disorders

Depression in Women

- Brain Chemistry Differences
- Seasonal Affective Disorder Sensitivity
- Menstrual Cycles
- Sex Hormones
- Menopause and Hormones
- Postpartum “Baby Blues”
- Postpartum Depression
- Postpartum Psychosis
- Relationship and Emotional Focus
- Stress of Caring for Others
- Physical and Sexual Abuse
- Miscarriage and Infertility
- Women Who Have No Children
Depression in Men

- Traditional Roles of Men to be “Tough”
- Depression May Show Up As Anger
- Believe Emotional Pain is a Sign of Weakness

Depression in Seniors

- Life Events
- Medications
- Medical Problems or Illnesses

Symptoms of Major Depression or Bipolar Disorder Depressive Episode

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

Symptoms of Persistent Depressive Disorder (Dysthymia)

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

DSM-5 Update: There were no changes in the core criterion symptoms of major depression episode nor the requisite duration of at least 2 weeks.

DSM-5 Update: The change in the DSM-5 is in the category from Dysthymia to Persistent Depressive Disorder. The symptoms have not changed.
Treatments for Major Depression and Persistent Depressive Disorder (Dysthymia) Are Effective

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

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.

<table>
<thead>
<tr>
<th>“1” is severe depression</th>
<th>“5” is average</th>
<th>“10” is severe mania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>Average Mood</td>
<td>Hypomania (milder form of Manic Episode)</td>
</tr>
<tr>
<td>Dysthymic Disorder (milder form of depression)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
- Manic Episode
- Mixed Episode

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 with “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.)
### Manic Episodes

- **Defined**
  - Euphoric: high or elevated mood with a sense of being in love with the world or “one” with the world
  - Dysphoric: high or elevated mood but in a different sense of being agitated, destructive, full of rage, anxious, paranoid, and panic-stricken

- **Symptoms**
  - Physical, Cognitive/Thinking and Emotional Symptoms
  - Behavioral Symptoms

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

### Mixed Episodes

- **Defined**

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

**DSM-5 Update:** This disorder is the combination of DSM-IV-defined chronic major depression disorder and dysthymic disorder. The change in the DSM-5 is from Dysthymia to Persistent Depressive Disorder. The symptoms of at least two years has not changed.

### Hypomanic Episode

- **Defined**

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

**DSM-5 Update:** No significant changes in the symptoms of Hypomania are in the DSM-5.

### Cyclothymic Disorder

- **Defined**

- **Symptoms**
  - Physical Symptoms
  - Emotional Symptoms
  - Behavioral Symptoms

**DSM-5 Update:** No significant changes in the symptoms of Cyclothymic Disorder.
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

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

Types of Anxiety Disorders

<table>
<thead>
<tr>
<th>Generalized Anxiety Disorder</th>
<th>Acute Stress Disorder &amp; Posttraumatic Stress Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder &amp; Panic Attacks</td>
<td>Obsessive-Compulsive Disorder</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>Adjustment Disorders with Anxious Features</td>
</tr>
<tr>
<td>Social Anxiety or Social Phobia</td>
<td>Anxiety Disorder Due to a General Medical Condition</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>Substance Induced Anxiety Disorder</td>
</tr>
</tbody>
</table>

Tips to Professionals


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.
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.

Generalized Anxiety Disorder (GAD)

- Defined
- Symptoms of GAD

<table>
<thead>
<tr>
<th>Physical and Cognitive/Thinking Symptoms</th>
<th>Emotional Symptoms</th>
<th>Behavioral Symptoms</th>
</tr>
</thead>
</table>

- Treatment of Generalized Anxiety Disorder

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

Panic Disorder and Panic Attacks

- Defined
- Symptoms of Panic Attacks

<table>
<thead>
<tr>
<th>Physical Symptoms</th>
<th>Cognitive/Thinking Distortions</th>
<th>Emotional Symptoms</th>
</tr>
</thead>
</table>

- 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.

Phobias

- Definition of 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.
SUBJECT REVIEW & TRAINING/TEACHING GUIDE

Author: Rhonda McKillip; Foreword: Kenneth Minkoff, MD

Subject Review Revision August, 2020

Phobias...continued

• Definition of Social Phobia
• Symptoms of Social Phobia

Phobias...continued

• Definition of Agoraphobia
• Symptoms of Agoraphobia

<table>
<thead>
<tr>
<th>Physical and Cognitive/Thinking Symptoms</th>
<th>Emotional Symptoms</th>
<th>Behavioral Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Cognitive/Thinking and Emotional Symptoms</th>
<th>Behavioral Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

Treatment of Phobias often includes..

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

Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD)

• Definitions

• 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 9/11 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, Kosovo, 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.
Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD)...continued

- Symptoms of Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD)

<table>
<thead>
<tr>
<th>Physical Symptoms</th>
<th>Cognitive/Thinking and Emotional Symptoms</th>
<th>Behavioral Symptoms</th>
</tr>
</thead>
</table>

- 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.

Obsessive-Compulsive Disorder (OCD)...continued

- Symptoms of Obsessive-Compulsive Disorder

<table>
<thead>
<tr>
<th>Cognitive/Thinking and Emotional Symptoms</th>
<th>Behavioral Symptoms</th>
</tr>
</thead>
</table>

- Treatment of Obsessive-Compulsive Disorder

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

Obsessive-Compulsive Disorder (OCD)

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

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

DSM-5 Update: OCD is now in the chapter “Obsessive-Compulsive and Related Disorders.”

Anxiety Disorder Due to a General Medical Condition

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

<table>
<thead>
<tr>
<th>Significant Use of Caffeine</th>
<th>Hypoglycemia</th>
<th>Lack of Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Hyperthyroidism</td>
<td>Premenstrual Syndrome</td>
</tr>
</tbody>
</table>

DSM-5 Update: Remained unchanged in the revisions.
Subject Review & Training/Teaching Guide
Author: Rhonda McKillip; Foreword: Kenneth Minkoff, MD

### Treatment of Anxiety Disorders

<table>
<thead>
<tr>
<th>Education</th>
<th>Family Therapy and Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive-Behavioral Therapy</td>
<td>Support &amp; Self-Help Groups</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>Medication</td>
</tr>
<tr>
<td>Exposure Therapy</td>
<td>Relaxation Techniques</td>
</tr>
<tr>
<td>Stress Management &amp; Balanced Living</td>
<td>Harm Reduction or Goal of Abstinence</td>
</tr>
</tbody>
</table>

### Thought Disorders

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

<table>
<thead>
<tr>
<th>Cognitive/Thinking &amp; Positive Symptoms</th>
<th>Cognitive/Thinking &amp; Negative Symptoms</th>
<th>Behavioral Symptoms &amp; Functional Difficulties</th>
</tr>
</thead>
</table>

DSM-5 Update: Thought disorders are now located in “Schizophrenia Spectrum and Other Psychotic Disorders.” The primary change in the diagnostic criterion was the number of symptoms required for a diagnosis.

### Stages of Schizophrenia

<table>
<thead>
<tr>
<th>Acute Phase</th>
<th>Stabilization Phase</th>
<th>Stable Phase</th>
</tr>
</thead>
</table>

### Subtypes of Schizophrenia

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

### Types of Schizophrenia

- Schizophreniform Disorder
- Schizoaffective Disorder

DSM-5 Update: This Subtypes of Schizophrenia has been removed and replaced with a dimensional approach to rating severity.

### Treatment of Schizophrenia

<table>
<thead>
<tr>
<th>Therapy &amp; Mental Health Services</th>
<th>Self-Help Groups</th>
<th>Medication Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Therapy</td>
<td>Psychosocial Treatment</td>
<td>Stress Reduction</td>
</tr>
<tr>
<td>Family Education, Involvement, Support &amp; Therapy</td>
<td>Multiple Family Group Therapy (MFGT)</td>
<td>Harm Reduction or Goal of Abstinence</td>
</tr>
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Subject Review Revision August, 2020

Personality Disorders

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

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).

Personality Disorder Clusters A, B, C

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Personality Disorder</th>
<th>Individuals Often Appear....</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A</td>
<td>Paranoid, Schizoid, Schizotypal</td>
<td>unusual or eccentric</td>
</tr>
<tr>
<td>2 B</td>
<td>Antisocial, Borderline, Histrionic, Narcissistic</td>
<td>dramatic, emotional, or changeable</td>
</tr>
<tr>
<td>3 C</td>
<td>Avoidant, Dependent, Obsessive-Compulsive</td>
<td>anxious or fearful</td>
</tr>
</tbody>
</table>
Cluster B Personality Disorders

Symptoms of Cluster B Personality Disorders

Antisocial Personality Disorder Symptoms

<table>
<thead>
<tr>
<th>Social Behavioral Symptoms</th>
<th>Interpersonal Behavioral Symptoms</th>
<th>Emotional Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Symptoms</td>
<td>Emotional Symptoms</td>
<td>Cognitive/Thinking and Perception Symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Borderline Personality Disorder Symptoms

<table>
<thead>
<tr>
<th>Behavioral Symptoms</th>
<th>Emotional Symptoms</th>
<th>Cognitive/Thinking and Perception Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Severity of Symptoms

Cluster B Personality Disorders...continued

Types of Personality Disorders & Related Behavioral Patterns

<table>
<thead>
<tr>
<th>Cluster A</th>
<th>Cluster B</th>
<th>Cluster C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcissistic</td>
<td>Narcissistic</td>
<td>Narcissistic</td>
</tr>
<tr>
<td>Paranoid</td>
<td>Borderline</td>
<td>Schizoid</td>
</tr>
<tr>
<td>Schizoid</td>
<td>Antisocial</td>
<td>Antisocial</td>
</tr>
<tr>
<td>Antisocial</td>
<td>Avoidant</td>
<td>Histrionic</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Dependent</td>
<td>Schizoid</td>
</tr>
<tr>
<td>Dependent</td>
<td>Histrionic</td>
<td>Antisocial</td>
</tr>
</tbody>
</table>

Histrionic Personality Disorder Symptoms

Behavioral Symptoms

Emotional Symptoms

Narcissistic Personality Disorder Symptoms

Cognitive/Thinking and Perception Symptoms

Behavioral and Emotional Symptoms

World View of Cluster B Personality Disorders

<table>
<thead>
<tr>
<th>Personality Disorder</th>
<th>Basic Belief</th>
<th>World Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antisocial Personality Disorder</td>
<td>People are there to be taken.</td>
<td>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.</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>Other people must satisfy my needs.</td>
<td>1. I can’t cope on my own; I need to keep those important to me immediately available or I will fail apart. 2. Tup of war: I need others - me I don’t need others. 3. My feelings change rapidly; I don’t understand how; my emotions confuse me.</td>
</tr>
<tr>
<td>Histrionic Personality Disorder</td>
<td>I need to impress.</td>
<td>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.</td>
</tr>
<tr>
<td>Narcissistic Personality Disorder</td>
<td>I am special.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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

Subject Review & Training/Teaching Guide Developed By: Rhonda McKillip M.Ed., LMHC, MAC, CCDCIII, CDP
Sources & References Are Located Within the Text for Each Subject – With Extensive Bibliographies at the End of Each Subject
Author: Rhonda McKillip; Foreword: Kenneth Minkoff, MD
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**Cluster B Personality Disorders...continued**

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

<table>
<thead>
<tr>
<th></th>
<th>Acting Out</th>
<th>3</th>
<th>Denial &amp; Clinging</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Avoidance &amp; Distancing</td>
<td>4</td>
<td>Projection</td>
</tr>
</tbody>
</table>

- Motivations to Change Vary From Person to Person

---

**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.

---

**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)

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**Myths & Facts About Personality Disorders**

**Eating Disorders**

**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 (Unger, 1997, cited in News Herald (U Belel))

**Fact:**

- The average American woman is 5’4”, weighs about 140 lbs., and wears a size 14 dress (Eating Disorders Awareness and Prevention, Inc. [EDAP], cited in Illinois Department of Public Health Office of Women’s Health, 2002).
Eating Disorders...continued

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

<table>
<thead>
<tr>
<th>Binge-Eating Disorder</th>
<th>Bulimia Nervosa</th>
<th>Anorexia Nervosa</th>
</tr>
</thead>
</table>

- Reluctance to Seek Treatment

DSM-5 Update: These disorders are now located in "Feeding and Eating Disorders."

Continuum of Eating Disorders

<table>
<thead>
<tr>
<th>ANOREXIA NERVOSA (severe restricting)</th>
<th>BULIMIA NERVOSA (binge-eating/purging syndrome)</th>
<th>BINGE-EATING (compulsive overeating)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Restricting Type</td>
<td>(a) Purging Type</td>
<td>Binge-Eating without Purging</td>
</tr>
<tr>
<td>(b) Binge-Eating or Purging Type</td>
<td>(b) Nonpurging Type</td>
<td></td>
</tr>
</tbody>
</table>

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.

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
Changing Negative Thinking to Positive Thinking

- Definition
- 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

Changing Non-Helpful Patterns and Habits

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

Negative Thinking – Defenses and Habits

- Negative Thinking As Defenses
- Negative Thinking Patterns Become Habits
- Optimism and Pessimism

Steps to Positive Thinking

- 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
Practice Increases The Strength of Positive Thinking

Make Positive Statements to Others

**Table of Contents**

**SUBJECT TWO: APPENDIX II**

- APPENDIX II Purpose: Cross-training 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

Table: The Basics About Depression and Men

Table: The Basics About Depression and Seniors

- Classic Symptoms of Depression
- Are Often Mistaken For Aging
- Lack of Understanding of a Psychiatric Illness
- Reluctant to Seek Treatment
- Physical & Sexual Abuse
- Miscarriage & Infertility
- Women Who Have No Children

- 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

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Schizophrenia

Table: The Basics About Schizophrenia
- Prevalence
- Categories of Symptoms
- Brain Chemistry
- Course
- Onset
- Course
- Symptom Severity
- Onset
- Co-Occurring Disorders
- Categories of Symptoms
- Onset
- Course
- Symptom Severity
- Co-Occurring Disorders

Table: Symptoms of Schizophrenia
- Positive Symptoms
- Functional Difficulties
- Negative Symptoms
- Physical & Behavioral Symptoms

Table: Differentiating Between Illusions, Delusions, and Hallucinations
- Illusions
- Delusions
- Hallucinations

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
- Men & Women
- Symptom Severity
- 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
- Emotional & Cognitive/Thinking
- Social & Vocational

Table: The Symptoms of Narcissistic Personality Disorder (Cluster B)
- Behavioral
- Emotional & Cognitive/Thinking, Emotional & Physical

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

Table: The Basics About Eating Disorders
- Prevalence
- Types of Anorexia Nervosa & Bulimia Nervosa
- Onset
- Causes
- 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

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”
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: Jan LaValley

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.