Subject Two: Psychiatric Disorders Within A Co-Occurring Diagnosis

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 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, 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.

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- Permission is granted to use this study guide for the purpose of training on THE BASICS, Second Edition: A Curriculum for Co-Occurring Psychiatric and Substance Disorders.
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You may contact me if you have additional questions.

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...

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. 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.
8. So this was my dilemma as the author of the curriculum...

8. 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?
9. I chose the latter…no additional cost to current owners and purchasers.
10. 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.
11. The limited references to the DSM on Substance Disorders are located in Subject Three, Substance Disorders Within A Co-Occurring Diagnosis.
12. 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.
13. You will find extensive lists of symptoms from other sources on Psychiatric Disorders in APPENDIX II and Substance Disorders in APPENDIX III.
14. 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.
**Subject Two: Psychiatric Disorders within a Co-Occurring Diagnosis**

**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.

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**Medical Disorders of the Brain**
- Medical Disorders of the Brain
- 20% of the population
- Primary locations of people with co-occurring disorders:
  - Incarcerated
  - Homeless

**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.
**Overview of Psychiatric Disorders**

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

**Overview of Psychiatric Disorders...continued**

- Causes of Psychiatric Disorders
- Categories of Psychiatric Disorders

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Axis II</th>
<th>Axis III</th>
<th>Axis IV</th>
<th>Axis V</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>Personality disorders (like borderline personality disorder) and Developmental Disorders (like autistic disorder)</td>
<td>General Medical Condition (like hyperthyroidism)</td>
<td>Psycho-Social and Environmental Problems (like housing or occupational problems)</td>
<td>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)</td>
</tr>
</tbody>
</table>

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

Types of Psychiatric Disorders

Most Often Associated With Co-Ocurring 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>

Mood Disorders – Types of Mood Disorders

- Major Depression
- Persistent Depressive Disorder (Dysthymia)
- Bipolar Disorder
- Cyclothymia


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

Depression in Women

- 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**

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

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.

**Symptoms of Persistent Depressive Disorder (Dysthymia)**

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

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.
Types of Bipolar Disorder

**Bipolar I Disorder**
- Classic Form of this illness
- Meets the criteria for a Depressive Episode 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.

**DSM-5 Update:** New wording describes Bipolar I as a person with a Manic Episode also experiencing Major Depression. Bipolar II is no longer considered "milder" than Bipolar II because of the amount of time these individuals spend in depression.

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.)

**Types of Bipolar Disorder**

- **Bipolar I Disorder**
  - Classic Form of this illness
  - Meets the criteria for a Depressive Episode 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.

**Manic Episdes**

**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**

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

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

**Mixed Episodes**

- Defined

- Symptoms

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

**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

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

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

**Cyclothymic Disorder**

- Defined

- Symptoms

<table>
<thead>
<tr>
<th>Physical Symptoms</th>
<th>Emotional Symptoms</th>
<th>Behavioral Symptoms</th>
</tr>
</thead>
</table>

**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

## Types of Anxiety Disorders

<table>
<thead>
<tr>
<th>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>

**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. Also 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 relevant to the actual treatment process.

## 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 would be expected in response to a particular stressor or situation.

## 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

## 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.

## Generalized Anxiety Disorder (GAD)

- Defined
- Symptoms of GAD

### Physical and Cognitive/Thinking Symptoms
- Tense muscles
- Fatigue
- Trouble concentrating
- Irritability
- Difficulty making decisions
- Restlessness
- sweater

### Emotional Symptoms
- Nervous
- Jittery
- Not sleeping
- Not eating
- Uncontrollable worry

### Behavioral Symptoms
- Needing to be near others
- Moving too fast
- Needing to be in control

**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

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

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

Phobias…continued

- Definition of Social Phobia
- Symptoms of Social Phobia

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

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

Phobias…continued

- Definition of Agoraphobia
- Symptoms of Agoraphobia

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

- 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:

<table>
<thead>
<tr>
<th>Traumatic events</th>
</tr>
</thead>
<tbody>
<tr>
<td>survivors of accidents, rape, physical and sexual abuse, and other crimes</td>
</tr>
<tr>
<td>rescue workers involved in the aftermath of disasters like the terrorist attacks of 911 in New York City</td>
</tr>
<tr>
<td>survivors of natural disasters such as earthquakes, tornados, floods, or hurricanes</td>
</tr>
<tr>
<td>military troops who served in combat like Vietnam and Gulf War</td>
</tr>
<tr>
<td>immigrants fleeing violence in their countries like Vietnam, Kosovo, Cuba, or Haiti</td>
</tr>
<tr>
<td>survivors of man-made disasters such as the Oklahoma City bombing</td>
</tr>
</tbody>
</table>

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)

| 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.

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.

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.

Thought Disorders

• Not “Thinking Straight” Versus a Thought Disorder

| 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 criterion was the number of symptoms required for a diagnosis.
**Stages of Schizophrenia**

<table>
<thead>
<tr>
<th>Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Phase</td>
</tr>
<tr>
<td>Stabilization Phase</td>
</tr>
<tr>
<td>Stable Phase</td>
</tr>
</tbody>
</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.*

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**Subheading:** Temperament

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

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**Diagnosing a Personality Disorder**

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).
Cluster B Personality Disorders

Symptoms of Cluster B Personality Disorders

Antisocial Personality Disorder Symptoms

Borderline Personality Disorder Symptoms

Severity of Symptoms

Types of Personality Disorders & Related Behavioral Patterns

Cluster B Personality Disorders...continued

Histrionic Personality Disorder Symptoms

Narcissistic Personality Disorder Symptoms

Cluster B Personality Disorders...continued

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.
**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 39-21-32, 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 Lifestyle).

- **Fact:** The Real World Body Image
  - 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).

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**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>

**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

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**Subject Review & Training/Teaching Guide**

*Text: THE BASICS, Second Edition: A Curriculum for Co-Occurring Psychiatric and Substance Disorders*  
*Author: Rhonda McKillip; Foreword: Kenneth Minkoff, MD*  

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**Subject Review Revision August, 2020**

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**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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**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

**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

### Negative Thinking - Defenses and Habits

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

### 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 isn’t!</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>
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<td>Subject Review Revision August, 2020</td>
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**Subject Review & Training/Teaching Guide**


Author: Rhonda McKillip; Foreword: Kenneth Minkoff, MD

Sources & References Are Located Within the Text for Each Subject – With Extensive Bibliographies at the End of Each Subject

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**Postpartum Baby Blues**

Not seriously... It’s sorry... I’m... She’s... Maybe... Definitin... This... some... and... B... conscientious... can... be... Prevalence... now?” Menstrual Cycles bad... made... be... attitude... just... day... her... she... Positive Thoughts Contribute to Good Physical... do... Be Surrounded With Possitives... I’ll... must... I’ll... beliefs... The... is... I... be... I... believe... “Oops... her... Menopause & Hormones Onset... let... I have... hate... Optimism and Pessimism... or... can’t... Ca... Causes... symptom... Course... Co-Occurring Disorders... Risk Factors... brain... Sex Hormones... Menopause & Hormones... Postpartum “Baby Blues”... Postpartum Depression...
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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

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 be bitter and hurt them as much as I can. I can have faith in myself, and believe what I say, and I personally intend to make the best of each day.

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.