NAADAC

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Food, Substance, and Anxiety: What I Learned about Recovery on a Year-Long Road Trip

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Hello everyone and welcome to NAADAC, substance disorders and anxiety presented by Robin Cruze and Leah Young. It's great you can join us today. My name is Samson, Director of training and professional comments for an association for addiction professionals-- homepage webinars is Debbie --NAADAC --/work on ours and bookmark this webpage to stay up-to-date on the latest in addiction. Captioning by caption access. Check your confirmation e-mail in the chat box with a link to use closed captioning. In an effort to continue the critical professional and business development for addiction professional, we were fortunate to welcome webinars sponsors as the field continues to grow and responsibilities involved, it's important to remain as often --best practices and resources of supporting addiction and recovery especially in times like these where we are all quickly realizing the importance of how technology can access and how it supports us and even enhances recovery so this webinar is sponsored by recovery record. Recovery record helps addiction -- meet the compact needs of patients with eating disorders and addictions. This app which has been evaluated in clinical trials engages patients is best treatment tasks in between apartments and equips providers with real-time patient progress data. Satan for instruction how to access CE quiz towards the end of the webinar immediately after a brief demo from our sponsor. As you can see, we are using go to local opportunities live events. You'll notice that go to open our control panel looks like when you see on my side critically used in anytime to or maximize the control panel. If you have any questions, type them into the questions box and we will gather those questions and give them to our presenter during the live Q&A. Any questions we don't get to look like strictly from the present and post those questions and answers on our website at a later date. Lastly, under the handouts tab you will see a PowerPoint PDF version of the slides in three slides per page for the notes and a user-friendly instructional guide on how to

access online CE quiz and immediately earned CE certificate. Please make sure to use those instructions if this is your first time taking the quiz. Let me introduce you to today's presenters. First, Leah Young, is the manager of the addiction recovery tracks and eating recovery center and pack light mood and anxiety center. She has been with ERC for nearly five years introducing substance treatment social commute, anxiety, and trauma those treatment and recovery and eating disorder programs at all levels. She earned her Masters degree from the Chicago school of professional psychology in 2007 -- upon graduation, hired at Resurrection behavioral health as a clinician running evening intensive outpatient group script groups with substance disorders and promoted to program manager -- presents behavioral health where she ran several years before coming to ERC. To reconnect with clinical work. Leah lives in Chicago with her exuberant seven -year-old daughter, hilarious husband, and to annoying cats. Let me also introduce you to our second presenter today, Robyn Cruze. Robyn is internationally recognized author and speaker. Robin published making peace with your plate, central recovery -- work featured internationally in media outlets including ABC, sky news Australia, CVS, the temper and refinery 29. She is the cofounder of the family's mental health initiative wide and wonder that aims to make mental health and addiction all recovery and every day conversation. She also serves as the director of efficacy consultant at recovery Center -- we are lucky to have them both here today. Robyn, with no further delay, I will turn this over to you. Thank you so much Sampson for having me here. To present. I am so excited about this presentation. I feel like the sum of everything I've been going there is an advocate, today, although I'm sharing a story to help educate on the occurrence of mental health issues in addiction, please know this presentation is not solely about what I have explained switches eating disorder and obsessive-compulsive disorder. If anything, it is to -- in hopes we educate on the great importance of how we must begin to recognize co-occurrence's fastest

mechanic to set our clients up with the utmost success. So today, we have three objectives. The first one would be describe the co-occurrence of mood and excited sort is in the eating and substance disorders. Second, verbalize the differences between various anxiety disorders in ways co-occurrence presents and clients. Third, participants will be able to apply effective tools and interventions and treatments for anxiety disorders. I will say before I begin, today I have the pleasure of sharing my story is a case study for you. The best way I know how to educate. Leah, you are in for a treat, help you reckon is co-occurrence and how to treat and assess that and treat them. Some looking forward to meeting her in getting to know some of her work. a little story about me as I said, as a case study, bring the stories of your clients to life so for many of you who know me, I've been mental health advocate for way over a decade now. Something I am so incredibly passionate about. I see the changes in fields becoming better a green light to the way language is being used, more access to care, more paths to recovery and one of the quickest ways I get to be of service is to constantly advocate to share stories and I and the stigma. Today that is my intention so I got recovery from eating disorder after struggling through 29, I've been recovery for a while, 16 years now. In that time, I was incredibly lucky. There is no text but definition of full recovery per for eating disorders. I will read a little bit about what I think my definition is there is none. The personal definition is this: I do not bend, purge, or starve in my body or food intake dictates my daily activities in today's society women men and children of all shapes races economic statuses are susceptible to media -- in my recovery, lip body -- in the moment -- no longer defines me. To me, recovery means my true self, not the words of an eating disorder Arvida and I defined my own definition of beauty. So that is my definition of eating disorder recovery and that may change for many visuals. I have been living that for 16 years. However, also in conjunction with that wonderful recovery, I also continue to deal

with daily anxiety. Daily anxiety which show itself in different ways so I did have the inter modal -- I cope with it by overwork -- the self-imposed urgency. Stress cycles of the daily routine of trying to keep up with everything for business owner, wife, mother of two, book writer, friend, community member. It was a constant going so I had constant anxiety and I do have these battles like flareups like my mom had lupus and mother she had a flight, station she's having a flip side like to say I was having a flare up of anxiety. These would come up bouts of stress that would cycle into panic attacks and when I would get these panic attacks, I will get whatever referred to a scary thoughts and they were so paralyzing to me. the often came in the form of figuring I would do harm to others or accidentally hurt myself or accidentally kill somebody in my sleep and wake up and find my family dead. I've come to know the scary thoughts as intrusive thoughts that come out of nowhere and cause distress. I would adapt -- what I would say about these intrusive thoughts that they would come out of nowhere in contact was so -- detached to the thing I like the most, family being the highest value so my family safety -- actually, they did relate to something to the amount of stress. I was having stress in my life and I hit a point where I needed to back off. Intrusive thoughts. I didn't know scary thoughts were in fact intrusive thoughts. I had no idea. I thought I believed that maybe I was going crazy. I found myself caught up in these intrusive thoughts and I would have come to learn as cognitive distortions where some -- all or nothing thinking. Testifies in -- magical thinking. Comparing myself and I would have these thoughts and I would also have no physical compulsions but a lot of mental compulsions so I would spend days figuring out what I had to do to get rid of the scary thoughts in my days would be like that. I'm constantly trapped in my thoughts and I would become incredibly exhausted. That was my life for 16 years in between that, really great days but when I was stressed, my scary thoughts, I didn't know I would escape them. Health advocate went through that has made me understand affluent importance of

sharing this with you. I have access and I'm blessed to work with people who have all this training therapy, psychiatrist, I did not ask him because -- I had my own teams and I went to my own team and asked countless professionals for help and I was treated for my scary thoughts, talk therapy, MDR, antidepressants, exercise, diet. I believe recovery is a combination, not just one thing but a variety to help in recovery. and I certainly try to tackle these scary thoughts and flareups of anxiety with that in all of these treatments helped for a little bit but they didn't address what was going on so I was stuck waiting for the scary thoughts to come in my life to shut down and ultimately, I would end up in another flareup. So one year in 2018, about of these anxiety and panic attacks, my husband said to me why don't we go on the family adventure and get away because I thought maybe I was under too much stress. Stop the stress and get away, massive clips would leave me and attacks of the scary thoughts so we thought let's do it. Who decided to get on a bus and converted a school bus into a tiny home and traveled the country for an entire year. My husband is also a mental health ever get so we decided to do this initiative called wide wonder. the goal -- recovery center and path late formally known as In Sight behavioral health, decided to travel the entire country and spoke at 20 events and community events. Went to communities and spoke there and decided we want to do a little different and expand -- here is a picture of us at Chicago holding -- stigma posters about I am not my mental illness. I have mental illness -- going to mainstream media and talk about mental health and while doing that wanted to have a family eventually the process. Two months into my trip on the bus, we had a great time but I've never been in Cruz Bay off the coast of Oregon -- such a beautiful place. My family see their and our dog are outside taking in the beauty while I was at the back of the bus and feel position having panic attacks and scary thoughts and at that time I thought to myself, I don't know how I'm going to escape. My .-dot did something I had not done before which seems like a small thing but when you

have intrusive thoughts, many of us will feel like you're too scared to find out what that means and maybe we are sociopaths or really are having something is going on so I would never look up what my sentence are and I had no reason to because I want to psychologist, therapist, you name it so there was no reason for me to get information off the Internet, but I was so desperate that he looked up these words. Scary thoughts on the Internet and they are in the middle of Cruz Bay, I discovered the possessive compulsive disorder. I have to tell you after 16 years of eating disorder recovery and being a mental health advocate, it has changed my life and set me on a different trajectory for my efficacy work. Talking more and more about co-occurrence and how we must start to assess immediately. We have a currency go deeper because many people try to help me. But if they asked a couple of other questions, I wouldn't have struggled for so long. So when it comes down to what I learned on the bus, until we identify and treat illnesses, cover really will be greatly diminished and that certainly in my case. Many people with OCD fact have been misdiagnosed and I am not alone -- misdiagnosis is generalized and since Heidi and you can have generalized anxiety and OCD at the same time. And 50 percent of interest with OCD are misdiagnosed and therefore do not get the treatment that they need. Other common diagnoses are ADHD, bipolar disorder, and sometimes even schizophrenia. It's typical that it takes. Fourteen to 17 years for an individual with OCD symptoms to be diagnosed. Because of this, it is believed there are far more people affected by the debilitating illness that we currently account for. Again, it's my hope you learn more about how to treat and assess cooccurrence bonuses. I'm going to take you through some of the steps. After this, questions. What are some ways we can remove addiction and mental health stigma? Type your answer in the Q&A box or go to the webinar control panel. Some going to take you through some of the statistics for the cooccurrence of substance -- mood and anxiety disorders. a whopping 42.5 million people in the US will have anxiety disorders. Hands up. Eating

disorders, 30 million people. In substance use disorder is 19 million. the co- occurring illness between eating disorders and eating disorder are the following. 5055 percent of individuals with eating disorders also misuse substance and up to 35 percent of individuals with substance use disorder also have eating disorder -- 10 percent in the general population. Twenty-seven percent have an axiom. 36.8 will have bulimia nervosa and 35 percent struggled with binge eating disorder. Women who had an accent of Ozark 19 times more likely to die from substance use disorder and approximately 57 percent of males with binge eating disorder will have substance use disorder. Here is the pool question. Why do you think people with eating disorders are more likely to misuse substances? One, distract them from eating. Two, curve their hunger. Three, cope with symptoms of other co- occurring disorders or for, all of the above. Please submit. Excellent, thank you so much Robin and everyone, the question is up on your screen now and half of you have already loaded. You'll see for answer options as not to mention. I will share with Robin and label it something shared in the question box. About ideas to decrease to, come someone said speaking about it openly and honestly said increasing awareness of the various illnesses through median committee involvement ensure you are active in the quality and normalized to talk about it and sharing stories, remove judgment. Great answers everyone. We and Robin will be back with you and one minute. Give you about five more seconds to answer the polling question you see. Perfect. Thank you everyone. I'm going to close and share the results and turn it back over to your presenters. That's great so this is Leah. I haven't finished these statistics. I'm waiting for the page to go back up I see the quick poll. And this is what we commonly see in the all the above can be other circumstances that contribute -- great job everybody. Moving on, statistics and eating disorders and co-occurrence events, anxiety disorders most commonly those who struggle -- 80 percent of any anxiety and mood disorder in patients with disorders is a huge statistic. an eating

disorder patients, the most common comorbidity are mood disorders and 53 percent of anxiety disorders at 18 percent obsessive compulsive disorder. Substance use disorder and -- disorder. 29.9 percent of those with substance use disorders had a lifetime incidence of anxiety disorder. 32 percent of those with me disorders also have substance use disorders. Individuals with lifetime major depression: 16.5 percent had alcohol use disorder and eating percent had drug use disorder. Individuals with substance use disorder particularly common among visuals with bipolar disorder, 56 percent had lifetime substance use disorder. Ms. Covid statistics come from her mental health America report they do in seared the state of America and they did monitoring of covid and these are some of the things they came away with so the number of people for help with anxiety depression has skyrocketed. The number of people screen with moderate to very symptoms of depression anxiety has continued to increase throughout 2020 and remains higher than rates prior to covid 19. No surprise there. I will say we had two pandemics with covid and mental health. the good news is we are talking about it I hope people will be asking for help and reporting frequent thoughts of suicide and health harm that have ever been reported in the mental health America screening program since its launch in 2014. Young people are struggling most with their mental health. It's of suicide ideation are highest among youth, especially LGBT Q classes. People screening at risk for mental health conditions struggling most with loneliness or isolation. People who identify as Asian or Pacific Islander are searching for mental health resourcing word 2020 than ever before. While rates of anxiety, depression, suicidal ideation are increasing for people of all races and endless disease, there are notable differences and those changes over time. Black or African-American screeners have had the highest average percent change over time for anxiety and depression. So the second objective is to Leah who will teach differences between anxiety disorders and the ways they display themselves uncovering. Thank you. Thank you Robin. It's always such

an honor to have you share your story. I think that there is not any way to make people feel more connected than here some story because we often hear ourselves and that so appreciate you. Thank you. The first polling question was put out there, those were great answers in terms of reducing the stigma and one of the things Robin and I are huge advocates for is changing the language and I believe we are cognizant of that is in using person first language. I honor my patients or clients what they would like to refer themselves as as but when I'm speaking, talk about a person they substance use disorder appeared I don't cite addict or alcoholic. Again, something once to own that term, that's fine. I'm not going to argue with that. I want to stay away from things like clean or dirty to someone who struggles with substance use I never use those what I'm talking about drug screen results. A site negative or positive. I recently started to wait from the word relapse. Quite honestly because substance use disorders or medical condition I can't think of metal and other medical condition I'm aware of where we say relapse. If somebody is a cancer survivor and have a recurrence of cancer, w women say they relapsed on it. Really starting to veer towards recurrence of use, words are important and I don't take anything away from somebody that's where they want to use. I try to be little more careful about it and move towards medical terms instead of the old terms we have used so that's a little bit of a note before we move forward so here's a lovely quote about anxiety. Being a thingy then stream of fear trickling through the mind and it can channel into which all of their thoughts are drained and the reason I selected this quote is because I am certain the author, and playwright, I believe he said this. Probably was not aware of the neuroscience you to understand you can create your own pathways that are like channels carved into the brain. Also have capacity to change doesn't work on them. Anxieties something that is managed. I don't believe there is a cure from it. Certainly, the idea that cutting the channel spoke to me. I want to talk about anxiety diagnoses. Anxiety is input from our brain

that tells us something important so it's adaptive and lets us know when there's something in the environment we have to pay attention to that may potentially be a source of danger or something is missing that makes us feel safe so people are objects that signify safety and can result in both cognitive and somatic symptoms. Like worry so things like heart rate, breathing increases, and those appears sympathetic -- they always switch these two. The nervous system cured in shape for -- those who struggle with pathological anxiety find that sometimes nothing creates this feeling of anxiety or something very small and we may have an oversize response to it. Anxiety is not bad. Just like anger, it is telling us something and given us a message and those of us things I didn't need to manage that and recognize when -- it's hyperactive -- typically what was he is is it impairs functioning in some way so the neuro-anatomy involved, I mentioned the amygdala. It helps us process salient stimuli in our environment. Things we need to pay attention to. If I'm walking on the street I got across an alley in a car comes flying from alleyway and hits its breaks late, I need to pay attention to those kinds of things. My survival mechanism kicks in and that helps with that. the medial prefrontal cortex is involved in modulation and effect. Then the hippocampus involved in memory including in retrieval so for example, if I have a fear of public speaking which I don't by the way, but if I do, the first time I go to give a presentation, technology goes on and the microphone gives out and I have a coughing fit, space out and trip walking off the stage, the next time I speak, probably my anxiety be high because of of that. Memory is there to remind it could be worse and how humiliated you were so important to recognize as parts of the brain that are involved. In terms of her work, it's been theorized that anxious behavior as a result of a function of processing. We still need more research but that something interesting to pay attention to so if I experience something and don't get as much reward from it as possible, what I may do is continue a behavior looking for the reward I expected or I

start scanning the environment. That's anxiety and in fact, it sounds a little bit like behaviors we see with folks with OCD so -- it creates more anxiety because the brain is saying the reward is what I expected and feeling like I missed something. So that's where we see some exciting coming and that is theorized. There is no -- nothing about that yet. I think it's a fascinating theory and one that should be looked into. We also have primary anxiety versus secondary and this is like many diagnoses in DSM where we have anxiety due to having primary anxiety disorder diagnosis or we can see it as secondary. So it might be medical condition or substance misuse or psycho social stress or psychiatric condition so we need to take a look at that as well and see if we can attribute this is something that may be conceived anxiety increase for. And decrease and end up being chronic but certainly substances if we continue to use and have that secondary anxiety could end up becoming something even once removed so those -- this is a general understanding of the anxiety don't diagnosis and we are going to get into some of these disorders so you will see I listed several. We have generalizing anxiety which mentioned is over diagnosed. Panic, for some folks, specific phobias, social anxiety, Agoura phobia, separation anxiety, substance induced that I mentioned -- obsessive compulsive disorder. Trauma is listed as its own column because as we know and learn more, recognize how much trauma is tied into so many diagnoses and we at ERC and half-life operate as though everyone has experienced trouble so that is the trauma formative approach we are all moving towards so we assume and going with that assumption that someone has experienced, and that can be a little tease -- whatever it may be, some memory there to result in anxiety diagnoses as a way -- response to the trauma so we will get into some of these and talk about the signs and symptoms. Let's talk about generalized anxiety disorder. They have the criteria. from the DSM, looking at excessive worry more days then -- we find it difficult to control worry and are mind races may be keeping us up at night and having hard time focusing on conversations

because we are worrying. We look for three or more of the following symptoms which might be restlessness or feeling keyed up or on edge. Easily fatigued, draining to be constantly worrying. We have a difficult time concentrating, your debility, muscle tension, a lot of people carry it here and I know I do and sleep disturbances what we are also looking for is it because a significant distress or impairment. the signs for starting to get help, people experience anxiety and telling us something we may not be paying attention to. This is where it starts to impair functioning. I have a hard time making the smallest of decisions because there is fear whatever I choose will be the wrong one and be catastrophic. I may constantly worry about what other would describe as minor events. To me may feel major but there typically minor events. I will restrict other behaviors so the sense of control so that I don't have to worry about them. I may find myself tightening rules around my kids and what they are allowed to do and not allowed to do. I may be right about mom leaving the house and I will do that for you because we'll trip and fall. Give myself back the sense of control which ends up increasing feelings of anxiety so this is generalizing -- as mentioned, you can see how it's over diagnosed because you look at the criteria. It's really general. a lot of us can look at it and say Yep and recognize we experience this quite frequently. It doesn't mean we have this disorder -- something to pay attention to. I'm going to look at my notes. I'm going to move forward and talk about the physical symptoms received. Restlessness and feeling on edge, TH, et cetera. Grimacing stomachaches, G.I. distress, acid or flux comes to people's minds, headaches, tension headaches. Nausea, sleep disturbance, chest pains, fluttering of the heart et cetera can be uncomfortable and tingling in fingers, reining in the ears, and difficulty breathing. Particularly in a situation where anxiety is heightened so these are the symptoms to look at at any of these things or appear together does not necessarily mean anxiety and we want to take a look at these. One of most common errors for someone thinking they are having

a heart attack because they feel similar and it's really anxiety so it could be due to something physical but we also have to consider this especially -- with talk about panic disorder. with panic disorder, we have criteria, recurrent and/or unexpected panic attacks followed by one month of one or more of another one. Winter wear so I'm constantly worried about the implication of what it means and what does it say about me? What are we talk we what a society telling me? What happens if I do and driving my kids? Do I have to worry about safety so lots of different locations. Internal as well as external. We may see significant change in behavior so because I had a panic attack getting on the freeway with kids, now I won't drive on the freeway and I restrict myself more. I don't take them anywhere because I'm afraid to have a panic attack so I may see the change occur. What are they? Panic attack is a discrete period of intense fear and we are looking for four of them were following symptoms that abruptly develop an peak within tenant so palpitations or rapid heart rate, sweating, shaking, breathing is one of the number one things and it might feel like I'm choking, chest pain or discomfort, sick to my stomach, chills or get flushed and feel hot, pierced seizure which is the tingling. Dizzy or faint, or depersonalize when what is happening does not feel real or a sense of attachment. I think I may be going crazy, fear of losing control and the fear of dying as well. So any one of those can be scary enough. Were more together and naturally we will have a panic attack because those things are telling us that something bad is happening. In our bodies reacting and overreacting to the stimulus some of the signs for you and help our frequent visits to PR were looking up to 60 percent of cardiology visits are for panic disorder and feeling the need to have a safe person around stainless a place at all times. Use of medications to get through, I'm okay if I have my Xanax and get into a panic if we have forgotten. And those fears of having that experience so you look at the description of what a panic attack is and it sounds like you are suffering and it is so we fear when that will happen again in our

heart rate pieces for natural reason and we are worried it's a sign panic attack so these are the things I want to take a look at and pay attention to patients and clients when they're talking about the stuff. Listen to the language they are using because it may give us an indication there something going on that was not considered before. Specific phobias. Usually greater than six month period of time like a marker persistent fear that is excessive or unreasonable and cute by the presence or anticipation of a particular situation like snakes or flying or those kinds of things so anxiety needs to be out of proportion to the actual danger of the situation is one of the keys. Pay attention to that. and interferes significantly with functioning or routine so for example, if I'm afraid, told buildings are avoided if a relative one and I prefer to drive so Mark was then taken a plane because I'm afraid of flying even though driving is statistically more dangerous than flying. A picture of a snake will send me running or blood or needles cause you to pass out. I think about when I was a kid if I was reading an encyclopedia if there is nothing else, flipping through a magazine and see a picture of the shark were spider and both I am not afraid of it when I was a kid count I was afraid to touch the picture. Anything about that. It didn't mean I have a specific phobia. It's pretty normal for kids to have big imaginations but if that continued into adulthood, we are talking about development of a phobia or existence of one. Social anxiety disorder is seen commonly and it's used a lot. A lot of people say they have social anxiety disorder and suspect many of them have not been diagnosed with it but this is something we want to take a look at and we are addiction professionals so one of the main meetings I hear -- not going to meetings as I have social anxiety. I say so to somebody else right. In any case, fear of one or more social performance situations -- worried about the scrutiny or what others think or may say something stupid or humiliate myself et cetera. If I'm forced to be in a situation, I am immediately anxious. In the anxiety tends to be out of proportion so I know a lot of

people who are charming and smart and witty and good conversations but have so much fear that they're going to feel a social situation from the outside we are thinking what? I wish I operate the way you do. It's a disproportionate fear or misunderstanding of how they present themselves to the world. We want to look at the lasting more than six months because we all go through periods of time where we feel uncomfortable and aren't sure and don't want to slap diagnoses on everybody. Take a look at a pattern in a period of time. I may end up avoiding situations and I work with a lot of folks used to be social but over time start to isolate because it's just easier than putting themselves in situations and it's one of the issues we come up with with people who use substances in the more social ones are using in the first place to lube up and feel better in a social situation only to find themselves relying on it and need to isolate because eventually it's not going to do it anymore either. Avoidance, fear distress -- fear with functioning. Getting help. Events from years ago to continue to harm so something embarrassing happened at a party and it continues to haunt me and I can't leave it behind. I may have a startle response above what is helpful for the situation. I may take a very long route to go over where I need to go where I witnessed a true medic event is a piece of trauma but I may find elaborate reasons to avoid social situations or make sure I'm not driving past the neighbors house who has people over because if they see me, they're going to run out and wave and invite me to come in so want to take a look at some of that in avoidance. Constant nightmares, becoming withdrawn as I mentioned. So taking a look at obsessive compulsive disorder and those related. About what obsessions are so recurrent thoughts or persistent thoughts, impulses, images that are intrusive as Robin described and on 110 and they cause us anxiety or distress. Do people say market -- forgive me if it sounds pretentious. In any case, unwanted. And increases anxiety especially when disturbing so I do is try to ignore or suppress the logs, urges, or images, or neutralize them. We are

missing text -- I apologize. Other thought or action. That is compulsion. I'm going to skip that for a moment -- to understand context. Compulsion is you're using to manage obsessive thoughts will be repetitive behaviors or mental acts that I feel compelled to perform in response to that obsession or according to a rigidly applied rules I've created. The behaviors or acts are aimed at reducing distress or preventing some dreaded situation; behaviors are not connected in any realistic way with what they are designed to naturalize works front. For example, I may feel the need to flick a light switch 12 times because if I don't, my mom will die so and is commonly thought for me and does the trick but in no way connected to whether or not my mom lives or dies and I often times you know this logically and I still feel compelled to do it that's where a lot of distress comes from because we are doing things that end up feeling embarrassing and shameful and I know looking light switch will not change anything and we still feel compelled to do it and that can create all sorts of internal conflicts. Please, Robin. I can't think of the word -- Lee is talking about compulsion physically like the light switch clicking on and off or walking and stepping on cracks and washing hands compulsively and things you can't see and we also don't see that are also compulsions are the mental compulsion so for example, if my mom -- if I say a prayer five times over in my head before good about, rightly that's the public into his we don't recognize compulsions are compulsions are not easily diagnosed. Thank you forever kidding for that as well and something you mentioned at the beginning so I think this is where we have to ask leading questions to folks if we are starting to suspect us. We might want to listen to what they are saying as well because again, especially high internal ones, hiding the physical and behavioral compulsions but someone might notice that and usually there is embarrassment. Mental ones we can hide from everybody forever and continue to suffer so it hires clinicians around us to ask the questions so we are starting to see this and hints of it -- as questions about ruminating thoughts

and engaging in untold gymnastics and repeating things over and over again so thinking for binding everyone of that. Speaking about intrusive thoughts, I think we have lost a part of that side but to let people know come through -- so disorders we may be looking at obsessive compulsive and the related ones are just more sick -- hair pulling and picking and chewing. There are a lot of little boxes on the screen. Looking at criteria, sessions or compulsions causing distress typically taken within one hour a day and cause clinically significant distress or impairment in function. We specify with good insight -- poor insight or absent -- I'm convinced the OCD beliefs are true in that case. Otherwise, good insight is I know doing that is not the key and still I feel the need to engage. We want to specify when signs for getting help is rituals day taking up more than an hour a day, the people used for reassurance or completing rituals, they may not be aware of it. You can rope others in. We would be embarrassed father's new what you are thinking or doing. The other thing, it amazes me that other things are able to do it quickly were easily so we want to take a look at some of these things that help us say I need to talk to somebody knows what they are doing. Anything else? I think OCD is one illness that comes in many forms so I think this could be a whole presentation and of itself. If you want to know more about OCD, please contact Leah or myself we have contacted the end of the slide. So me things to know in this important topic to think about because we know more people are struggling then we have documented. While I need to keep moving. I can talk. Holy mackerel. It's like we have two brains, a rational and irrational constantly fighting. You can imagine this was Austin also talk about recognizing cooccurrence. Once we recognize there is anxiety disorder, it's critical to screen other site psychiatric diagnoses -- I think there is more important stuff to narrate so this is some numbers about adults 18 or over substance use disorder or any other illness and we have some slides about -- and any mental illness, serious mental illness, and no mental and also understanding

-- serious mental illness is a smaller were severe subset of diagnoses so substantially leading activities. Addressing one or two genetic and very mental factors come into play, treatment does work but we have to think about it in terms of managing it like diabetes, not the flu. We don't get cured and it goes away. Traditional treatment isn't the norm anymore. We'll talk about what treatment you work with at ERC path light -- on other facilities. Let's talk about assessment in order to start. That is the question. Sometimes one of these three circles requires focusing on that first so substance use disorder may need to be treated before we get anywhere because we have medical complications, somebody struggling with withdrawal. We won't necessarily do talk therapy someone struggling chronic alcohol use. Not right away. We have to come in a place where they can start to retrain information and be in the present in the room. Self safety first is what I say and we want to try and manage all this is much as possible at the same time. The things I know is at times we may be establishing every pre-existing disorder or substance use only to find there were underlying health issues that were un-diagnosed because symptoms weren't as obvious in the percent of themselves as a function of my eating disorder substance use disorder or maybe more manageable and as I get to recovery become less manageable because I don't have my coping skills of alcohol or an eating disorder so we can find that over time is not necessarily that something was missed but we need to be vigilant for new things that might come up that were there in the first place and lurking in the shadows. When we are engaging in assessment, we have to make assumptions. The identification of substance use disorder is difficult at times. As we know, people will hide or withhold the truth because there is so much stigma were don't want to address it or not ready to. If any of you have found I found, even when patients minimize use, still enough to cause concern in their thinking is that what normal people -- so denial and minimize station and ambivalence because they may have fun with or get relief from the use of substance. Flip-flopping back and

forth. One of my favorite tools which is a little cruel of me is that intake, incoming patient say one thing about use when they sit down with me tell me something completely different and I say help me understand when you reported intake -- I was like Boston. Intention to story and help me change so this is where it's helpful to work as a team can sometimes one person gets more of a story than the other. Substance use disorder, mental health, eating disorder diagnoses all carry shame. Think about it, can you have one week if I don't eat?'S questions imply there is something wrong. That you can't just eat so thinking about that and being conscious of how we approach it and not making world judgments their questions print substance use disorder mimic mental health diagnoses -- increase sometimes with mental health diagnoses and psychiatric -- eating disorders can be massed by substance abuse. Folks with substance use disorder may not be good historians -- issues with memory and blacking out in the shame can lead to minimize nation and cultural aspects. I worked with people who come from leftist families were Muslim families to admit they have been drinking at all let alone in a way it's problematic can be terrifying so asking some of those questions. If culture comes into play. You mental health substance use disorder and addictive behavior -- collecting data over time. Get a chronological history as best we can and have knowledge of substance use disorder, and mental health disorders. Eating disorders, you don't have to be an expert in all these. Have an awareness. If we ignore eating disorders substance used clinicians, it's almost unethical. We need to be aware and notice there is something going on outside my scope of practice and refer them out to get evaluated. I can't tell you how many times looking back when I was in primary substance use Howdy people who struggled with eating disorders. They bend on candy and ice cream and doughnuts and it may have been a function of binge eating disorder that was remaining hidden or controlled because they were drinking and stencil you don't want to write those off as normal behaviors per I can't tell you how many people got recovery from alcohol use or

drugs and ended up running 13 marathons. It's not good for the body so we may look at and exercise compulsion so we went to look at behavior swapping as well. Develop mental stages and stages of change so we can conceptualize what's going on create a structured yet flexible assessment. I was training somebody working under me and one of the things they noticed I was doing assessments is feels like -- sometimes folks are coming to us and sharing and I never shared it with anyone so it's the first time seeing some of the stuff out loud and it can be challenging and emotionally draining is still pausing when I had a patient say she was worried in the one night that woke -- when she passed out in the tub drinking and she could've drowned in a building that space bar her, she started to cry and set of moving onto the next question was important in building rapport and her feeling heard and recognizing someone was listening. We have to be a bit flexible. the initial assessment, some elements. Safety first. We had to assess for suicidality come risk to self or others come withdrawal -- medical risks. We want to take a look at these for us because we made to put everything else aside to take care of this. I mentioned the dimensions. I imagine most of you are familiar with those. Looking for the acute intoxication withdrawal, biomedical conditions, legal consequences which are no longer included in criteria but we still want to take those into account. I medical conditions -- gather as much as been can't even seem related. Just want to pay attention. Four, readiness has to change my now? Are they forced to be here or is it volunteering? How do they conceptualize use quick today think of it as problematic or not with a capital P or lowercase. Is everybody freaking out like overreacting and what are the goals for treatment? If they are forced to be here. Have they explored groups create have they been in treatment before? Have they established Friday and weren't at that happen and what helped? with dimension five, triggers, coping skills, to they believe they need to make challenges in lifestyle or otherwise? Six, where do they live? Who ethically shoot those people use cream what is their appreciation

of substance use? Are they a family big drinkers which we knows code for folks who use problematically worth -- to look at those things but who do they rely on? Are they going to work or school or volunteering how much free time do they have with who -- when someone says I drink socially scope for I just don't drink alone alone so drink with friends but how much and how frequently and et cetera because that can be a misunderstanding. But we need to do is determine healthcare. He have outpatient, least restrictive. Case management. IOP here, residential care, and patient care sober living facilities, and some may need extended care which is long-term. Determine the level of care and what is most appropriate. Assessment tools that may be helpful. You screening so none left unturned -- gives you the idea that I many to open some other folks to help. a lot of insight is out there and if you -- depression, mood disorder, SAS tea can be helpful. And cage questionnaires helpful to give an idea of someone definitively have a problem. This SCO FF questionnaire to determine if Summit has a new disorder so and what the letters stand for -- have I felt guilty about it we do you make yourself second terms of food, intake or restricting? Loss control over how much you eat so the C, cost one stone in three months --'s not American screening. One stone is 14 pounds in three months is about right. Do you believe yourself to be fat and as f for dominate your life? So do you believe yourself to be fat when others think of you as then so can give us an idea but there's something there. When indicated, neuropsych testing. So we have a pool question. Thank you Leah and Robin. We will launch this point on the screen and the question is asking does your clinical assessment should screening for food, anxiety, and eating disorders? You will see three auctions. Yes, though, and the third, I'm not sure. I will give you 20 seconds or so. Great questions you sent into the questions box. Please feel free to keep sending in those questions for presenters and we will do our best to get questions answered and if we don't get to it, glad them on the Q&A document and post to the website for the Morgan are

at a later date. Also remember to stay tuned for a demo from a webinar sponsor covering your talking seconds -- perfect comes to Q so much everyone. and I will share the results and turned back over to the present are. That's what I like to see, thank you. Most of you know we are screening for these things. So we will move on to discussing the principles of integrated treatment. I so so so there is no best practice guideline but with integrated treatment, what mental health and substance use treatment indicated to meet the needs of people with Coke occurring disorders. With ERC, you're integrating eating disorder in there as well. People who are trained -- serious mental health issues and utilize multidisciplinary teams are not one person has to know all the things. It's wonderful by the way working with psychiatrists and dietitians and nurses and the therapists and substance abuse specialist. It's a dream. I love it. Coke occurring disorders are treated in a stage wise fashion with different services provided at different stages based on the client patients need and we see this combined treatment for mental illness and substance use disorders from the same practitioner can attain and they receive one consistent message about treatment in Calgary makes it a lot harder to split team members and stuff does not get lost in the shuffle and you c go next room knock on the office door next to us talk to the psychiatrist and set of waiting to call back. It's a dream. They are going to be some issues with that I will get into that in a moment. the basic tasks or stabilize acute symptoms and engage the client in a program of treatment foster rehabilitation and recovery over time. the specific interventions depend on specifics of diagnoses and severity and phase of recovery and motivation for treatment with each disorder so a lot of folks come in -- as well as any disorder. They have not bought into recovery at all yet and have a hard time showing up or joining groups when here so I will back off. I will not force them and get them into groups if they haven't even gotten her built trust with their team and once that happened, I swoop in and snag them. We take a look at a menu of options if you will and everything

is based on. It can also be hopeful to provide an instruction to various sober community support groups including eating disorders anonymous. Refuge recovery -- smart recovery -- stucco horse. the associated positive outcomes you can see so we went to see substance use decreased and hospitalized less skills in increase in medication compliance and psychiatric functioning and job and school performance and et cetera as a reminder, I talked about this but they are brain based and very mental genetic factors contributing. Trauma history contributes as well. We have to pay attention to that. We will talk about building an integrative model so here are the challenges mentioned. I couldn't ask for a better model. Some challenges become the cost of staffing and training, resistance from existing system, providing comprehensive and integrated care with efficient protocols. If you're trying to get your footing to figure out the best way to do it, much like a good business, constantly revising interviewing practices and going back and trying to find finding them. It's really helpful is to do it my commencing getting psychiatrists who have attended drug centers. Relapse prevention groups and mental health centers. All do it mother and a check or not with relapse prevention plans on what that looks like and that includes mental health and eating disorder. During staff exchanges, cross training, and hopefully can get a shift in funding so we want to focus on consumer goals and functioning and not hearing to treatment that we imagine it to be if we have to shift treatment or progress to look like and shared decision-making. I'm overtime now. I'm going to move into sharing some of these therapies and then I will wrap up so motivational handsome therapy I would be nowhere without. It is absolutely necessary. Those who utilize it know it's helpful for people who are persistent in early on. People will become wormwood rated -- obviously, cognitive behavioral therapy, mindfulness, family therapy, and exposure and response prevention. I'm assuming most of us know the stages of change as you access the presentation and what our job is to do so pre- contemplation is my job to increase

awareness around the potential for need to change. and maintenance to help encourage active program solving as they live their lives. I think most of us are probably aware of CBT at this point in time and I don't need to explain it too much. Cognitive distortions and meant coping strategies and behavioral interventions like breathing, relaxation, social skills, et cetera. Orchid model of CBT information that talks about the event and what I think of the event and how that impacts me and how I act so you can see like a bill going to collection, for example. Exposure response prevention training. A person to a situation they feared and help them deal inside of escaping so increasing the window of distress tolerance and you get permission to do the work it never happened to it -- we never send somebody who struggles with on-call use to set it apart for ERP. That is not necessary. I would prefer to work on coping skills otherwise. and never have them do anything personally would not do. It reminds of DPT. Emotional which is not based on national but logical rituals logical and very scientific and the wise mind which is a combination of the two. Allow for feelings and try to problem solve as well. Fundamental skills. Mindfulness come distress tolerance, emotional regulation, interpersonal effectiveness. Great bio social therapy of pervasive emotional just dysregulation. Non- shaming theory so if you're not familiar with the biosocial theory, look at because it's a great way of being non- shaming and non- blaming. In a notional sensitive person being put into an environment that is validated and validated so I may be sensible -- groping family figures and are not necessarily abusive and it may be wonderful and it's just not a great environment or sensitive to son and I live near the equator so those are silly analogies to help us understand heightened emotional sensitivity of some folks who are environments that are invalidated. ACT is wonderful and mimes up with the 12 steps who have familiarity with the 12 steps. We're just about done so it's perfect. Create a rich and meaningful life accepting the pain that comes with it and we may be in a process of change but this is the end if you are not

fully or come I recommend it. Simple stuff. Finally, lots of medications as you are probably aware just treat substance abuse disorders I'm so sorry -- I had a lot there and I talk a lot. So I'm done and I'll hand it back to you. I little tangents. We have to bring you back to give us part two because this was so good and I have a page and have filled with notes. Great information. I don't know if we have time to squeeze in question but first, on the slide and yes, you'll see Robert and Leo's contact info center site leader -- LE take a quick break and squeeze a question at the end. So let me turn this over to cover a record. a brief Q&A at the end of the uptime but first, I don't know from our sponsor and afterwards I will give you permission on how to get your CDs from the webinars and take the CE quiz. Right now, I will turn this over to Alyssa, manager for every record. the four zeros. Thank you so much Sampson and Robin and Leah were in important a presentation. I will go ahead and share my screen. As Samson mentioned, mechanical manager. I am excited to share a set of apps that will help you meet the urgent need facing to deliver high-quality care to your clients and keep them connected to them covering processes between sessions. Now I will jump and show you how works. Here on my phone what you are seeing is the recovery record apps installed on the right-hand side in these focus on eating disorders as a primary diagnoses while addressing comorbid substance use and anxiety and depression could also every app for addiction and links for the treatment of substance --dash mood and anxiety disorders so I'm in the inclusion app and accepted two goals my clinician set for me and I'm also putting a meditation my clinician set for me remember when I would need going through a couple check ins. to show you what a trigger looks like based on the cognitive behavioral approach so they can select what going on in this example. This example, an upcoming happy ever were there the only one who cannot drink any urges they are experiencing or in related to the eating disorder and thinking about negative thoughts to challenge of still feeling triggered and if they used any evidence-based skills

the clinician may have set for them. After the client completes the law, the commission can access the entry from the app and you are seeing the clients getting evidence-based hoping skills Lenin there. So what we now is walking through my client has a diagnosis and the questions reflect behaviors typical to the diagnoses I also have also taken a picture of Emile -- we have the most -- algorithm because -- users so it's very accurate in the scale which can be very helpful. Clients are saying coping skills so helpful information the moment and if they don't have their clinician without because between sessions, it can be challenging to meet their need. The client can give specific information and we talked about what they shared having the data and the client seen exactly what's going on the client is also answering questions about anxiety and substance use struggles. But I'm going to do next is walking through one other type of log which is the thought record. Dysfunctional thought record. They can use this for any clinical struggles mother about body, anxiety and anything going on. They might be able to identify what's going on physically, emotionally and if they don't know what distortion means, click on the informational buttons get information about what the distortion may be. They will work through how to think about the situation in another way the person in the elevators that looking at me be thinking about themselves and evidence for and against this thought. Can be really helpful for clients and an alternate real were more realistic thought and you can review these sessions with clients and they are getting affirmations and coping skills based on what their innards entering so if interpersonal, interpersonal skills. We will shift to the clinician app and from the home screen you can access data from all the client so you can see this going on and it glanced level of impeachment and behaviors cured one important feature as a clinician is the office hours to set up appropriate boundaries and thereby domains expected to check the apt 247 and by connecting with clients what you are doing is a boosting accountability with recovery but not expected check-in except just

before or during session clients. What's helpful with interacting with logs to help remaining gauged is there's a couple ways. Here, I'm giving contact specific feedback on mill log or a trigger lock or dysfunctional thought record as I showed you. You can send affirmation and images which is nice way of connecting with clients and help them feel seen and heard the transition so that their animal engine images and for the client and they might be a perfectionist I want them to strive for progress and I want to end with reasons to recovery it can complete and they can add images of their own that are embedded in the recovery record. Because we have limited time, it precludes my demo and recovery occurred and the apps are available for download on iPhone and android and you can login on desktop via our website so I think you for the critical work you are doing with clients and look forward to answering questions you may have about the apps. Back to you Sampson. Thank you Alyssa and complete record for sponsoring this webinar and supporting just critical education. As Leah said a few times, I agree. We are doing our clients a disservice and not assessing and fully looking at all diagnostically. Making sure they pay attention to potential they may also have reoccurring issues or eating disorders especially residential care. See them eat your premises and if there's something latent sure is a potential, raising some -- quality care. We don't have time for questions, want to get your chance to share 20 seconds when closing thoughts were final thoughts for the audience. I want to say sorry he didn't have a lot of time. Our patients every record this wonderful and so helpful. FYI. Thank you for happiness. Of course, thank you for letting me sponsor. Clinicians, think you for all you are you and say you and thank you for having us. Thank you close and everyone please save their contact information here. Plug it in you, we're gracious to share ways you can stay in touch with them if you are having trouble getting it going too fast coming to have the PDF slides of this was our so those of you interested getting CE, a quick reminder that every has its own webpage it houses everything to know

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