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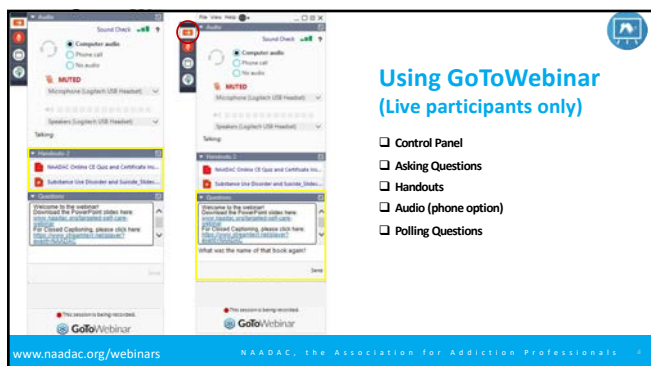
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**Learning Objective 1:**  
Participants will be able to describe the co-occurrence of mood and anxiety disorders in the eating and substance use disorder population.

**Learning Objective 2:**  
Participants will be able to verbalize the difference between various anxiety disorders and ways co-occurrence presents in clients.

**Learning Objective 3:**  
Participants will be able to apply effective tools, interventions, and treatments for anxiety disorders.

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**What One Year On A Bus Taught Me About Mental Health**  
Robyn's Story

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**Signs & Symptoms**

- Recovered from ED
- Daily anxiety
- Coped by overworking, doing more, being more
- Stress cycles led to panic attacks, then scary thoughts:
  - Intrusive thoughts are thoughts that appear to come out of nowhere and cause much distress
  - Cognitive distortions
- Trapped in my thoughts, fear, what-if's, rumination
- Exhausted and stuck
- I feared I was going crazy, or already was



**My Attempts For Help**

- I ask for help from countless professional help
- Treated it with talk therapy, EMDR, anti-depressants, exercise, diet etc.
- Helped for a while
- Then I'd get stressed
- Cycle repeat

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### Robyn's Story: The Bus



"It's going to be an adventure of a life time and we can help others in the process..."

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### Robyn's Story: The Plan



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### Robyn's Story: What I Learned On The Bus



- Until we identify and treat co-occurring illnesses, our quality of our recovery from our primary illness will be greatly diminished:
  - I had misdiagnosed and undiagnosed OCD for 16 years into my eating disorder recovery.
  - And I am not alone...
- The most common misdiagnosis is GAD
- Over 50% of individuals with OCD are misdiagnosed and therefore do not get the treatment that they need.
- Other common misdiagnosis: ADHD, Bipolar Disorder, and sometimes even Schizophrenia.
- It typically takes between 14-17 years for an individual with OCD symptoms to be diagnosed. Because of this, it is believed that there are far more people affected by this disabling illness than we can currently account for.

SOURCE: <https://pubmed.ncbi.nlm.nih.gov/312693/>

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**Questions Box Activity:**

What are some ways we can remove addiction and mental health stigma?

Type your answer in the **Q&A box** of your GoToWebinar control panel.

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**1. Identify Co-Occurrence Of Substance, Eating and Mood & Anxiety Disorders**

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**Statistics In The USA**

Disorder	Prevalence
Anxiety Disorders	42.5M
Eating Disorders	30M
Substance Use Disorders	19M

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**Statistics: ED and SUD\***

- 50-55% of individuals with eating disorders also mis-use substance
- Up to 35% of individuals who mis-use or are dependent on alcohol/drugs also have an eating disorder, compared to up to 10 percent in the general population.
- Lifetime rates of substance use disorder in the various eating disorder subgroups are as follows:
  - AN, 27.0%
  - BN, 36.8%
  - BED 35%
- Women who have Anorexia Nervosa are 19 times more likely to die from SUD
- Approximately 57% of males with BED will experience SUD

\*Eating Disorders and Substance Use Disorders

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**Poll Question 1:**  
Why do you think people with eating disorders are more likely to misuse substances?

1. To distract them from eating.
2. To curb their hunger.
3. To cope with symptoms of other co-occurring disorders.
4. Other

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**Statistics: ED and Anxiety/Mood Disorders**

- Anxiety disorder is the most common co-occurring illness for those struggling with ED
- 80% comorbidity of any anxiety and mood disorder in patients with and ED
- In ED patients the most common comorbidities are:
  - Mood disorders (with estimates between 20% and 98%)
  - 53% anxiety disorders (18% obsessive-compulsive disorder)

Anxiety's like a rocking chair. It gives you something to do, but it doesn't get you very far.  
—Jodi Picoult

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**Statistics: SUD and Anxiety/Mood Disorders**

- 29.9% of those with SUD had a lifetime incidence of an anxiety disorder
- 32% of those with mood disorders will also have SUD
- Individuals with lifetime major depression:
  - 16.5% had an alcohol use disorder, and
  - 18% had a drug use disorder
- Individuals with SUD were particularly common among individuals with bipolar disorder—56% had a lifetime SUD

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**COVID Statistics**

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- The number of people looking for help with anxiety and depression has skyrocketed
- The number of people screening with moderate to severe symptoms of depression and anxiety has continued to increase throughout 2020 and remains higher than rates prior to COVID-19
- More people are reporting frequent thoughts of suicide and self-harm than have ever been recorded in the MHA Screening program since its launch in 2014
- Young people are struggling most with their mental health
- Rates of suicidal ideation are highest among youth, especially LGBTQ+ youth
- People screening at risk for mental health conditions are struggling most with loneliness or isolation
- People who identify as Asian or Pacific Islander are searching for mental health resources more in 2020 than ever before
- While rates of anxiety, depression, and suicidal ideation are increasing for people of all races and ethnicities, there are notable differences in those changes over time. Black or African American screeners have had the highest average percent change over time for anxiety and depression.

”

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**2.  
Learn The Difference Between Anxiety Disorders and The Way They Display Themselves In Recovery**

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Anxiety is a thin stream of fear trickling through the mind. If encouraged, it cuts a channel into which all other thoughts are drained.  
—Arthur Somers Roche

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### Anxiety Diagnosis

**NORMAL VS. PATHOLOGICAL ANXIETY**

- Normal anxiety is adaptive
- It is an inborn response to threat or to the absence of people or objects that signify safety and can result in cognitive (worry) and somatic symptoms
- Pathological anxiety is anxiety that is excessive and impairs functioning

**FOCUSED NEUROANATOMY**

- Amygdala: involved with processing of emotionally salient stimuli
- Medial prefrontal cortex (includes the anterior cingulate cortex, the subcallosal cortex and the medial frontal gyrus): involved in modulation of affect
- Hippocampus: involved in memory encoding and retrieval
- Reward

**PRIMARY VS. SECONDARY ANXIETY**

- Anxiety due to one of the primary anxiety disorders or secondary to substance use (Substance-Induced Anxiety Disorder)
- A medical condition (Anxiety Disorder Due to a General Medical Condition)
- Another psychiatric condition, psychosocial stressors (Adjustment Disorder with Anxiety)

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### Anxiety Disorders

**Anxiety Disorders:**

- Generalized Anxiety Disorder
- Panic Disorder
- Phobia Related Disorders
- Social Anxiety Disorder
- Agoraphobia
- Separation Anxiety
- Substance-Induced Anxiety Disorder
- Anxiety Disorder NOS
- Obsessive Compulsive Disorder
- Trauma

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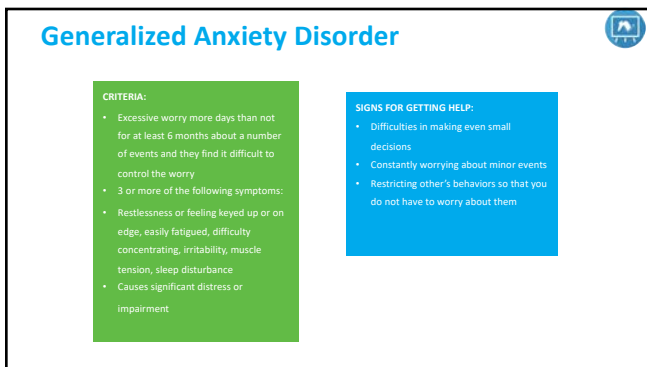
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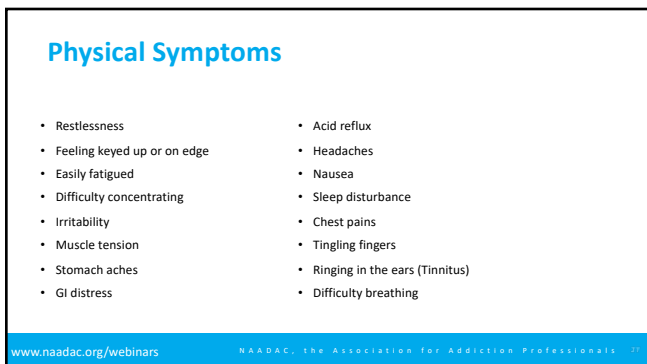
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### Panic Disorder

**CRITERIA:**

- Recurrent and/or unexpected panic attack/s followed by one month of one or more of the following:
- Persistent worry about having additional attacks
- Worry about the implications of the attacks
- Significant change in behavior because of the attacks

**WHAT ARE PANIC ATTACKS:**

- A discrete period of intense fear in which 4 of the following symptoms abruptly develop and peak within 10 minutes:
- Palpitations or rapid heart rate
- Sweating
- Trembling or shaking
- Shortness of breath
- Feeling of choking
- Chest pain or discomfort
- Nausea
- Chills or heat sensations
- Paresthesia
- Feeling dizzy or faint
- Derealization or depersonalization
- Fear of losing control or going crazy
- Fear of dying

**SIGNS FOR GETTING HELP:**

- Frequent visits to the ER or cardiologist (up to 60% of cardiology visits)
- Feeling the need to have a safe person around or to stay in a safe place
- Use of medications to get through situations (I am OK if I have my Xanax with me)
- Fears of bodily sensations or changes

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### Specific Phobias

**CRITERIA:**

- Marked or persistent fear (>6 months) that is excessive or unreasonable cued by the presence or anticipation of a specific object or situation
  - Anxiety must be out of proportion to the actual danger or situation
  - It interferes significantly with the person's routine or function

**SIGNS FOR GETTING HELP:**

- Driving, which is more dangerous than flying, is preferred
- A picture of a snake sends you fleeing
- Blood or needles cause you to pass out
- All tall buildings are avoided, even if a relative lives in one

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### Social Anxiety Disorder

**CRITERIA:**

- Marked fear of one or more social or performance situations in which the person is exposed to the possible scrutiny of others and fears they will act in a way that will be humiliating
- Exposure to the feared situation almost invariably provokes anxiety
- Anxiety is out of proportion to the actual threat posed by the situation
- The anxiety lasts more than 6 months
- The feared situation is avoided or endured with distress
- The avoidance, fear or distress significantly interferes with their routine or function

**SIGNS FOR GETTING HELP:**

- Events from years ago still haunt you
- Startle response is above what is helpful for the situation
- You take a very long way to get to places to avoid passing a place where you witnessed a traumatic event
- Constant nightmares
- Person becomes withdrawn

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### Obsessive Compulsive Disorders & Related Disorders

<b>OBSSESSIONS:</b> <ul style="list-style-type: none"> <li>• Recurrent and persistent thoughts, impulses or images that are intrusive and unwanted that cause marked anxiety or distress</li> <li>• The person attempts to ignore or suppress such thoughts, urges or images, or to neutralize them with some other thought or action (i.e. compulsion)</li> </ul>	<b>CRITERIA:</b> <ul style="list-style-type: none"> <li>• The obsessions or compulsions cause marked distress, take &gt; 1 hour/day or cause clinically significant distress or impairment in function</li> <li>• Specify if:             <ul style="list-style-type: none"> <li>• With good or fair insight- recognizes beliefs are definitely or most likely not true</li> <li>• With poor insight- thinks beliefs are probably true</li> <li>• With absent insight- is completely convinced the OCD beliefs are true</li> </ul> </li> </ul>	<b>DISORDERS:</b> <ul style="list-style-type: none"> <li>• Obsessive-Compulsive disorder</li> <li>• Body Dysmorphic disorder</li> <li>• Hoarding disorder</li> <li>• Trichotillomania</li> <li>• Excoriation</li> </ul>	<b>COMPULSIONS:</b> <ul style="list-style-type: none"> <li>• Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession or according to rigidly applied rules</li> <li>• The behaviors or acts are aimed at reducing distress or preventing some dreaded situation; however, these acts or behaviors are not connected in a realistic way with what they are designed to neutralize or prevent.</li> </ul>
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**SIGNS FOR GETTING HELP:**

- Rituals are taking up more than an hour a day
- Other people are used for reassurance and completing rituals
- You would be embarrassed if others knew what you were doing
- It amazes you that others do things so quickly

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On OCD:  
It's like you have two brains--a rational brain and an irrational brain. And they're constantly fighting.  
-Emilie Ford

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## Recognizing Co-occurrence

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### Comorbid Diagnosis

- Once an anxiety disorder is diagnosed it is critical to screen for other psychiatric diagnoses since it is very common for other diagnoses to be present, and this can impact both treatment and prognosis.

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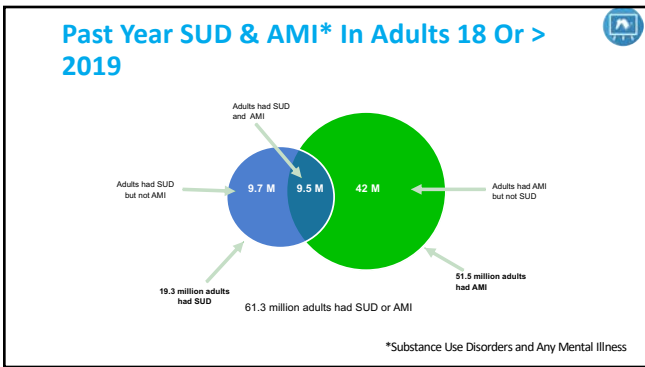
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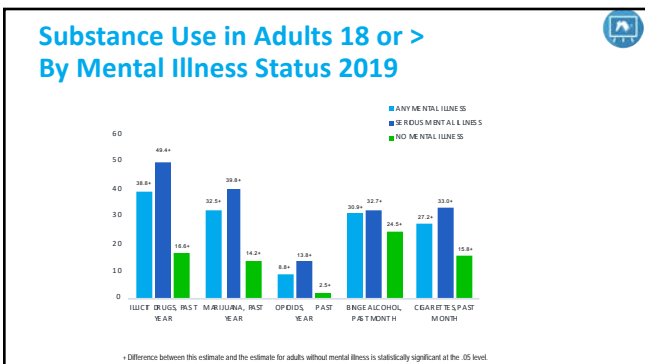
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**People with Co-occurring Disorders**

- Use greater treatment resources
- Have a more complicated course of treatment
- Higher rates of recurrence of use or behaviors
- Higher rates of re-hospitalization
- More frequent ER visits
- Violence, suicide, homelessness
- Increased morbidity and mortality
- Poorer treatment compliance
- More contact with criminal justice system

**REMINDER:**

- Substance use disorders and mental illnesses are brain based
- Genetic and environmental factors
- Treatment works-but change expectations; think diabetes, not "flu"
- "Traditional" treatment isn't the norm anymore...

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**3. Recognize Effective Tools and Interventions In Management of Anxiety Disorders**

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**Assessing**

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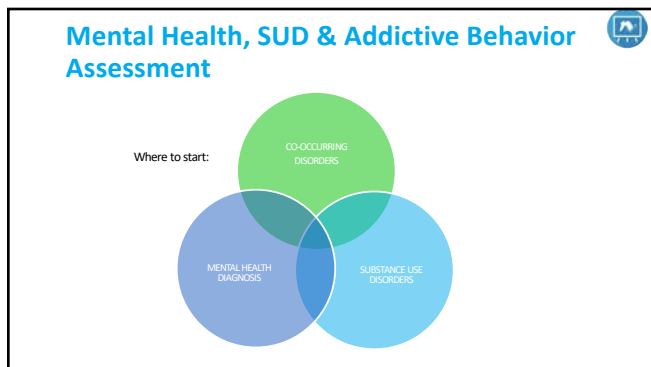
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**Mental Health, SUD & Addictive Behavior Assessment**

**ASSUMPTIONS**

- Identification of substance use disorder (SUD) is difficult at times to determine
- Many clients hide/withhold the truth of their substance use
- Denial & minimization
- Ambivalence
- One second this and the other that
- Carries shame or is perceived as a moral weakness
- SUD mimics mental health diagnosis or increases the symptoms
- Psychiatric symptoms can be masked by the substance use
- Patients with SUD may not be good historians, use impairs memory and shame can lead to minimization or omission
- Cultural aspects

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**Mental Health, SUD & Addictive Behavior Assessment**

**KEYS TO MH/SUD ASSESSMENT**

- Collection of data
  - Data over time
- Knowledge of SUD
- Knowledge of mental health diagnoses
- Developmental stages
- Stages of change
- Structured yet flexible assessment ...

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### Elements of Initial Assessment

- Preliminary assessment of mental health and substance use focuses on urgent conditions as follows:
  - Suicidality
  - Risk to self or others
  - Withdrawal potential
  - Medical risks associated with alcohol/drug use or engagement in behaviors that may be compulsive

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### SUD & Addictive Behavior Assessment

*American Society of Addictive Medicine (ASAM)*

- Dimension 1 Acute Intoxication/Withdrawal Potential
- Dimension 2 Biomedical Conditions
- Dimension 3 Emotional, Behavioral or Cognitive conditions or complications
- Dimension 4 Readiness to change
- Dimension 5 Relapse, Continued Use or Continued Problem Potential
- Dimension 6 Recovery Environment

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### Determine Level of Care

- Outpatient
- Case management
- IOP
- PHP
- Extended care
- Halfway House or sober living
- Acute hospitalization

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**Assessment Tools**

- Biological/psychological/social/spiritual screens
- Anxiety: OCI-R, BAI, ASI-3, Worry Questionnaire, PTSD Screen, PHQ
- Goldberg Depression Questionnaire, Beck Depression Inventory
- Mood Disorder Questionnaire
- SAST
- CAGE, SCOFF
- Neuropsych testing when indicated

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Poll Question 2: Does your clinical assessment include screening for: Mood, Anxiety, and Eating Disorders?

1. Yes
2. No
3. I'm not sure.

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**Treatment: An Integrated Approach**

Mood  
Anxiety  
Substance Use Disorder  
Eating Disorder  
Traumatic Stress

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### Practice of Principles of Integrated Treatment For Co-Occurring Disorders

THERE IS NO ONE BEST PRACTICE GUIDELINE

- Mental health and SUD treatment are integrated to meet the needs of people with co-occurring disorders
- Integrated treatment specialists are trained to treat both substance use disorders and serious mental illnesses, multidisciplinary teams
- Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages
- Consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team. They receive one consistent message about treatment and recovery
- Services provided at the same physical location

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### Integrated Treatment

- Basic tasks for treatment of either Mental Illness or SUD are to:
  - Stabilize acute symptoms
  - Engage the client in a program of treatment
  - Foster rehabilitation and recovery over time
- Specific treatment interventions depend on careful assessment of specific diagnoses, degree of severity, phase of recovery and motivation for treatment for each disorder.
- Interventions should be drawn from a menu of options based on need
- Provide an introduction to various sober/community support groups

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### Associated Positive Outcomes For Integrated Treatment

- Reduced substance use
- Improvement in psychiatric symptoms and functioning
- Decreased hospitalizations
- Increased coping skills
- Improved medication compliance
- Increased job/school performance
- Improved quality of life

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**Integrated Treatment**

**REMINDER:**

- Substance use disorders and mental illnesses are brain based
- Genetic and environmental factors both contribute
- Treatment works, but change expectations: think diabetes, not "flu"
- "Traditional" treatment isn't the norm anymore...

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**Building An Integrated Model**

- Challenges of building an integrated model
  - Cost of staffing
  - Training of staff
  - Resistance from existing system
  - Providing comprehensive, integrated care with efficient protocols
  - The most likely strategy for moving toward this system is in increments
    - Psychiatrist attend at AOD centers
    - Relapse prevention groups introduced to mental health centers
    - Staff exchanges; attending case conferences; joint trainings
    - Gradual shifting of funding
- Focus on consumers' goals and functioning, not on adhering to treatment
- Consumer choice, shared decision making, and consumer/family education are important

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**Integrated Recovery Model**

- Hope is critical
- Services and treatment goals are consumer-driven
- Unconditional respect and compassion for consumers is essential
- Integrated treatment specialists are responsible for engaging consumers and supporting their recovery

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### Evidence Based Therapies:

- Motivational Enhancement Therapy (MET)
- Cognitive-Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT) and Mindfulness
- Acceptance and Commitment Therapy (ACT)
- Family therapy and Education
- Exposure and Response Prevention (ERP)

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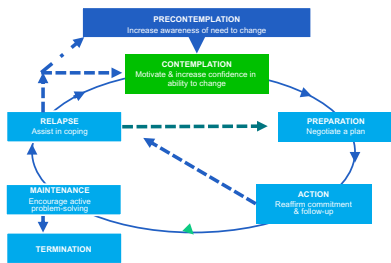
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### Stages of Change



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### Cognitive Behavioral Therapy (CBT)

#### WHAT IS CBT?

- Active, here and now, problem-focused vs cause focused
- Focused on Emotions/Feelings
- Focused on Thoughts
- Focused on Behaviors
- Client-centered, collaborative
- Present-centered

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### CBT

**COGNITIVE DISTORTIONS:**

- Clients tend to make consistent errors in their thinking
- Often, there is a systematic negative bias in the cognitive processing of patients suffering from psychiatric disorders
- Help patient identify the cognitive errors they are most likely to make

**EFFECTIVE COPING STRATEGIES:**

- Identify triggers and relapse prevention
- Cost- risk benefit
- Anger management
- Problem solving

**BEHAVIORAL INTERVENTIONS:**

- Breathing retraining
- Relaxation
- Behavioral activation
- Interpersonal effectiveness training
- Problem solving skills
- Exposure and response prevention
- Social skills training
- Graded task assignment

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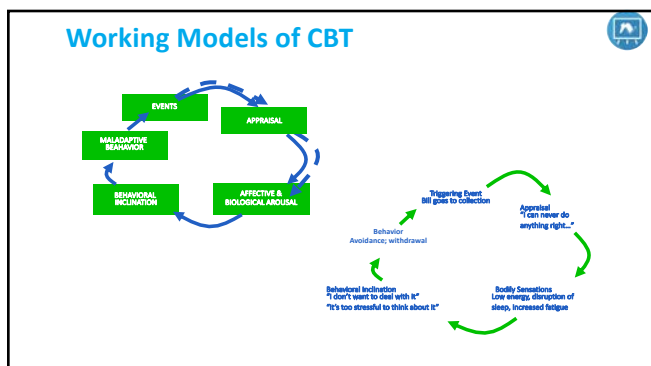
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### Exposure Response Prevention (ERP)

**WHAT IS ERP?**

- Put a person into a situation that they have feared
- Assist the person in dealing with the situation instead of escaping from it
- Assisting the person does not mean giving them reassurance but rather that they can sit with the discomfort (increase window of distress tolerance)
- Best for patients/clients who struggle with hyperarousal

**GUIDELINES FOR USE OF ERP**

- Always get a patient's permission to do this work
- Never have a patient do anything that would put them in significant danger
- Never have a patient do anything that you would not do (luckily, I do a lot of things)

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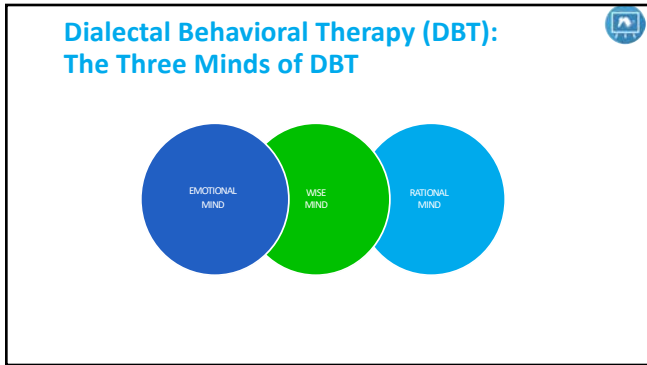
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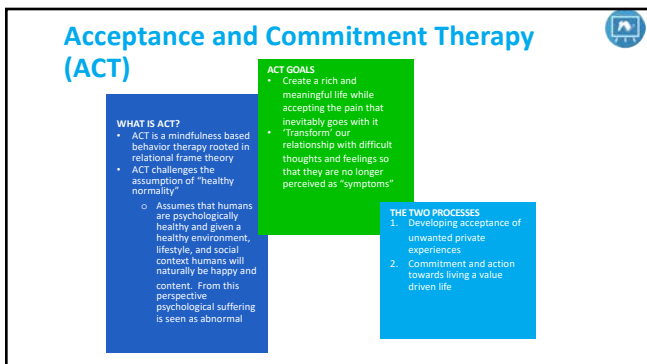
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### Medications Used to Treat SUD

- TOBACCO**
  - Nicotine replacement therapies (available as a patch, inhaler, or gum/lozenge)
  - Bupropion
  - Varenicline
- OPIOID**
  - Methodone
  - Buprenorphine
  - Naltrexone
- ALCOHOL & DRUGS**
  - Naltrexone
  - Disulfiram
  - Acamprosate

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**Thank You**  
Robyn Cruze and Leah Young  
Phone: 877.825.8584  
Ercpathlight.com

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**RecoveryRecord**  
Technology assisted addiction and eating disorder recovery. Built on research, made with compassion.  
Contact  
jenna@recoveryrecord.com  
www.recoveryrecord.com

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**Questions?**



**Robyn Cruze, MA**

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- Robyn.Cruze@ERCPathlight.com
- @RobynCruze



**Leah Young, MA, LCPC**

- Eating Recovery Center and Pathlight Mood & Anxiety Centers
- Leah.Young@ERCPathlight.com
- @maeday74

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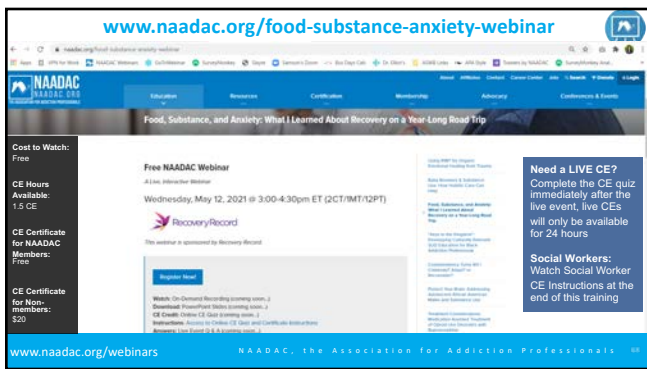
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The screenshot shows the NAADAC website for a webinar titled "Food, Substance, and Anxiety: What I Learned About Recovery on a Year-Long Road Trip". The page includes details about the cost (free), CE hours (1.5), and registration information. It also features a "Need a LIVE CE?" section and a "Social Workers" section.

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The poster lists four upcoming webinars:

- May 19<sup>th</sup>, 2021**: "Keys to the Kingdom": Developing Culturally Relevant SUD Education for Black Addiction Professionals. By: James B. Golden, PsyD
- June 9<sup>th</sup>, 2021**: Protect Your Brain: Addressing Adolescent African American Males and Substance Use. By: Faye Barner, PhD, LPC, LSATP, CSOTP and Melendez Byrd, PhD
- May 26<sup>th</sup>, 2021**: Codependency Turns 40! Celebrate? Adapt? or Reconsider? By: Robert Weiss PhD, LCSW
- June 18<sup>th</sup>, 2021**: Advancing Awareness in LGBTQ Care, Part I: History of Specialized Treatment for LGBTQ+ Clients. By: Joe Amico, MDiv, LADC I, CAS and panel discussion

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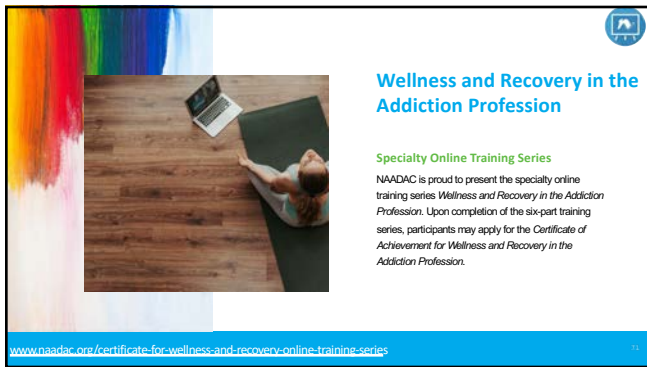
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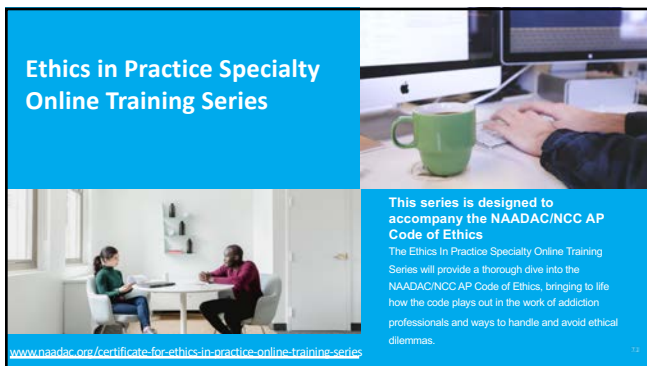
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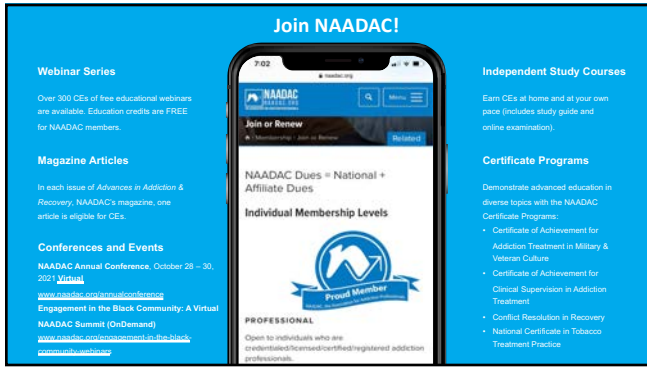
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**Join NAADAC!**

**Webinar Series**  
Over 300 CE's of free educational webinars are available. Education credits are FREE for NAADAC members.

**Magazine Articles**  
In each issue of *Advances in Addiction & Recovery*, NAADAC's magazine, one article is eligible for CE's.

**Conferences and Events**  
NAADAC Annual Conference, October 28 - 30, 2021 [Virtual](http://www.naadac.org/annualconference)  
[www.naadac.org/annualconference](http://www.naadac.org/annualconference)  
Engagement in the Black Community: A Virtual NAADAC Summit (OnDemand)  
[www.addictiontreatmentinblack.com/blacksummitwebinar](http://www.addictiontreatmentinblack.com/blacksummitwebinar)

**Independent Study Courses**  
Earn CE's at home and at your own pace (includes study guide and online examination).

**Certificate Programs**  
Demonstrate advanced education in diverse topics with the NAADAC Certificate Programs:  
• Certificate of Achievement for Addiction Treatment in Military & Veteran Culture  
• Certificate of Achievement for Clinical Supervision in Addiction Treatment  
• Conflict Resolution in Recovery  
• National Certificate in Tobacco Treatment Practice

**Individual Membership Levels**

**PROFESSIONAL**  
Open to individuals who are credentialed/licensed/certified/registered addiction professionals.

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**Thank You**

**NAADAC**  
THE ASSOCIATION FOR ADDICTION PROFESSIONALS  
NAADAC.ORG

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 NAADAC.org  
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