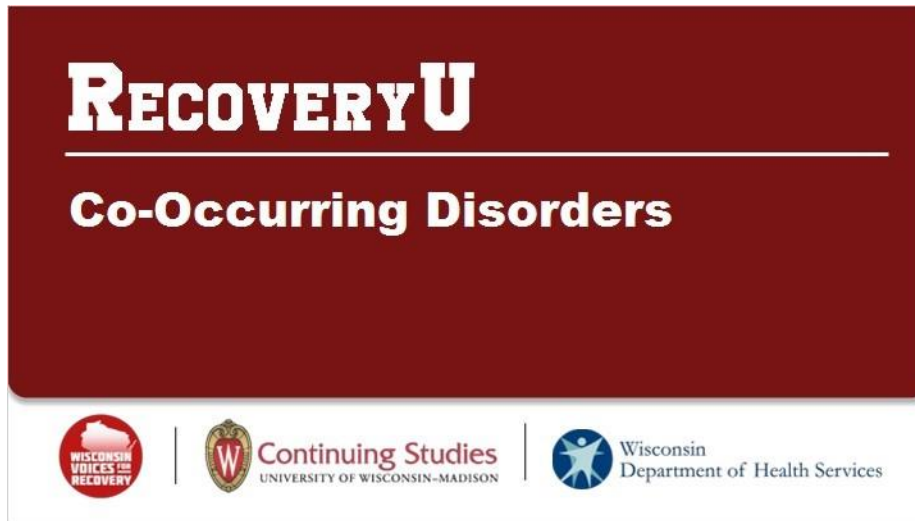



## Co-Occurring Disorders



Hi, everyone. Welcome to the RecoveryU online learning community co-occurring disorders module. I have Dr. Matt Felgus with me, I am Skye Tikannen. Both Dr. Felgus and I work with a number of clients who have co-occurring disorders, which means a mental health disorder and a substance abuse disorder. And we'll be teaching you a little bit about those clients here today.

### Module Goals

1. Be able to identify the prevalence of co-occurring disorders.
2. Gain understanding of anxiety disorders.
3. Gain understanding of depressive disorders.
4. Gain understanding of trauma.
5. Be able to explain what Paradigm Theory is and how it shows how MH and SUD intersect.
6. Learn strategies for how to be compassionate yet hold accountable those with co-occurring disorders.



All resources and references are located in the Resources tab of this presentation.

The goals for our session are to be able to identify the prevalence of co-occurring disorders, gain understanding about anxiety disorders, depressive disorders, and trauma. Be able to explain what Paradigm Theory is and how it shows how mental health and substance use disorders intersect. And learn strategies for how to be compassionate, yet hold accountable those with co-occurring disorders.

## Co-Occurring Disorders

1. In 2014, the National Survey on Drug Use and Health found 7.9 million people in the U.S. had both a substance abuse and mental health disorder.
2. The lack of co-occurring services has been cited as a barrier to the success of medication assisted treatment.
3. The integration of substance abuse and mental health is one of the keys to a successful program.

So let's talk a little bit about the prevalence. The National Survey on Drug Use and Health found 7.9 million people in the US had a substance abuse and mental health disorder in 2014. The lack of co-occurring services has been cited as a barrier to the success of medication-assisted treatment programs, and the integration of substance abuse and mental health is one of the keys to a successful program.

## Co-Occurring Disorders

Approximately 80% of those who have a substance use disorder have a co-occurring mental health disorder.

### The "Big 3":

#### Anxiety

*33%-44% of people entering substance use disorder treatment have an anxiety disorder.*

#### Depression

*People with Major Depressive Disorders are more than twice as likely to have a substance use disorder than those.*

#### Trauma

*77% of women entering SUD treatment had a trauma disorder.*

Approximately 80% of those who have a substance use disorder have a co-occurring mental health disorder. The big three—the three disorders with mental health that we see the most commonly are anxiety—33% to 44% of people entering substance use disorder treatment have an anxiety disorder. With depression, people that have a major depressive disorder are more than twice as likely to have a substance use disorder than those in the general population. And for trauma, 77% of women who enter a substance use treatment program have a trauma disorder.

We don't have good data on the number of men entering substance use disorder treatment that have a trauma disorder, because trauma is so underreported in male populations.

**Prevalence** **Co-Occurring Disorder Resources**

SAMHSA:  
<https://www.samhsa.gov/disorders>

Behavioral Health Trends:  
<https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>

National Registry of Evidence Based Practices:  
<https://www.samhsa.gov/nrepp>

There's a lot of really great resources for understanding how big co-occurring disorders are and ways to help. So I would direct you to the Substance Abuse Mental Health Services Administration web site, the Behavioral Health Trends reports, and then—this is the big one, you guys—the National Registry of Evidence-Based Practices.

So any time that you're thinking about referring a client to a co-occurring service, this gives you all of the types of therapy, the types of counseling services, that have an evidence base behind them. We want everyone to be able to get effective treatment. And for it to be effective we have to know that it works, which is what evidence-based practices give us.

**“The Big 3”:**  
**Anxiety,**  
**Depression,**  
**& Trauma**



All right, so next we'll talk about the big three. Now, the big three is not something you're going to be able to look up in a book. It's not something that is standard. If you ask an addiction doctor that's never listened to one of my talks, what about the big three? They're probably going to have no idea what you're talking about.

The big three is anxiety, depression, and trauma. And in my experience in the field, which goes back about 25 years now, I do not think that I have come across an individual that is coming in for treatment of a substance use disorder that does not have one of those big three—either anxiety, depression, or trauma—going on that is co-occurring with their use disorder.

Now sometimes the client is not in agreement with this. Sometimes the client just says, look, this is—this is just about addiction and withdrawal. I don't have anxiety, I don't have depression, I've never had trauma. So what I'm going to hopefully do is give you a little bit of information so that you'll be able to maybe say, hmm, a little bit. Just give you some things to look for.

**“Big 3”:  
Anxiety**

## Opioids and Anxiety

Can present as panic attacks, social withdrawal, phobias, obsessions and compulsions.

Common for teens and adults to “discover” treating anxiety with opioids. The anxiety is not treated, just covered up.



I want to start by talking about opioids and anxiety. Anxiety can look a lot of ways in a lot of situations. There's different ways to have anxiety. People can have panic attacks, that's a type of anxiety. Social anxiety. So when they're not having panic attacks but that they are having a whole lot of difficulty either being in crowds, or being in a situation where they have to talk about themselves, or being in groups.

And this can be a challenge. There can be clients who are very resistant to the idea of going to a 12 step meeting. And it's always worth asking because it may not be that they're resistant to 12 steps. They may have social anxiety and the idea of being around a bunch of people that they do not know—in a closed room—is unbearable for them. So it is always worth asking.

There are some clients that are resisting. They're not doing what you may think they ought to do, which is go to a 12 step meeting. It's always worth asking that important question, "why?" And finding out—is it about the idea of just being around people they don't know? Or being in a crowded, closed room—just makes them entirely anxious. So important distinction.

Anxiety can also present itself as phobias—fear of a specific situation. Having obsessions, which are thoughts that they just can't get rid of. Or compulsions—most people know there's plenty of movies out there on people with obsessive compulsive disorder or OCD. That is a type of anxiety.

Like I said, there's lots of different types of anxiety but it is very common for both teenagers and adults to discover that using substances—opioids certainly do work, but it may not be limited to opioids. It may be alcohol, it may be marijuana—that they discover that if they are under the influence of a substance, then their anxiety is not bothering them as much.

And this is important because, again, that example of the client who is fighting the idea of going to a 12 step meeting—more because of social anxiety. This may be the first time that they are being asked to do this when they are not under the influence. And this idea can be scary and this is something that they are going to need to get additional help.

The myth is that the substance is treating the anxiety. Because opioids, alcohol, any of those, marijuana as well—none of those treat anxiety, it just covers them up. It just covers it up. So the anxiety is still there, it is still present, it is still just as much of a factor. The person's just numbing themselves out to it.

**"Big 3":  
Anxiety**

## Assessing Anxiety

- Palpitations
- Sweating, chills or hot flashes
- Trembling or shaking
- Shortness of breath, smothering or choking
- Chest pain
- Nausea or abdominal distress
- Dizzy, unsteady, lightheaded or faint
- Derealization or depersonalization
- Fear of losing control or going crazy
- Fear of dying
- Numbness or tingling sensation

**MAY BE IN RESPONSE OR FREE-STANDING**

So these next two slides are a list of symptoms that people have when they do get anxiety. And there's quite a lot on this list. Heart palpitations, sweating, chills or hot flashes, trembling or shaking, shortness of breath, feeling like they're smothering or choking, chest pain, nausea, or abdominal distress. So you can have tightness in your stomach, diarrhea, just GI upset. Feeling

dizzy, unsteady, lightheaded or faint.

Derealization or depersonalisation—and what that means is they feel like they're not really there. So they may be there—they either feel like they're not in their body or they just feel like they're floating, or they're not really part of whatever is going on around them. A fear of losing control or going crazy, a fear of dying, a numbness or a tingling sensation. And this could be either just happening for no obvious reason, or happening in response to a situation that makes the person anxious.

**“Big 3”:  
Anxiety**

## **Assessing Anxiety: Panic Attacks**

A discrete period of intense fear in which symptoms develop abruptly and peak usually within ten minutes.

May be in response to a situation or “out of the blue”.



I do define panic attacks. It is common for clients to say, well, I don't have anxiety because I have never had a panic attack. It is important to know what the definition of a panic attack is—a discrete period of intense fear, in which symptoms develop abruptly and peak usually within 10 minutes. It can be in response to a situation or out of the blue.

Now this is the definition of a panic attack that's in the Diagnostic and Statistical Manual, which is the psychiatry Bible basically. And this is what a panic attack is. The average panic attack lasts 20 minutes. And people that have panic attacks—many millions of individuals have had a panic attack at some point in their life. People that have had panic attacks can get very afraid of having future panic attacks. So that the, it becomes a cycle basically, where you have a panic attack, then you get very scared about having more panic attacks, which can raise your anxiety and bring on more panic attacks.

So it is important to know when that is going on because that is a common reason for people to want to use. It's also a common reason for somebody to get cravings. Because this does not feel good, any of these anxiety symptoms can bring on cravings for substance use.

## **Opioids and Anxiety**

- Extremely common presentation.
- High degree of overlap between withdrawal and anxiety symptoms.
- While anxiety isn't responsible for the opioid epidemic, it is a major barrier for individuals to stop using.
- Opioids are wonderful numbing agents and individuals with anxiety want to be numbed.
- We as treaters need to be more mindful of our messages about anxiety as it is very easy to mislabel anxiety symptom as opioid withdrawal.


The combination of people using opioids and having anxiety is an extremely common presentation. As far as the evaluations that I do, I would say that over 50% of the individuals that I evaluate with opioid dependence also have anxiety underneath it.

There is a high degree of overlap between withdrawal and anxiety symptoms, and I'm going to illustrate that in a minute. While anxiety is not responsible for the opioid epidemic, it is a major barrier for individuals to stop using. And I had mentioned that before, because anxiety is not comfortable and people want to numb it out. Opioids are wonderful numbing agents and individuals with anxiety—they want to have that anxiety numbed out.

Now there is treatment for anxiety but it's not as easy as just numbing it out. We as treaters and as recovery coaches—you folks are among us—we need to be more mindful of our messages about anxiety as it is very easy to mislabel anxiety symptoms as opioid withdrawal. And it's going to be important for us to help our clients get that level of education.

## **Opiate Withdrawal Symptoms**

From an addiction textbook:

- 
- Increased BP
  - Increased HR
  - Sweating/Chills/Hot flashes
  - Restlessness
  - Dilated Pupils
  - Muscle Aches
  - GI Cramps/Diarrhea
  - Nausea/Vomiting
  - Feeling of Dying
  - Tremor
  - Yawning
  - 'Gooseflesh'
  - Runny nose/Watery eyes
  - Bone Pain

Now this next slide. In the circle—this is opioid withdrawal symptoms. So pretty straightforward. This is out of a standard addiction textbook. These are the opioid withdrawal symptoms. Increased blood pressure, increased heart rate, sweating, chills, hot flashes, restlessness, dilated pupils, muscle aches, GI cramps or diarrhea, nausea, vomiting, feeling of dying, tremor, yawning, gooseflesh, runny nose, watery eyes, and bone pain. So this is pretty standard stuff. This is opioid withdrawal.

Now you may notice where I'm going with this if you remember what I listed as the anxiety symptoms just a little bit ago.

**"Big 3":  
Anxiety**

## Anxiety Symptoms

From a mental health textbook:

- Increased BP
- Increased HR
- Chest pain
- Shortness of Breath
- "Room closing in"
- "Out of Body"/Numbness
- Sweating/Chills/Hot flashes
- Restlessness
- GI Cramps/Diarrhea
- Shaking/Tremor
- Inability to Concentrate
- Dizzy/Lightheaded/Tingling
- Fear of losing control/Going crazy/Dying

This next slide is anxiety symptoms. This is from a mental health textbook so they are not talking about addiction at all in this slide. Anxiety symptoms—increased blood pressure, increased heart rate, feeling like you're having a heart attack, chest pain, shortness of breath, smothering or choking feeling, feeling as though the room is closing in, out-of-body, feeling that depersonalization that I talked about before, or numbness, sweating, chills, or hot flashes, restlessness, GI cramps and diarrhea, shaking, tremor, inability to concentrate, dizzy, lightheaded, tingling, fear of losing control, going crazy, or dying.

So the overlap is pretty substantial and this surprises a lot of people, including clients, because it is very common. When somebody does have a habit on opioids, it is very common for them to attribute every uncomfortable feeling they are having to opioid withdrawal.

So what do you do? Because sometimes it is not opioid withdrawal. Sometimes it is anxiety.



## **Anxiety vs. Opioid Withdrawal**

### **How to Distinguish?**

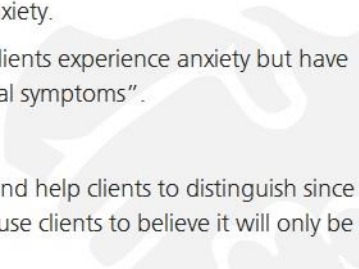
- Take a good history.
- Obtain history from family and friends on whether they believe the client has anxiety that is separate from being in withdrawal.
- Were there anxiety symptoms when abstinent?
- Were there anxiety symptoms prior to use?
- In the moment, look for physical evidence of opioid withdrawal (e.g. gooseflesh, runny eyes/nose).

How do you distinguish? Probably the most important thing is to ask questions.

Get as much history as you can. Is this somebody who has had problems with these anxiety symptoms, even when they know that they're not withdrawing from substances? Or do members of their family have anxiety problems? Because anxiety conditions do tend to run in families. There is very much a genetic predisposition to this. Are there anxiety symptoms both when abstinent from opioids and not in withdrawal? As well as prior to use and in the moment. When somebody is convinced that they are in opiate withdraw and you're wondering, hmm, this could be anxiety as well.

Look for the physical evidence of opioid withdrawal, which would be the goose bumps, runny eyes, or nose. Now if somebody has a cold that's going to be difficult, or if the room is very cold that may be difficult. But those physical symptoms are what distinguishes opioid withdrawal from anxiety symptoms.

## **Anxiety and Opioids: How to Help**


- Become familiar with symptoms of anxiety.
  - Understand that many opioid-using clients experience anxiety but have come to believe these are "withdrawal symptoms".
  - Educate clients about anxiety.
  - Try not to call anxiety "withdrawal" and help clients to distinguish since believing anxiety is withdrawal will cause clients to believe it will only be helped by using.
- 

How to help? Become familiar with the symptoms of anxiety, understand that many opioid-using clients experience anxiety but have come to believe that these are withdrawal symptoms, educate clients about anxiety, and try not to call anxiety withdrawal. As well as helping clients to distinguish between the two, since believing anxiety is withdrawal will cause clients to believe that it will only be helped by using. So this is a major reason that people relapse.

**"Big 3":  
Depression**

## Opioids and Depression

- Still under-diagnosed.
- May present as behavior problems in teens.
- Opioids act as a short-term numbing agent.
- Opioids mimic some symptoms.
- Because it is a depressant, it may cause as well as mask depression.



Opioids and depression. Depression—even though it may seem like everybody and their brother is on antidepressants right now—depression is still actually underdiagnosed. And when most people think of depression, they think of being overly sad, tearful, moping around, having no energy. The younger somebody is, the more likely that depression does not look like that prototypical sadness and it looks more like behavior problems. Acting out.

So sometimes it is hard to tell, and this is important to be aware of. Teenagers, college students, even individuals in their early 20s—they don't always have that moping around—those moping around symptoms that you think of as being depression. And it could look more like they're just being rebellious or just causing problems. But when you talk to them, you ask them how they're feeling, they will tell you that they just feel hopeless. That there is just nothing to live for, things like that.

Opioids, which are central nervous system depressants, will mimic some symptoms of depression. So if somebody is using on a regular basis, they are going to be more down. They're not going to have a normal amount of energy level. They may have a depressed appetite, have sleep problems, things like that.

Because opioids are depressants it can cause, as well as mask, depression. We talked about how opioids will mask anxiety symptoms, they also mask low mood symptoms. Although when we're talking about depression, opioids can actually cause depression if somebody is vulnerable


to having depression.

**\*Big 3\*  
Depression**

## Assessing Major Depression

**Sleep Issues:**

- Insomnia (not enough) or hypersomnia (too much)
- Trouble falling asleep
- Frequent awakenings
- Early AM awakening before one needs to awaken and up for the day (very indicative of major depression).



So how do you know if somebody has major depression? There are approximately nine basic symptoms of depression.

And I want to specifically talk about sleep because a lot of people will say that they have sleep problems. And there's a lot of different ways to have a sleep problem and sometimes people can't sleep because they're using or because they're in withdrawal. And that's not a depression symptom if it is just from that.

It is important to sort out—Somebody can have insomnia where they can't fall asleep, or they can't stay asleep, or they are waking up earlier than they need to wake up and they are up for the day. So they may be up at 4:00 in the morning and then can't get back to sleep—and that's assuming that they don't need to get up that early for their job.

The early morning awakening—and again, this is not a 100% rule—but that third category, those folks that are getting up early. They're waking up, they don't want to be up that early, and they cannot get back to sleep. That is, of those three ways to have insomnia, that is the one that is most indicative of a biological depression. Even though there are always people that break the rules. But compared to those other two, if somebody is saying that that's their insomnia problem, that is more likely to be depression than the other ones.

## Assessing Major Depression

### Other Symptoms:

- Appetite (abnormally low or overeating)
- Concentration is impaired
- Diminished interest or pleasure in activities
- Loss of energy
- Psychomotor agitation or retardation
- Worthlessness or excessive guilt
- Hopelessness that anything can get better
- Recurrent thoughts of death

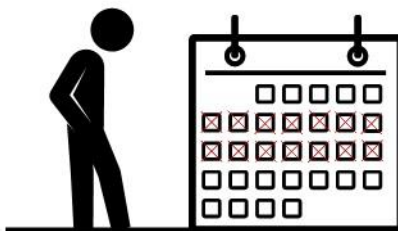


Other symptoms. Just an abnormal appetite—which could be either too low or too high—impaired concentration, inability to enjoy things that should be enjoyable, low energy, what we call psychomotor agitation or retardation, which means—it's just an abnormal, I guess in a way it's an abnormal energy level. In other words, they just can't sit still, they're just constantly fidgety, or they just seem like they're melting into the furniture. Feeling worthlessness or excessive guilt about things, hopelessness that anything can get better, recurrent thoughts of death.

So not everybody that has a biological depression is suicidal but that is always something that you would want to have the individual be assessed. If somebody is depressed, you do want to make sure that they're not suicidal and in danger of attempting to harm themselves.

## Assessing Major Depression

Low mood most of the day  
nearly every day for at least two weeks



Now to give somebody a diagnosis of major depression, they need to have a low mood most of the day. So I'll usually ask, is it more than half the day nearly every day for at least two weeks?

So everybody can have a bad day or a bad couple of days. That does not mean that you have biological depression. If this is something that is going on consistently for two weeks or more, then it is certainly suspicious for if this could be a depression.

**"Big 3":  
Depression**

## Dual Diagnosis: Depression

- Depressed opioid users often can not maintain abstinence if depression is not treated.
- Opioids may "neutralize" medications for depression (depressant + antidepressant = little change in symptoms).
- It is still important to assess and treat their depression.
- Opioid abusing depressed individuals often have their opioid use brought to attention before their depression.
- Best treatment is a combination of therapy and medication management with cessation or at least decreasing use of opioids.



Depressed opioid users often cannot maintain abstinence from opioids if their depression is not treated. However, opioids can neutralize the medications for depression. So the way that I'd like to just put this out in a schematic is the depressant plus an antidepressant equals not enough change in symptoms. So the medication will still help. However, not as much as it would help if the person was not using opioids.

Because opioids are depressants to the central nervous system, it can be harder to treat a depression when somebody is using. So, what that includes--this is not just people that are getting their opioids from the street--this can also be prescribed opioids. If a doctor is giving somebody pain medication--hydrocodone or oxycodone--long term, it can make it harder to treat the depression. If somebody is on methadone, as well as buprenorphine, it can be a little harder to treat the depression. It's still worth treating the depression. These folks usually just need higher doses of antidepressants.

This is also important—and again this is more about educating and advocating for clients. There are doctors, most of whom are not addiction trained, that will say we cannot treat your depression if you are using substances. And that is somewhat of an old school way of thinking. But there are still a good number of doctors out there that are not comfortable treating somebody's depression if they are using.

The medications for depression—again, while it's not ideal if you're using—it is not dangerous. It is not going to be life-threatening for somebody to be on an antidepressant if they are using opioids. So my bias is to treat the depression. That is going to give them their best chance of being able to get abstinent and stay abstinent on opioids.

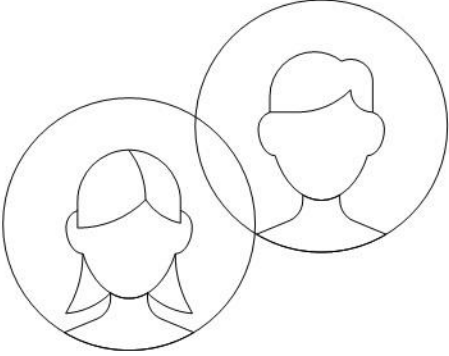
Usually people that are depressed and abusing opioids will usually have their use brought to attention before their depression, so it's important not to ignore the depression because it is much harder to stay abstinent from the opioids if when you're not using, you're feeling that depressed mood that much more. It is not a comfortable feeling. The best treatment is a combination of therapy and medication management with, ideally, stopping the opioid use, but at the very least, decreasing the use with the eventual goal to stop. So, it is worthwhile to treat the depression.

**"Big 3":  
Depression**

## Opioids and Depression

**Why is depression is frequently overlooked in teenagers?**

- Poor historians: often out of touch with feelings.
- In treatment under duress.
- Behavioral problems may be the primary manifestation.



Depression is frequently overlooked in teenagers. They are usually not in touch with their feelings. They're poor historians. They may not be in treatment voluntarily. Usually teenagers are being forced to be in treatment either by family or the legal system. And as I mentioned before, they may not look like your typical sad, moping, what you would think of as depression. The behavior problems may be the primary manifestation.

So it is important to keep that in mind when you are working with a younger person. Again, not everyone acting out has a depression, but it is important to ask that question and at least be aware of that.

## Thoughts for Discussion

### To treat or not to treat depression and anxiety?

Is 3-6 months substance free necessary before treating with medication?

Do medications compromise sobriety and the ability to "work a program"?

There can be an issue of a "magic bullet" among substance abusers in that they may over-focus on getting a medication. Does that mean they should not?

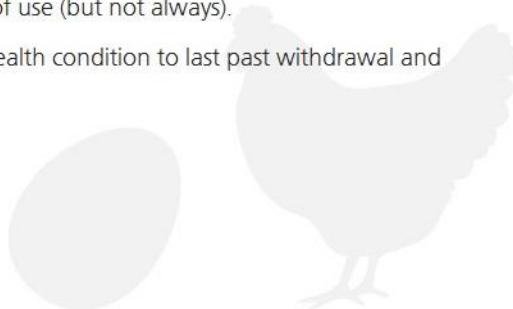


These are thoughts for discussion. Is 3-6 months being substance free necessary before treating with medication? Do medications compromise sobriety and the ability to "work a program"? And there can be an issue of a "magic bullet" among substance abusers in that they may over-focus on getting a medication. I have patients that come into my office that have a depression or an anxiety as well as using. And they'll basically say to me, "Doc, just give me a pill, any pill, I just want something, just fix me." And that is not treatment, they're looking for an easy way out. Does that mean that they should not get a medication?

So these are all important thoughts for discussion.

## When Substance Use Comes First

- May improve with cessation of use (but not always).
- It is possible for the mental health condition to last past withdrawal and even well into abstinence.



Now I want to say something about the substance-induced disorders, because this is part of the reason that a lot of doctors do not want to treat people that are using substances and also have

a depression. They may say, well, this may be a substance-induced disorder. So that's when the substance use comes first.

So if somebody has a substance-induced depression versus a major depression, that means that we as treaters—and we're not always right—but we as treaters may think, well, this person would not have been depressed if they were not using.

So how do you find out? Well, the goal is to get people to not be using. And if it is a substance-induced mood disorder, or even anxiety disorder, that condition should get better—it should start getting better actually within one to two weeks. Now some doctors will treat regardless because it may be very hard to stay abstinent for one to two weeks if you are feeling your anxiety or your depression a lot worse.

It is possible for the mental health condition to last past withdrawal and even well into abstinence. So what that means is that—let's say somebody is convinced that they never had any kind of a mood disorder before they started using. But now they've been using for a while, and now they have a depression. And they stop using, and they still have a depression. And that absolutely can happen to people.

So the substance—again, opioids are depressants—the substance actually creates or helps create that chemical change in somebody's brain where they have a depression and the depression may or may not get better. So again, this is not something that recovery coaches are going to be doing as far as prescribing medication. But educating clients and acting as an advocate among treatment systems—it is appropriate to bring this up. Keeping in mind again that the majority of doctors are not experts in addiction. Sometimes the best thing you can hope for is somebody, a doctor who is at least open.

The antidepressants are not going to cause any harm. If somebody is looking like they have a depression it can be beneficial to advocate for, well, can we at least try a medication for depression? It's not going to hurt and maybe it can help.



## Which Came First?

Did the opioid use cause the mental health condition or the mental health condition lead to the substance use?

- We don't always know.
- *Always ask the client. They may have an opinion and it is usually accurate if they do.*
- Treatment works. It is important to treat the mental health condition either way.



A lot of times people will question, well, how do I know which came first? Is this person depressed because they're using opioids, or did they have a depression first and they started using opioids after? And I've seen treaters tie themselves in knots basically trying to figure this out. When one of the easiest ways to find out the answer to this question is to ask the client.

Now sometimes your client may say, I don't know, I've been using since I was nine years old. I can't remember what I was like before that. So not everybody knows but in my clinical experience I would say at least half, maybe even a little over half, of clients do have an opinion on this. They will be able to tell you, you know what, I think I was depressed first, then I started using. Or they may say, you know what, I know I was never depressed. I started using and now I'm depressed. Either way it's still worth treating the depression.

## Things to Consider

- Higher risk of suicide and self injury in Substance Induced Depression vs. Major Depression.
- Higher likelihood of panic attacks with Substance Induced Anxiety.
- SO, it is important to treat these conditions if they are not improving in the first month of stopping use OR sooner if worsening.



Davis, L; Frazier, E, et.al; American Journal on Addictions: July-Aug 2006 (15) 4 278-285  
Smith JP, Book SV. Anxiety and Substance Use Disorders: A Review. *The Psychiatric times*. 2008;25(10):19-23

There are some important statistics to keep in mind. There is a higher risk of suicide and self-injury in substance-induced depression versus a major depression. Again, this is a good

argument to treat.

Most of you will be working in emergency departments. And when you're working with someone the idea often is that they had an unintentional overdose. Please be aware that some of the people that you're working with will have used to the point of overdose. And an intentional overdose—that was a suicide attempt. Those people in particular really need to have access to co-occurring services.


There is also a higher likelihood of panic attacks with substance-induced anxiety. Meaning substance-induced anxieties—meaning that the treaters are believing that the anxiety symptoms are only a condition of using. I would say more often than not, the anxiety is existing by itself. But there is a higher likelihood of panic attacks. And again, the purpose, the reason for me putting this out is because it is important to treat these conditions.

If somebody wants to wait for medication and some clients will—they'll say, look I don't want to go on an antidepressant right now. I really do think that this is just because of my use. If somebody's mood or anxiety is not improving in the first month of stopping the use, or if it seems like it's getting worse as the weeks go on, I would say you really want to be an advocate to the treater. But sometimes an advocate to the client. Because I have met many, many clients who have said, well I don't like medication. I don't want to go on medication. I don't think I need that. So it's important to have as much education as possible.

**"Big 3":  
Trauma**

## Trauma and Substance Abuse

- Use alcohol or drugs to cope.
- Drink/use not to feel anything.
- 29-59% of women in SUD treatment have trauma. Likely much higher.
- Women with PTSD have a 1.4-3.6x higher likelihood of substance abuse.



Najavits, et. al, *American Journal of Addiction*, 1997 6: 273-283.

And moving on to the relationship between trauma and substance abuse. It is very common for individuals that have been through trauma—and trauma can mean several things. A lot of times people think about PTSD, post-traumatic stress disorder, as somebody who has gone through—a combat veteran, somebody that has gone through war or just going through a very horrific experience. That part is true. The individual who has post-traumatic stress disorder has gone through an experience where they felt like their life was endangered.

But this does not necessarily need to be a combat response. This can be a past history of physical abuse. A past history of sexual abuse. Either something acute that happens, such as a rape, or somebody who had been abused by a family member over a period of time. This is all something that can lend itself to post-traumatic stress disorder. These are all traumatic situations.

Trauma may also—in addition to the physical abuse, things like being in combat, sexual abuse. Trauma can also occur from emotional circumstances. So somebody in childhood may not have ever actually been physically struck or sexually abused, but they may have been emotionally abused. There may be neglect. This may be a child whose basic needs were not being taken care of. The parents either were not around or they were just too busy doing other things. And the child's needs just went unmet over a period of time. This will also lend itself to trauma and the development of post-traumatic stress disorder, PTSD.

Individuals who have post-traumatic stress disorder are much more likely to develop a substance abuse condition. And if you think about it, it makes sense. Because these are folks that just feel very uncomfortable. They have higher anxiety. They may have memories that are intruding upon them. If it was an acute trauma, they may have flashbacks back to the traumatic event.

And it makes sense when you think about it. We've spoken about this several times where substances are—especially opioids—are numbing agents. So if somebody is having thoughts that they would rather not think or feelings that they would rather not feel, it actually makes sense that somebody with this history would be more vulnerable to using substances and liking that numbing out that they get from it.

Now there's a lot of statistics that can run the gamut. One study said anywhere from 29% to 59%—which is a very wide range—of women in drug and alcohol treatment have trauma. The reality is that this is probably underreported.

There have not been a lot of studies on the percentage of people that are coming in for addiction treatment that have had underlying trauma. Part of that is that researchers have not been as interested in this as they should be. But another part of this is one of the hallmarks of trauma is that it's almost as though people—and they don't always do this intentionally—they may erase their memories.


So if you've gone through something that's very traumatic, one of the ways that our brains deal with this is to actually forget about the episode. Especially if it's something that happens when an individual was very young. So you may forget about the memory. However, what can often happen in trauma is that the memory comes up at a point in time. There may not be any rhyme or reason to why this comes up. But all of a sudden it may come up.

Now this can happen when somebody is doing treatment for substance use because—again, if we remember, the substance was numbing out the feelings and the memories. So when somebody is stopping the use, sometimes these memories can come back and this is important

to keep in mind.

**“Big 3”:  
Trauma** **Trauma and Substance Abuse**

- Lack of validation in many AODA programs
  - “All that matters is the use.”
  - “Stay in the present.”
  - AA concept of the “pity pot.”
- 66% of residential programs believe they’re trauma-informed. Not what patients are telling us.



Capezza, N.M. & Najavits, L.M. (2012) *Psychiatric services*, 63,390-394.

Looking again at the interface between trauma and substance abuse. There are some programs that actually can make individuals that do have trauma feel almost bad about themselves. Or feel less than. There can be a lack of validation. Some programs will say all that matters is the use. We don't want to deal with those old memories. Stay in the present. The idea of if you're too focused on your past and what's happened to you, that you're basically being on the pity pot. All of those ideas can actually make folks that have been through trauma, that are having symptoms of PTSD, feel less good about treatment.

Trauma-informed care is a buzzword that is—or I should say a buzz phrase—that is getting more attention. And I think that that is a good thing. We are starting to realize in the addiction field that being trauma-informed—recognizing that a lot of individuals who are getting into treatment have had traumatic episodes in their lives. And that in fact, this is part of what's been fueling the use. It's a good thing that more programs are realizing this and trying to incorporate this into their treatment.

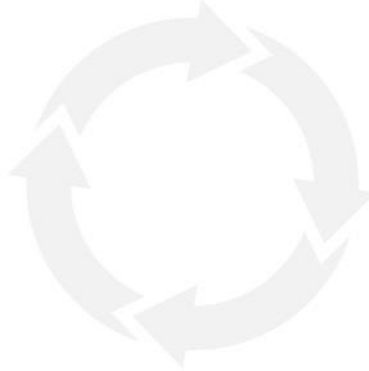
However, the majority of programs are still not trauma-informed. And of the ones that are saying that they are—it's about 2/3 of programs are saying that they do provide trauma-informed care for their clients. However, it's far lower than 2/3 of patients when they come out of treatment and they are asked if their treatment program did trauma-informed care. It's nowhere close to 2/3 of the patients.

So there is a disconnect between what the programs think they're doing and what our clients are telling us that they're experiencing. Although I believe that the trend is moving in a positive direction. And more programs are recognizing how important recognizing and giving some basic treatment for trauma is. But the reality is the average residential program in 28 days is not going to be able to do more than scratch the surface. Trauma treatment is something that takes years to really engage in.

**“Big 3”:  
Trauma**

## Connection Between SUDs & Trauma

- Never learned to manage feelings in a healthy way (bad modeling from family of origin).
- Drugs are the “perfect” solution to getting rid of memories and unpleasant feelings.



The connection between substance use and trauma. So somebody who has been traumatized—oftentimes they are traumatized in their family of origin. So a lot of times, individuals never learned how to manage feelings in a healthy way. Because, honestly, they were not given good role models. Trauma does tend to run in families. So individuals who have gone through trauma, who have gone through abuse or neglect in their families, more often than not their parents were also traumatized as well. And likely their parents as well. So it becomes this generational continuing cycle. And as I mentioned before, drugs feel like the perfect solution. Obviously not really—but feels like a perfect solution to getting rid of memories and unpleasant feelings.

**“Big 3”:  
Trauma**

## Trauma and SUDs: How to Help

- Notice the connections between use and feelings.
- Recognize that as use lowers, uncomfortable feelings will increase.
- As coping increases, feelings will be more manageable (hang in there).
- Decrease use if unable to fully stop.
- Work on both trauma and use together.



Trauma and substance use disorders. So how can you best help? For individuals that have had trauma—with substance use—helping them notice the connections between their use and their

feelings.

One way to look at that is to say that there can be a learning in every relapse. My first question when one of my patients relapses is, what did you learn from that? And I don't say that in a sarcastic or a punishing way. I really am interested. Because the reality is it does make a difference if somebody is actually noticing the connection between—what did cause them to use? And I will ask those kind of questions. What was it?

Another important point is that recognizing as somebody's use of substances lowers, their uncomfortable feelings are going to increase. This is true for anxiety and depression, as well as trauma. But it is very important in trauma. The best thing we can do for our clients is educate them about that. Because as their ability to cope increases, the feelings are going to be more manageable.

It is a risky place early in treatment for somebody that has been through trauma. Once they are experiencing more of those uncomfortable feelings, it can lead to a relapse. And it's important to be educated yourself but also help your client to be aware that this can happen. Because if they do hang in there, it is a temporary blip up the uncomfortable feelings. But then it will get—it will improve as they get better at coping.

The whole idea of decreasing use if unable to fully stop—which we will refer to as harm reduction. For people with trauma that can be a very legitimate step in their recovery. So if somebody is—every time they try to stop—getting to where they become suicidal and they're at risk of hospitalization, then it may make sense to work on gradually lowering their use. Now this is somewhat of a controversial idea. But this is part of what encompasses harm reduction.

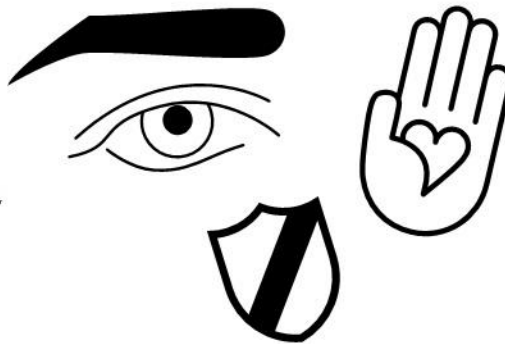
Or there may be people where—if they're using marijuana and opioids, they stop the opioids. They try to stop the marijuana but their trauma symptoms become unmanageable. They may need to work on gradually lowering the marijuana and stopping the opioid.

And it is also important to work on both the trauma and the substance use together. So that usually means having a therapist in addition to doing the addiction treatment work. For people that have had past trauma it is essential to have a therapist that they're working with.

**“Big 3”:  
Trauma**

## Trauma Treatment

- DBT
- Seeking Safety
- EMDR
- Brainspotting
- “Trauma-informed care”



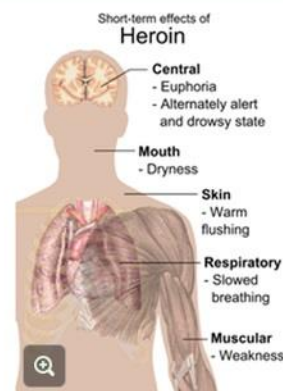
There are many types of trauma treatment and it's not one size fits all. It's really about finding the best match for the patient. DBT is dialectical behavioral therapy. And Skye is going to say a little bit more about all of these types of treatment in a minute.

Seeking safety is another modality. EMDR—which is an eye movement therapy. Brainspotting—which is another type of eye movement therapy that was developed from EMDR. And just the whole rubric of trauma-informed care. And again, we're going to get into more details about this.

**“Big 3”:  
Trauma**

## Effects of Opiates

- Slows down Sympathetic Nervous System
  - Breathing
  - Heart rate
  - Blood pressure
  - Constricts blood vessels
- Analgesic (pain relief)
- Anti-anxiety



Matt talked a little bit about the overlap between opioids and trauma. I wanted to kind of bring that idea out even a little bit more.

So the effects of opiates or opioids are to slow down the sympathetic nervous system. They slow down breathing, heart rate, blood pressure, constricts the blood vessels. It's an analgesic

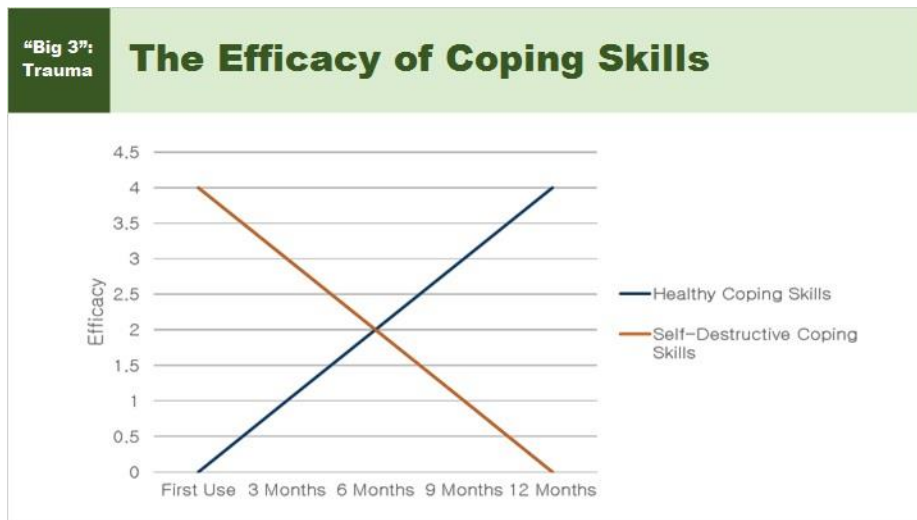
which means it relieves pain. And it also decreases anxiety felt by the person using it.

**“Big 3”:  
Trauma**      **Effects of Opiates**

PTSD Symptoms	Effects of Opiates
Intense or prolonged distress after exposure to traumatic reminders	Euphoria, analgesic, anti-anxiety
Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.")	Euphoria, analgesic
Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame)	Disconnection from emotional state
Feeling alienated from others (e.g., detachment or estrangement)	Euphoria, Connection to using community
Irritable or aggressive behavior	Slows down sympathetic nervous system (breathing, heart rate) effect is body relaxes
Self-destructive or reckless behavior	Use can be fatal
Hypervigilance Exaggerated startle response Sleep disturbance	Slows down sympathetic nervous system (breathing, heart rate) effect is body relaxes, alternately alert and drowsy state, anti-anxiety

The symptoms of post-traumatic stress disorder I've taken right from the DSM-5. And you can see that on one side of the slide there is the symptom of post-traumatic stress disorder. And on the other side of the slide is the effect of opiates. And you see how each effect of opiates actually helps the person to deal with that post-traumatic stress disorder symptom.

I think that this is really important to understand because we are not stupid and we did not start using for no reason. We started using because in some way it helped us.



The bad thing is that it does not continue to help us. So this is my favorite graph in the world. And it is not exactly scientifically accurate but it gives you a good general idea.



So healthy coping skills are skills like meditation, yoga, going to a meeting, reaching out to a support person. Self-destructive coping skills are skills like using, gambling, eating disorder activities, self-harm, anything that hurts us. When you feel uncomfortable because of trauma, anxiety, depression, whatever it is that's going on in your life—the first time that you use a self-destructive coping skill, it works really well to make you feel better.

But what happens over time is that your tolerance increases. And as tolerance increases, the efficacy—how well that self-destructive coping skill works—goes down and down and down and down and down. Until you are much worse off than you were when you started.

Healthy coping skills. The first time I ask a client to do a progressive muscle relaxation or a loving kindness meditation with me in my office, they're like, why did you even make me do that? It didn't work at all. And I would disagree that it didn't work at all. It probably worked the tiniest little bit. But the thing is that healthy coping skills don't work until you start to practice them. And the more that you practice those healthy coping skills, the better that they work. So this is really a way to help people learn how to be comfortable in their own skin over the long term.

I was one of the people that struggled with co-occurring disorders. And for all of you that are listening—that when you got sober, your life got better—I am very jealous of you. When I got sober, my life got a little bit better. And then all of my co-occurring symptoms came back. And all that sobriety did for me was give me a chance to figure out healthier ways to deal with those mental health symptoms.

So it takes a longer period of time. The more complex a person is—the more complex their mental health is—the longer it's going to take for them to feel better.

**“Big 3”:  
Trauma**

## Intervention Considerations

- Understand paradigm theory.
- Explain types of trauma:
  - One time event
  - Recurrent or complicated
  - Mini-traumas
- How have your experiences changed your ideas of:
  - Yourself
  - Your family of origin
  - Your current family or important relationships
  - Your body
  - Your boundaries
  - Your emotions

So there's a number of intervention strategies that I have here. I think that it's important to understand paradigm theory—to explain that there is not one type of trauma. So there is those

one-time event traumas. There is a recurrent or complicated traumas. And then there's mini traumas that are just those negative experiences that happen over and over and over and over and over again in life.

When talking to somebody about their personal paradigms, it's important to understand how those personal paradigms are still impacting them today. So how did those experiences change their ideas of themselves, their family of origin, their current family or important relationships, their body, their boundaries, and their emotions?

**"Big 3":  
Trauma**      **Strengths-Based Intervention Strategies**

The Power and Price of Survival: Understanding Resilience, Stress and Trauma  
<http://www.humanpriorities.com/>

Strengths Mapping  
<http://ibr.tcu.edu/wp-content/uploads/2013/09/tw-tmaps.pdf>

Authentic Happiness  
<http://www.authentichappiness.sas.upenn.edu/Default.aspx>

Jung Typology Test  
<http://www.humanmetrics.com/cgi-win/JTypes1.htm>

The next slide will give you a number of resources that you can pass along to the people that you work with—that they can use themselves. There are different handbooks, exercises, there's all kinds of good stuff on there. And it is all strengths-based.

So one of the things that we want to be aware of—in trauma work—is re-traumatizing somebody by going in-depth about their experiences before they're ready to. All of the resources that I've listed here are all strengths-based. So that way the person doesn't feel forced to revisit any of their trauma. This is really building up their strengths so that they can more effectively cope.

## Evidence-based Intervention Strategies

- [Boston Consortium Model](#)
- [Helping Women Recover and Beyond Trauma ICCD Clubhouse Model](#)
- [Trauma Affect Regulation](#)
- [Trauma Recovery and Empowerment Model](#)
- [Seeking Safety](#)
- [Dialectical Behavioral Therapy](#)
- [Eye Movement Desensitization and Reprocessing \(EMDR\)](#)
- [Brainspotting](#)



And then I talked to you guys earlier about the National Registry of Evidence-based Practices. All of the intervention strategies listed here are available on that website and have that evidence base behind them. So there's the Boston Consortium model. The Helping Women Recover and Beyond Trauma ICCD Clubhouse model. The Trauma Affect Regulation. Trauma Recovery and Empowerment model. Seeking Safety. Dialectical behavioral therapy. And eye movement desensitization and reprocessing. Brainspotting that Matt mentioned earlier is a newer offshoot of EMDR and so I'm sure that that will be added soon.

## Paradigms Defined

A philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated; *broadly*: a philosophical or theoretical framework of any kind.




All right, I want to talk a little bit about paradigms. If you don't know what a paradigm is—it's a framework to understand a big set of ideas. The example that I like to give is that there was a paradigm that the Earth was flat. And when that paradigm existed, all of the math, and geography, and everything, was wrong because it started with this assumption that the world was flat. When we learned that the world was round, all of that changed. With the new understanding that, yes, the world is round. So astronomy and math and geography and

everything had to change because that understanding changed.

**Paradigm Theory**

## Paradigm Theory

- Once paradigm is adopted the brain will:
  - Search out data that supports.
  - Discount data that contradicts.
- Developed by Thomas Kuhn in 1962.




Paradigm theory is the idea that once a paradigm is adopted, our brains will search out data that supports that paradigm and discount data that contradicts it. It was developed by Thomas Kuhn in 1962.

**Paradigm Theory**

## Selective Attention Test

Video

Click "Next" to advance once video is over.



So I'd like you to watch this video now. Go ahead and take a look and we'll talk again after. Link to video: <https://www.youtube.com/watch?v=vJG698U2Mvo>

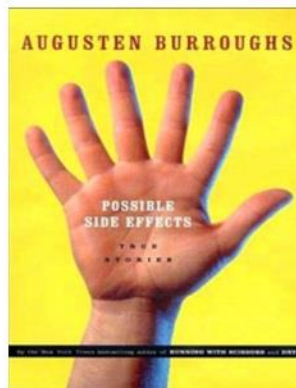
## Selective Attention Test



So for those of you who haven't seen the video before and didn't see the gorilla—that is because when the video asked you to look for the people in the white shirts, that's what your brain did. And it discounted everything else that was going on in that frame.

So what I want you to think about is how often do we do that? How often do we only look for what we're expecting to see? And how often do we discount other things that don't immediately make sense to our brain?

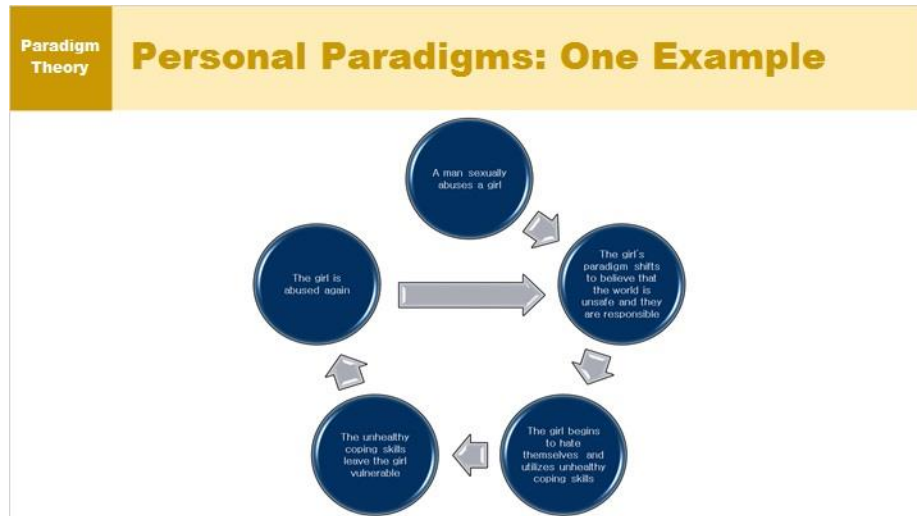
## Paradigm Theory



Here is my own silly example of how my brain does that. I read this book, which is actually written by a man who is in recovery from co-occurring disorders. It is a very funny book and I do recommend it if you have time to read it.

After reading the whole book—which was a collection of short stories—I looked at my partner and said, I don't understand why there's a hand on the cover of this book. And he looked at me

like I was a moron and said, "Skye, there's six fingers on that hand and the book is called Possible Side Effects." I must have a very strong hand paradigm because I totally did not see that sixth finger until he pointed it out to me.



Understanding that paradigms happen with these big theoretical ideas is one part of paradigm theory. But the other part is that we all have personal paradigms. So this is one example of a personal paradigm.

A young girl is sexually abused by a man. The girl's paradigm shifts to believe that the world is unsafe and that they were responsible for what happened to them. The girl begins to hate herself and utilize those unhealthy coping skills to be able to deal with that. The unhealthy coping skills leave the girl vulnerable.

So if she struggles with addiction, or she is self-harming, or in dangerous circumstances because of those unhealthy coping skills, then the girl is more likely to be abused again. Unfortunately, that just reinforces her paradigm that it was her fault. And that she is unsafe. And that she is the one to blame. In order to help people with co-occurring disorders, we need to understand their personal paradigms and understand how those beliefs came about for them.

## Balancing Compassion & Accountability



In the work that I've done, one thing is just staggeringly clear to me. That every intervention to help someone get into recovery has to be a balance between compassion and accountability.

If people that you work with don't think that you care about them, they're not going to want to work with you. You have to build that relationship. It is your job to gain their trust. It is your job to build that relationship as strong as you possibly can.

And when you build that relationship, and when you have their trust, we can help push people in the right direction. Because we all know that when addiction takes over your brain, often what you think is best and what anybody else in the world would say was best for you might be two very different things. When you have that relationship and you have that trust, you can be one of the forces that push people in the direction where they do take care of themselves.

Compassion & Accountability

### Be Compassionate

Guilt	<ul style="list-style-type: none"><li>• I made a mistake</li><li>• Useful</li><li>• Consequence that change behavior</li></ul>
Shame	<ul style="list-style-type: none"><li>• I am a mistake</li><li>• Counterproductive</li><li>• Continues unwanted, self-destructive behavior</li></ul>

In order to be compassionate, one of the things that I really like to focus on is the difference

between guilt and shame. So guilt is the idea that I made a mistake. So when somebody has a relapse and they feel guilty about it, I'm actually very, very happy that they feel guilty about it.

It's a consequence that changes behavior. So if they didn't like their relapse, if they were thinking about how they had to come and tell me about it two days later—and they were going to have to tell group—and they would have to start their days over—right? I want them to have a crappy relapse because that makes it less likely that they're going to relapse again.

Shame is different. Shame is the idea not that I made a mistake, but that I am a mistake. I'm sure all of us have heard or thought, I'm just an addict. I'm just a criminal. I'm just a junkie. That's all I'll ever be. When we use language that promotes shame, what we're doing is taking away all compassion from that person. And taking away hope from that person.

If someone feels like they're only an addict and that's all they can ever be, why would they try to change to be anything different? It's counterproductive. It continues unwanted self-destructive behavior. And so I know that in the 12 step traditions it's important to identify as an addict or alcoholic. I would very much push you as professionals in the field to call yourself whatever you would like to. But when you're working with somebody use person first language.

Say that they are a person that's struggling with addiction. Or they're a person that's in recovery from addiction. Don't call them an addict. Don't call them an alcoholic. If you want to use that terminology for yourself, please feel free to. But as professionals we have to use the most respectful language we can.

Compassion & Accountability

## Hold Them Accountable

- Use Immediacy - **Call it like you see it!**
  - If they don't want to be there it's OK to say that and say how you feel about it.
  - If you think they're still using, call them on it.
- It's easier to be silly than to be stupid, use humor to soften confrontation.
- State your boundaries and hold those boundaries unless you have sound justification not to.
- Focus on their goals.
- Use guilt to motivate change.
- Use urine analysis and collateral contacts to verify.
- Trust your gut! Your instincts are your greatest asset.

All right, on the other side of that compassion balance is the accountability. So one of my favorite techniques is to use immediacy. When somebody says something in group about how—cannabis is green, it comes from the ground, it can't be bad for you. I will openly mock them and say that back to them. And the rest of the group laughs. And I am not afraid to do that because that is a very silly thing to say in a substance use disorder group, where we're all



trying to be in recovery.

If you aren't comfortable talking about how you feel, they're not going to be comfortable. And there's going to be this sense of falseness between the two of you. If they don't want to be there it's OK to say, hey, it seems like you don't want to meet with me today. If you think that they're still using, call them on it. Say, you look high today. What's going on?

In any confrontation it's easier to be silly than it is to be stupid. Use your humor to soften confrontation. State your boundaries. Tell them what you will do, tell them what you won't do. Unless you have sound justification not to—hold those boundaries always.


Focus on their goals. So if they want to reduce their use, or they want to not use opioids but continue to use other substances, focus on their goals. If you're both on the same side of a goal, you'll reach it. If you're pushing against each other, you won't.

Use guilt to motivate change. Urine analysis and collateral contacts—you guys probably won't have access to. But if you are in a setting that you do, those are really important pieces of information. Collateral contacts are anybody that's associated with the person that you're working. Family, friends, significant other.

And then trust your gut. Your instincts are your greatest asset. So with anybody that you're working with, try to trust yourself. You know more than you think you do.

## Module Review

1. Be able to identify the prevalence of co-occurring disorders.
2. Gain understanding of anxiety disorders.
3. Gain understanding of depressive disorders.
4. Gain understanding of trauma.
5. Be able to explain what Paradigm Theory is and how it shows how MH and SUD intersect.
6. Learn strategies for how to be compassionate yet hold accountable those with co-occurring disorders.



All resources and references are located in the Resources tab of this presentation.

So, in conclusion, co-existing disorders are common, and client complexity should be expected. Remember, it's the rule rather than the exception that there is something else going on, other than just the use.

Remember the big three: Anxiety, depression, and trauma can be screened for, and treated concurrently. So while you're treating the addiction, you need to treat the mental health

condition, as well, in order to have effective treatment. Paradigm theory can help to explain the complex interplay between substance use and mental health disorders. Effective interventions must always balance compassion and accountability.

And finally, in the end, and this is coming from a doctor, doctors are all about medications and neurotransmitters. But in the end, good treatment is about what we do to help people heal. That is what it's about.

