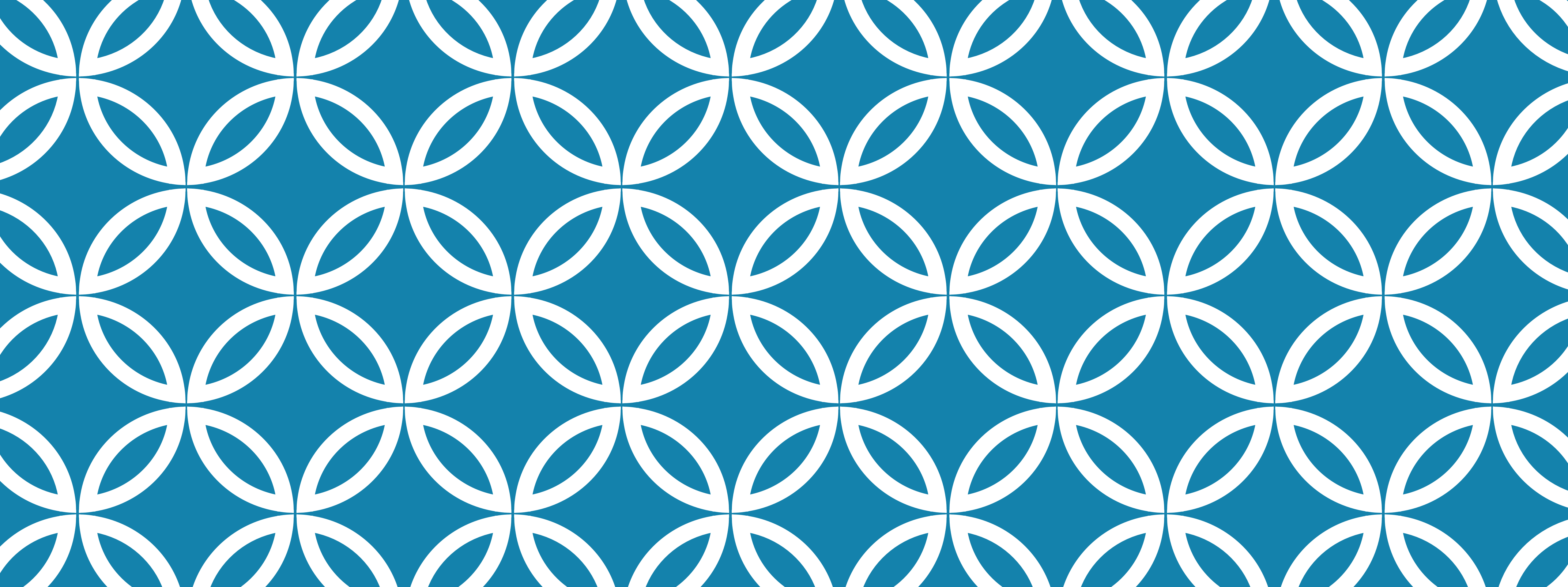
PRESENTER'S BIO

Kate Wolitzky-Taylor, Ph.D.

Dr. Wolitzky-Taylor is an Associate Professor in the UCLA Department of Psychiatry and Biobehavioral Sciences. Her research and clinical expertise in cognitive and behavioral treatments for anxiety and related disorders was developed during her doctoral program in clinical psychology in the Laboratory for the Study of Anxiety Disorders at the University of Texas at Austin, her clinical internship at the Medical University of South Carolina, where she focused on trauma-related problems, and a postdoctoral research fellowship in the Anxiety and Depression Research Center at UCLA.

In addition to her research, she treats patients with anxiety and depression in the UCLA Faculty Practice, supervises and trains psychology and psychiatry trainees in CBT in a variety of clinics, is Director of Clinical Services for the UCLA Depression Grand Challenge Screening and Treatment for Anxiety and Depression (STAND) clinic, and the Practicum Director for the UCLA Integrated Substance Abuse Programs.



SUBSTANCE USE DISORDER (SUD) AND MENTAL HEALTH INTEGRATION

SATURDAY, OCTOBER 1, 2022 BEHAVIORAL HEALTH CONFERENCE
DIRECTLY PROVIDED CME/CE ACTIVITY BY L.A. CARE HEALTH PLAN

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DISCLOSURES

The following CME planners and faculty do not have relevant financial relationships with ineligible companies:

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LEARNING OBJECTIVES

AT THE COMPLETION OF THE ACTIVITY, LEARNERS CAN:

1. Specify considerations when integrating treatment for anxiety disorders into SUD specialty care.
2. Describe how emotional disorders (i.e., anxiety, depression) and substance use disorders mutually maintain one another.
3. Identify the components of behavioral treatment for anxiety disorders.
4. List some of the limitations of the current systems with regard to integration of mental health care and SUD care.

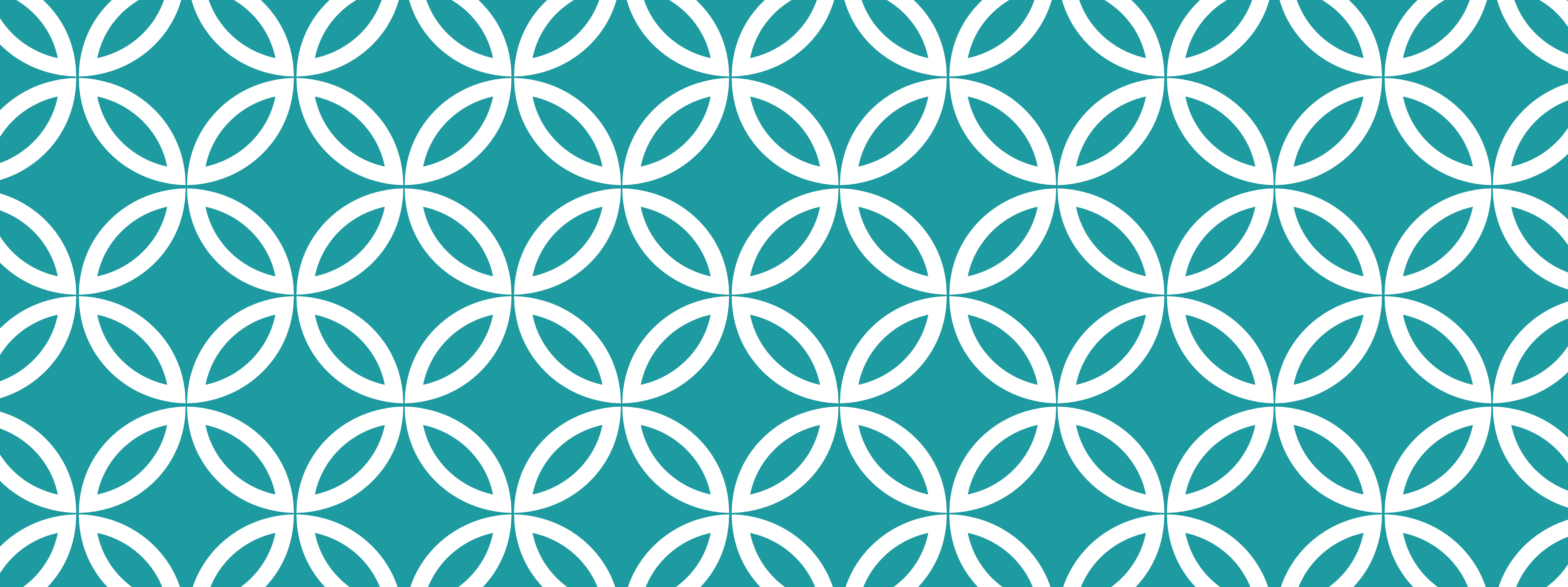
SUD AND MENTAL HEALTH COMORBIDITY IS PREVALENT

- SUD is highly comorbid with mental health problems, including anxiety disorders, PTSD, and mood disorders
  - Those with SUD are nearly 3 times as likely to have a mood disorder and nearly twice as likely to have an anxiety disorder than those without SUD
  - Those with anxiety and mood disorders have an elevated prevalence of SUD compared to those without anxiety and mood disorders
  - Estimates of ~1/2 to 2/3 of individuals in SUD specialty care have PTSD
- Co-occurring emotional (mood and anxiety) disorders and SUD tend to be:
  - slightly more common among men compared to women
  - less prevalent among older age groups

(Grant et al., 2004; Chilcoat & Menard, 2003; Mills et al., 2006; Hawkins et al., 2012; Bowe & Risenheck, 2013; Pietrzak et al., 2009; Blanco et al., 2013; Calabrese et al., 2011; Dreissen et al., 2008; Geilen et al., 2012; Rush et al., 2008).

THE CURRENT STATUS OF THE FIELD IN INTEGRATING SUD AND MENTAL HEALTH CARE

- SAMHSA recently came out with a new TIP (Treatment Improvement Protocol) calling for integrated mental health and SUD care, calling it their "no wrong door" policy
- However, despite improved awareness and a slight increase in the presence of "dual diagnosis" programs, SUD and mental health care typically remain siloed at many levels (training, specialties, systems of care)
- This siloing of care creates barriers to accessing treatment and inadequate clinical approaches to address these complex patient populations



THE CASE OF ANXIETY DISORDERS AND SUD

To illustrate the importance of integrating mental health and SUD care, and to provide a framework for how to address it, I will use anxiety disorders as a case example

ANXIETY AND SUD COMORBIDITY

Anxiety and substance use disorders (SUD) are highly comorbid and associated with:

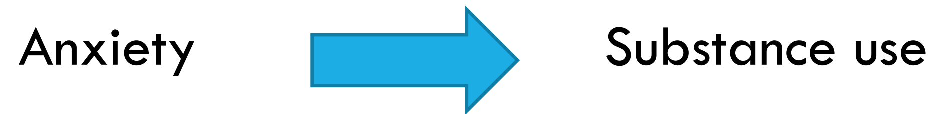
- Greater symptom severity, impairment, and health care utilization
- Poorer substance use treatment outcomes
- Poorer engagement in addiction treatment

Anxiety and SUD comorbidity is observed across the anxiety disorders and substances of dependence

Grant et al. (2004); Conway et al. (2006); Compton et al. (2007); Kushner et al. (1990); Smith & Book (2010); Zvolensky & Schmidt (2003); Stewart & Conrod (2008); Ouimette et al. (2002); Bruce et al. (2005)

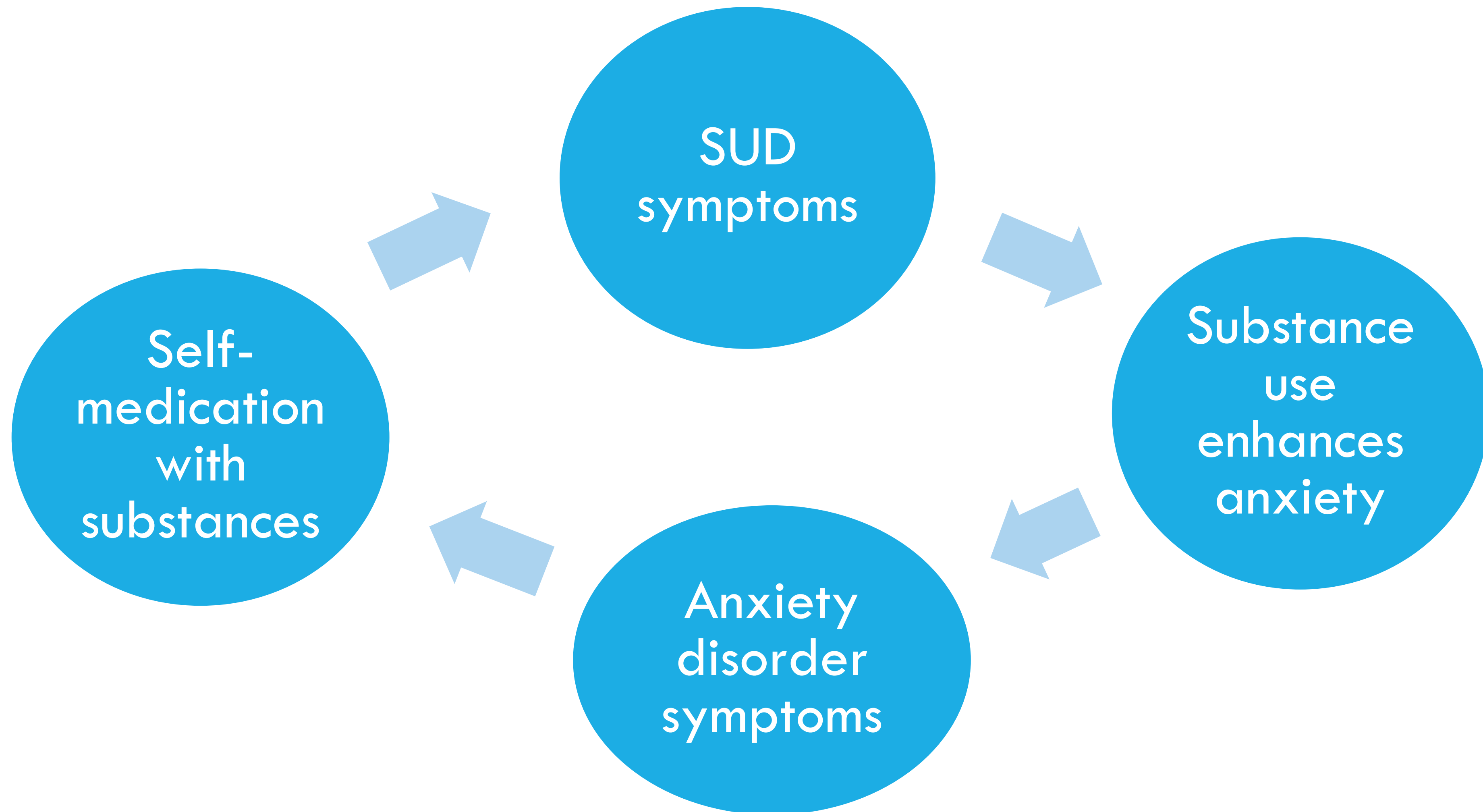
UNDERSTANDING THE NATURE OF ANXIETY AND SUD COMORBIDITY

Tension-reduction/Self-medication hypothesis



Substance-induced anxiety enhancement theory

THE MUTUAL MAINTENANCE MODEL



Stewart & Conrod (2008)

WHAT DO WE MAKE OF THIS?

- Treating anxiety should improve SUD outcomes
- Integrated approaches that simultaneously address both problems should break the "vicious cycle"
- Unfortunately, most addiction clinics do not diagnose or treat underlying anxiety disorders that may contribute to relapse; and most mental health programs refer out for addiction treatment, yet most people don't end up receiving it.

COMPONENTS OF CBT FOR ANXIETY DISORDERS AND SUDS

Anxiety

- Psychoeducation
- Cognitive restructuring
- **Exposure to feared/avoided stimuli (situations, images, physiological sensations, memories, thoughts)

SUDs

- Psychoeducation
- Cognitive restructuring
- Relapse prevention/coping skills tools (identifying triggers, coping plans, alternative, adaptive behaviors)

ADAPTING CBT FOR ANXIETY DISORDERS INTO SUD TREATMENT CLINICS

- Groups
- Brief
- Focus on psychoeducation about the mutual maintenance model
- Cognitive restructuring
- Exposure

PSYCHOEDUCATION

- Anxiety, fear, panic attacks
- Different anxiety disorders
- How anxiety and addiction work together
- Introducing the idea of alcohol and drugs as “safety aides” to mitigate or avoid anxiety in the short-term, but maintain anxiety in the long-term
- Components of anxiety

EXAMPLE OF ALCOHOL AS A SAFETY AIDE

Imagine you are afraid of going to parties and meeting new people because you are worried others will negatively evaluate you. You are afraid people will think you are boring or unintelligent. There is often alcohol at the social events you attend, so you start to drink in order to reduce your anxiety. You find that this helps you get through these social situations with much less anxiety. Now you think, *"It's a good thing I drank a couple of beers at that party! I had the courage to talk to people and some of them actually liked me and thought I was interesting!"* Soon you believe you need alcohol in every social situation to get the same result, and are drinking much more frequently and begin to develop an addiction to alcohol.

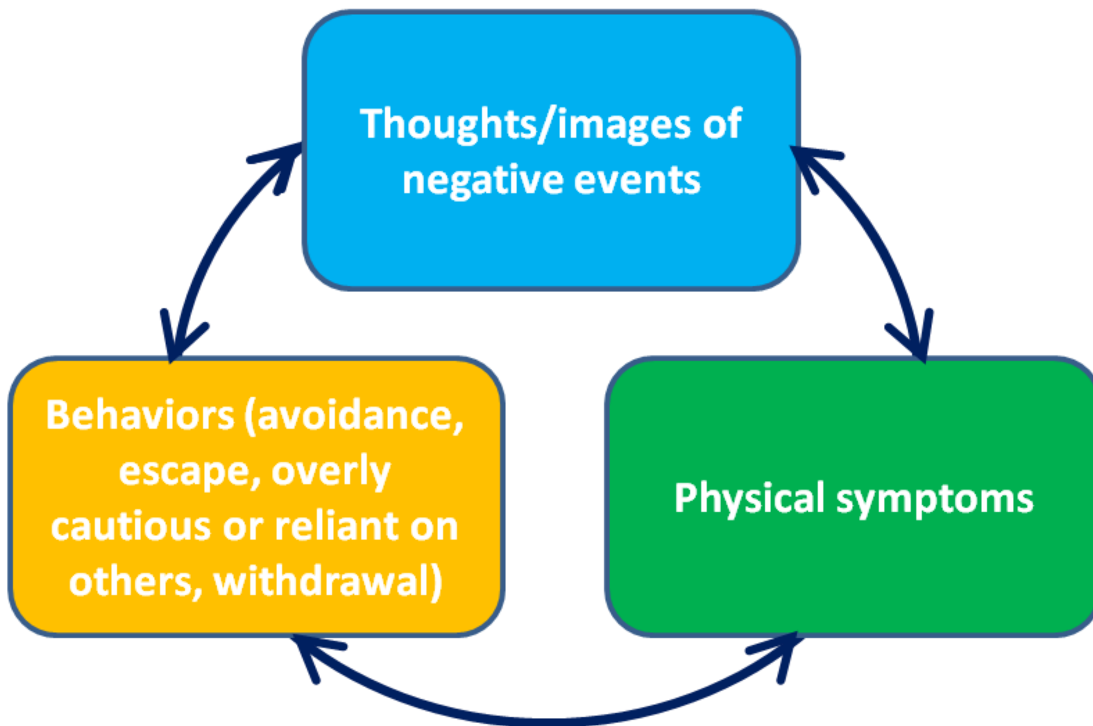
EXAMPLE OF HOW SUBSTANCES CAN LEAD TO ANXIETY PROBLEMS

Imagine you take a large amount of cocaine. You feel a lot of intense physical sensations and have a panic attack. You may start to become afraid of the panic attacks and even days later you may still find yourself worrying about what will happen if those physical sensations come back. You may start avoiding things (like exercise) in order to prevent those physical sensations (with the goal of avoiding panic attacks). However, you are already addicted to cocaine so you take it again, and you have a panic attack in the mall, and then another while you're driving. Now you avoid the mall and driving too. Soon your anxiety becomes a problem that is getting in the way of your life.

EXAMPLE OF THE MUTUAL MAINTENANCE OF ANXIETY AND SUD COMORBIDITY

Imagine you worry a lot about all sorts of things: your job, how you will pay the bills, and your relationship. All of this worry causes so much distress that you start to take prescription pills (such as opioids or benzodiazepines) to help you relax. Soon every day you get home and find that taking those pills is the easiest way to "forget about it all." The problem is, soon your time and money is being spent on getting, using, and recovering from taking the pills. You have trouble concentrating at work and end up losing your job. Your romantic partner is tired of you always using and not spending time as a couple and now you are fighting more. Money is getting tighter and tighter. This makes you worry more and more, so you need more pills to get through it. Now you are addicted to the pills and your worry feels too difficult to manage without the help of the drugs.

COMPONENTS OF ANXIETY



How this can work in the context of SUD: You know you will be going out to dinner with a few new friends you just met in a class. You are anxious about getting to know the new people. You **think,** *"They will think I'm weird."* This makes you more anxious. You may feel the **physical** sensations of anxiety. You **think,** *"I will be more relaxed if I smoke some marijuana,"* so you **behave** by smoking marijuana. You go to the dinner while you are high, and realize that it is harder to make good conversation while you are high than you expected. This makes you more anxious and you begin to feel **physical** symptoms like feeling detached. You **think,** *"Now they will notice I am anxious and really think I'm weird,"* so you **behave** by not talking, and you leave as soon as you can.

COGNITIVE RESTRUCTURING

Overestimation of likelihood

- Downward arrow to identify anxious thought
- Examining evidence for/against thought
- Generating alternative explanations

Catastrophizing

- Identifying the worst case scenario
- Imagining how you could cope
- Generating less catastrophic ways it is more likely to turn out

EXAMPLE OF TEACHING COGNITIVE RESTRUCTURING

Situation: Going to dinner with new friends from AA

Layers of Negative Thought:

- *I will have nothing to say*
- *They will think I'm boring*
- *They will not invite me to go out again*
- *I will have no friends*

What are the odds that this thought is true (consider what you think in the moment during the situation)? Select out of 0-100%: **75%**

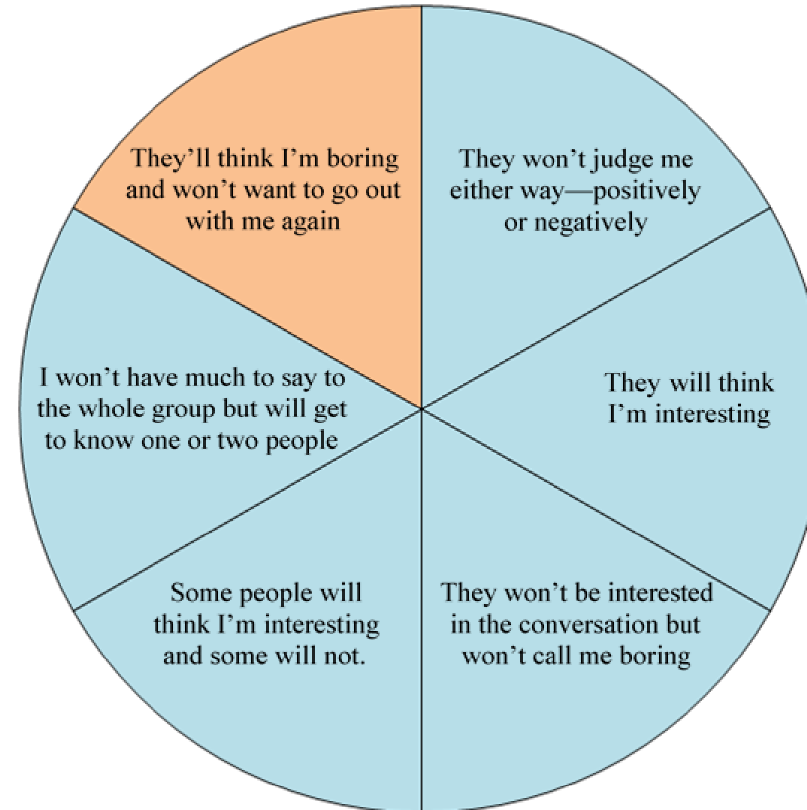
EXAMPLE OF COGNITIVE RESTRUCTURING CONTINUED

Evidence for the thought being true	Evidence against the thought being true
There have been a few times when I have been out in groups and not been able to think of anything to talk about, especially when I'm sober.	*If I don't talk, that is a choice I'm making. It's not because I can't think of anything.*
	I can usually come up with something to say.
	I have been out to lunch with this group before and they invited me again, so they must not think I'm completely boring.
	If I don't think of anything to say, they might just think I was tired or didn't know much about the topic, not that I'm boring.
	Nobody has ever told me I'm boring.
	I haven't heard from anyone that others think I'm boring.
	Even if they think I'm boring they might give me another chance and invite me out one more time.
	Even if they don't invite me out again, it doesn't mean I won't have friends. I have four friends outside who I spend time with, and one friend I met at a meeting last week who wants to hang out.

EXAMPLE OF COGNITIVE RESTRUCTURING CONTINUED

Now that I've considered the evidence and facts, what are the real odds? Select out of 0-100%: **20%**

Different Ways of Thinking

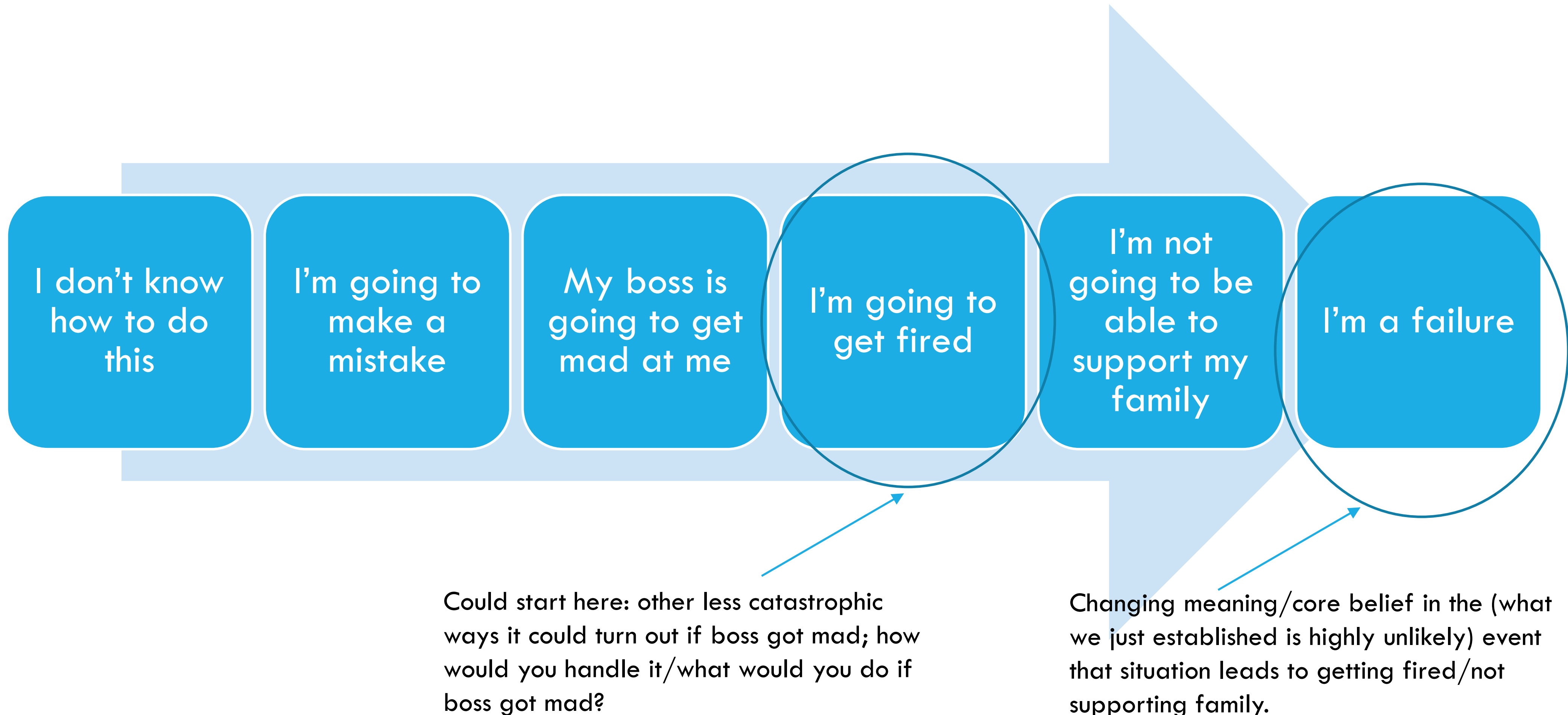


DECATASTROPHIZING

If the feared outcome did come true

- How bad would it really be?
- How would you cope?
- Would it really mean the awful thing you think, or could it turn out less terribly?

EXAMPLE: GAD
TRIGGER: AT WORK, COMPLETING DIFFICULT TASK



QUESTIONS TO ASK TO GET AT CORE BELIEF IN THIS EXAMPLE

How would you define failure?

What does that mean?

Do you meet that definition?

What else could it mean to lose your job?

Do you know anyone who has lost a job?

What did you think of that person?

What would you tell a friend?

Would it last forever? Would you eventually be able to get back on your feet? How would you do that? What support/resources do you have? Skills?

EXPOSURE!

Do this as soon as possible

Identify avoided situations, memories, images, bodily sensations

Create a fear hierarchy

In-session and homework exposures

Focus is not on fear habituation but on new learning/testing hypotheses

COMMON TYPES OF EXPOSURE FOR DIFFERENT ANXIETY DISORDERS

Disorder/Focus of Anxiety	Type of Exposure
Panic If with agoraphobia	Interoceptive (bodily sensations of fear) Add in vivo (situational) to avoided situations
Social phobia If also afraid of showing physical signs of anxiety	In vivo (situational) to avoided situations Interoceptive + in vivo (social situations) in combo
OCD	Obsessions/feared images or thoughts attempting to avoid Refrain from using compulsions during exposure
GAD	Feared images of catastrophic situations attempting to avoid Confronting situations without using safety behaviors
PTSD	Images/story of traumatic memory attempting to avoid In vivo (situational) to avoided situations/reminders

EXAMPLE OF A FEAR HIERARCHY

Situation	Fear Rating
Leading an AA meeting	100
Asking someone out on a date	90
Reading a passage during an AA meeting or group	80
Stating an opinion to a group of people at a social gathering	75
Telling a story to a group of people at a social gathering	70
Approaching someone at an AA meeting and having a conversation	65
Asking a question in an addictions recovery group session	60
Telling a using friend that I'm sober now	55
Going to a (sober) party	50
Disagreeing with a friend	40
Having lunch with sober friends	35

UNDERSTANDING THE BASICS FOR ASSIGNING EXPOSURE

What we convey to our patients

- The rationale and how we think it works
- That it's OK (and expected) that they will be anxious and that they need to let themselves get anxious for it to work
- It's collaborative (they have a say in what happens)
- In-session exposures are important!
- Repeated practice within a session (e.g., at least 20-30 min, preferably more, doing things over and over if the duration of the exposure is short) is essential - a sufficient duration of time confronting anxiety-provoking stimuli is needed for it to work
- Repeated practice for homework (at least 3 times per week) is essential for consolidating new learning (and potentially seeing fear decline over time)

EXAMPLE OF SETTING UP AN EXPOSURE

Before:

What I will practice: Going to a party. I will approach 3 or 4 people I don't know well and start a conversation.

What am I afraid will happen? I will have nothing interesting to say. They will walk away from me or tell me they are not interested in talking to me.

What safety behavior(s) do I usually use in this situation? I avoid eye contact. I drink.

What behavior(s) will I do instead? I will make more eye contact. I will stay sober.

REFLECTING ON THE EXPOSURE

After:

Peak distress/fear rating: 50

Did my prediction come true?

- No, three of the four people were interested in talking to me. One person talked to me only for a minute and then did walk away though.

If it did come true, how did I handle it?

- When that person walked away after a few minutes, I told myself that there could be many possible reasons why she walked away. It was possible she thought I was boring but it was also possible that she saw a friend come in or wanted to get something to eat at the snack table. I reminded myself that not everyone will find me interesting, just like how I don't find everyone interesting. I reminded myself that the other three people seemed to like me.

What did I learn?

- I was overestimating the odds that someone would ignore me or not like me. I was able to use eye contact and people seemed interested. I learned that I could handle that one person not wanting to continue the conversation and nothing bad came of it. And I did it all sober!

ADAPTING TRADITIONAL CBT FOR SUD FOR THE COMORBID ANXIETY/SUD POPULATION

What works really well:

- Scheduling activities (improves depressed mood often also comorbid) but need to consider whether the activities are actually pleasurable v. more like exposure
- Drug refusal skills (assertiveness practice can be woven into exposures)
- Psychoeducation about withdrawal and craving, understanding the trigger → urge → use links
- Mindfulness-based distress tolerance skills (e.g., urge surfing)
- Building sober social support network

ADDING MOTIVATIONAL INTERVIEWING?

- When to add motivational interviewing:
  - Patient is reluctant to “jump in” to make changes
  - Patient is not completing homework
  - Patient is missing sessions
  - Patient wants help with anxiety but has a hard time seeing how it is connected to substance use
- In general, it can’t hurt to start with it if there is any hesitation about making change
- Weave it in throughout by looking at pros and cons of making change v staying same, exploring Socratically how SUD (and anxiety) cause impairment and how change could improve quality of life

ADAPTING TRADITIONAL CBT FOR SUD FOR THE COMORBID ANXIETY/SUD POPULATION

What gets tricky:

- Avoiding “people, places, and things”
- Need to help patients make the distinction between:
    1. objectively safe situations that result in the internal trigger of anxiety (which should be faced and may improve quality of life) v.
    2. drug/alcohol cues in the environment that are not safe, especially in early recovery (such as going to the liquor store)

CASE EXAMPLE: PATIENT

25 year old Caucasian male

Social anxiety disorder

Generalized anxiety disorder

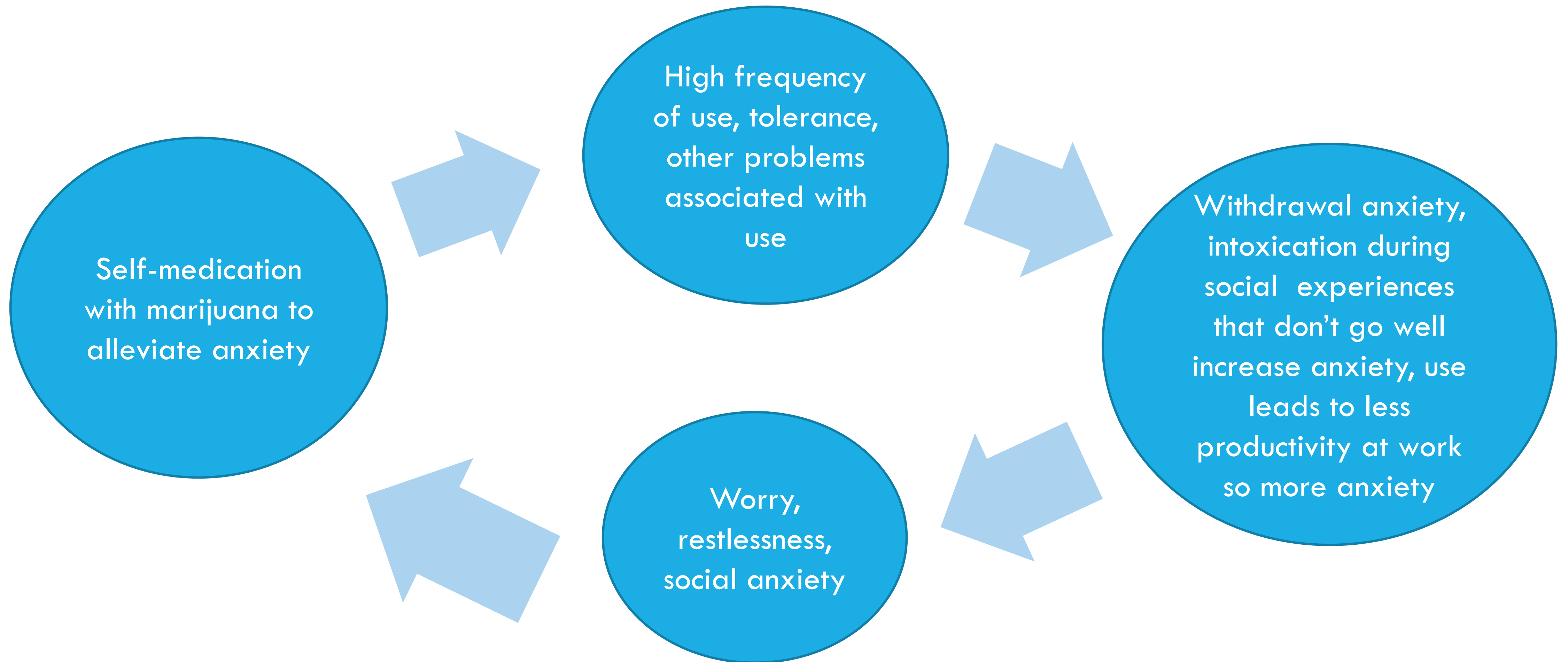
Cannabis use disorder: daily marijuana use when he gets home from work, nightly with friends and before he goes to sleep

Reports that he uses marijuana “to relax” and stop worrying

Reports restlessness, feeling keyed up, and insomnia when he does not smoke marijuana

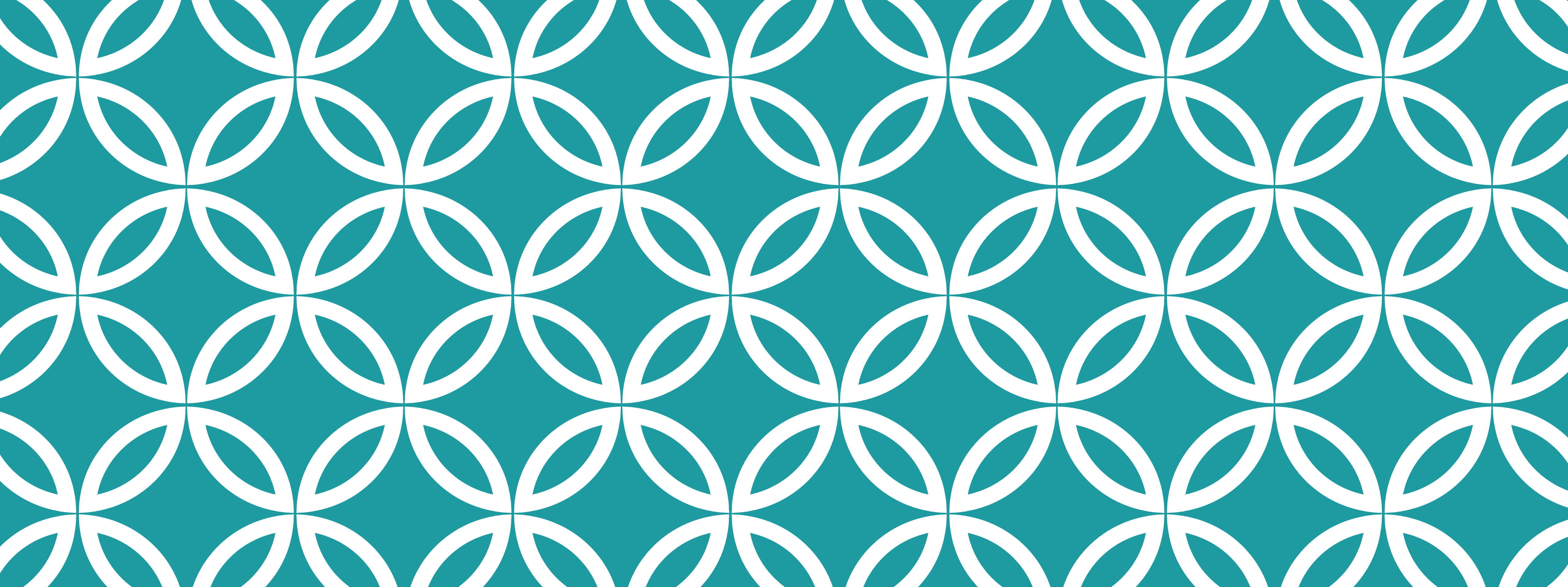
Reports that he would feel “awkward” and people would “think I’m weird” if he tried to have a conversation at a social event without smoking marijuana.

CASE EXAMPLE: MAINTENANCE MODEL



CASE EXAMPLE: TREATMENT PLAN (TO ADDRESS CANNABIS USE AND ANXIETY DISORDER)

- Psychoeducation about anxiety, marijuana's effects, and how are anxiety and marijuana problems tie together
- Cognitive restructuring to address anxiety-related thoughts as well as thoughts related to marijuana use
- Identifying external triggers for marijuana use and develop coping plans for high-risk situations for using marijuana
- Exposure to social situations without using marijuana
- Worry time and exposure to worry-related images
- Fading of safety behaviors including marijuana use



EXAMPLE OF A STUDY DEMONSTRATING THE BENEFIT OF INTEGRATING TREATMENT

Coordinated Anxiety Learning and Management for Addiction Recovery Centers (CALM ARC)
NIDA K23 DA031677
PI: Wolitzky-Taylor

CALM ARC: COORDINATED ANXIETY LEARNING AND MANAGEMENT FOR ADDICTION RECOVERY CENTERS

- Development of a brief CBT protocol for anxiety disorders to be delivered by addiction counselors in community SUD specialty clinics
- Computerized, therapist directed
- Developed for clinicians with minimal to no training in treating anxiety disorders or delivering CBT
- Included Web-based assessment and homework components
- Brief (6 sessions plus orientation) and interactive
- Content specifically designed for this comorbid population
- Evaluated in an effectiveness trial in a community-based SUD specialty clinic

calm arc

COUNSELOR: 3C014
USER: 3P050 LOGOUT

COUNSELOR TOOLS

WELCOME TO CALM ARC

PRE-TREATMENT

- [ ] Start Pre-Treatment

GROUP ORIENTATION

- [ ] Overview of CALM ARC
- [ ] Information 1
- [ ] Information 2

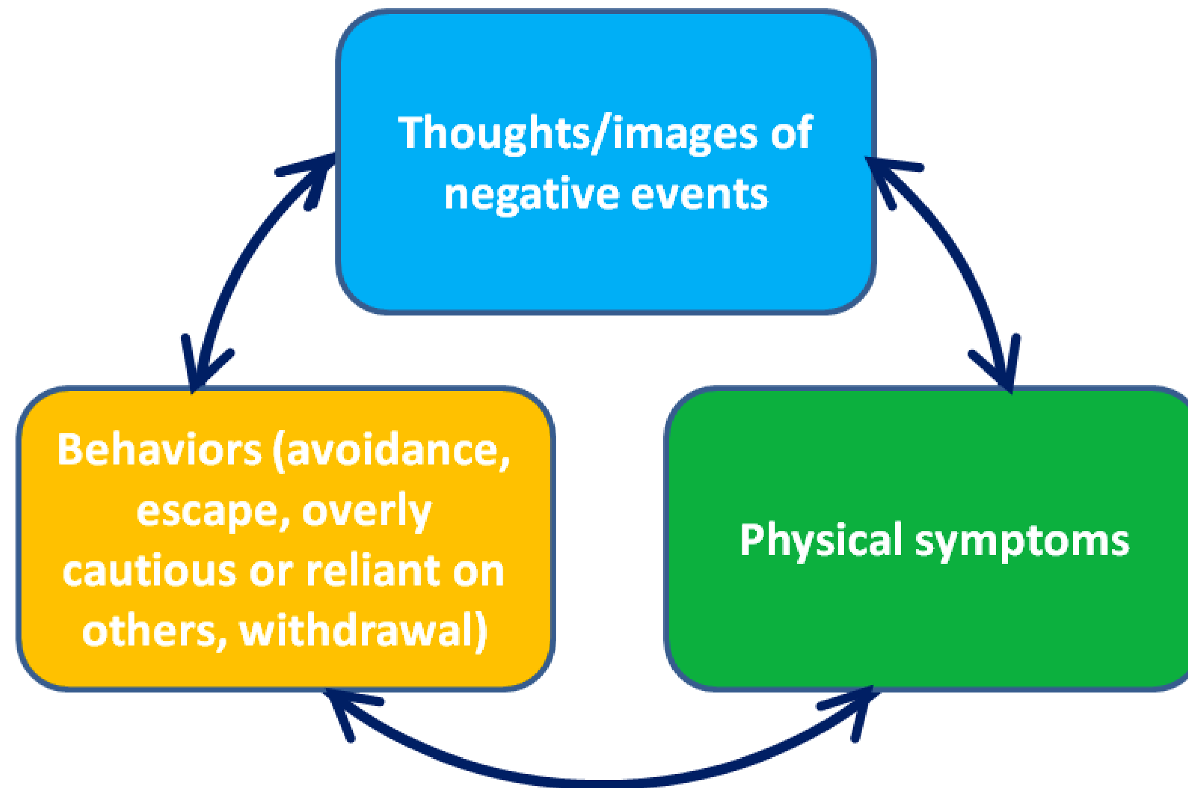
HOME ORIENTATION

- [ ] Summary
- [ ] Identifying my Anxiety Problem

INFORMATION

How the three parts of anxiety work together

Your physical, thinking, and behaving parts of anxiety all work together in different ways.



Let's go through a few examples:

- You are at a concert and it is crowded. You start to feel detached, like things around you aren't real. This **physical** sensation makes you **think**, *"I am going to lose control or pass out."* This makes the **physical** feelings even worse. Now your heart is racing and your fingers are tingling. You **think**, *"I will die if I don't get out of here."* You **behave** by making a quick rush to the exit and

IDENTIFYING AND CHALLENGING MY THOUGHTS

Situation

Layers of Negative Thought:

1.
2.
3.
4.

What are the odds that this thought is true (consider what you think in the moment during the situation):

Evidence *for* the thought being true

FEAR LIST

Exercise: Using your **"What makes me anxious," "Sensations exercises," and "What thoughts and images do I avoid?"** lists, work on your **Fear List**. And remember, there are plenty of examples online.

Fear List

Fear/Distress Scale

0---10---20---30---40---50---60---70---80---90---100
none mild moderate strong extreme

Situation	Fear Rating
	✓ 0 5 10 15 20 25 30

ASSESSING FEARS OF PHYSICAL SENSATIONS VIDEO

Exercise 1: Running in Place

0---10---20---30---40---50---60---70---80---90---100
none mild moderate strong extreme

Fear rating

Sensation rating

Similarity to panic

Overall Anxiety Severity and Impairment Scale (OASIS)

The following items ask about anxiety and fear. For each item, circle the number for the answer that best describes your experience over the past week.

1. In the past week, how often have you felt anxious?

- 0 = No anxiety in the past week.
- 1 = Infrequent anxiety. Felt anxious a few times.
- 2 = Occasional anxiety. Felt anxious as much of the time as not. It was hard to relax.
- 3 = Frequent anxiety. Felt anxious most of the time. It was very difficult to relax.
- 4 = Constant anxiety. Felt anxious all of the time and never really relaxed.

2. In the past week, when you have felt anxious, how intense or severe was your anxiety?

- 0 = Little or None: Anxiety was absent or barely noticeable.
- 1 = Mild: Anxiety was at a low level. It was possible to relax when I tried. Physical symptoms were only slightly uncomfortable.
- 2 = Moderate: Anxiety was distressing at times. It was hard to relax or concentrate, but I could do it if I tried. Physical symptoms were uncomfortable.
- 3 = Severe: Anxiety was intense much of the time. It was very difficult to relax or focus on anything else. Physical symptoms were extremely uncomfortable.
- 4 = Extreme: Anxiety was overwhelming. It was impossible to relax at all. Physical symptoms were unbearable.

3. In the past week, how often did you avoid situations, places, objects, or activities because of anxiety or fear?

- 0 = None: I do not avoid places, situations, activities, or things because of fear.
- 1 = Infrequent: I avoid something once in a while, but will usually face the situation or confront the object. My lifestyle is not affected.
- 2 = Occasional: I have some fear of certain situations, places, or objects, but it is still manageable. My lifestyle has only changed in minor ways. I always or almost always avoid the things I fear when I'm alone, but can handle them if someone comes with me.
- 3 = Frequent: I have considerable fear and really try to avoid the things that frighten me. I have made significant changes in my life style to avoid the object, situation,

DESIGN OF THE RCT PHASE

Recruitment through collaborative referral process with clinic

Baseline eligibility assessment

Eligible participants randomized to either:

CALM ARC + UC (without family ed)	UC (with family ed)

Pre-treatment assessment

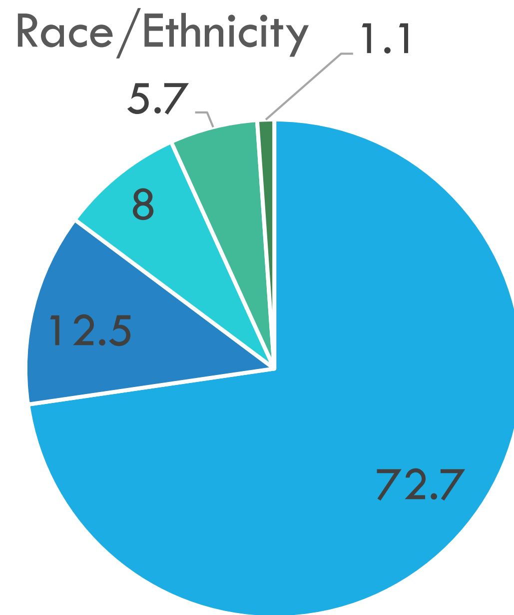
7 weeks of acute phase of treatment

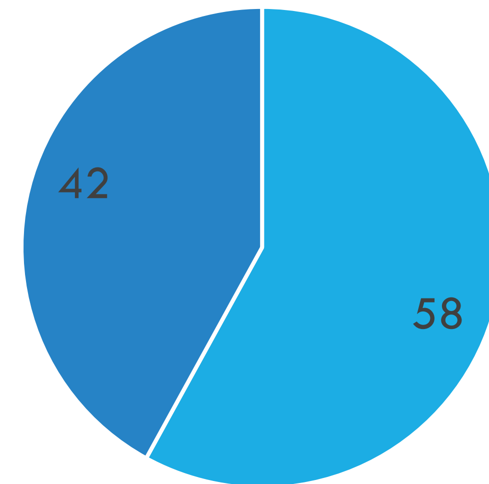
Weekly CALM ARC Sessions	Matched Weekly Assessment

Post-treatment assessment

6-month follow-up assessment

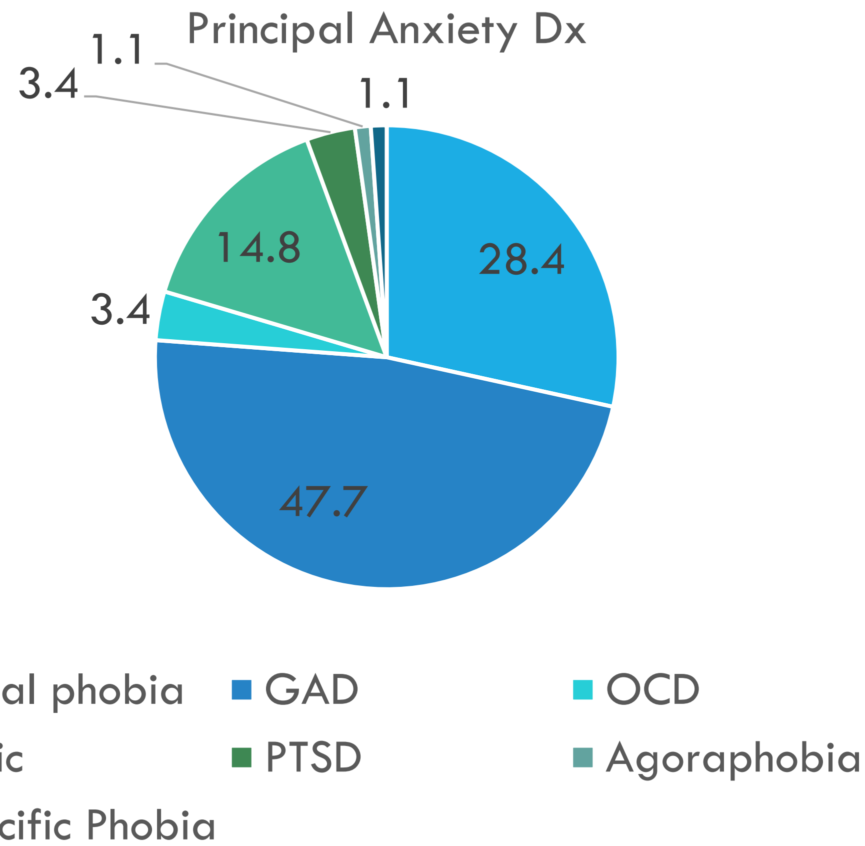
DESCRIPTION OF PARTICIPANT SAMPLE





Mean age = 36.24 (SD = 12.34)

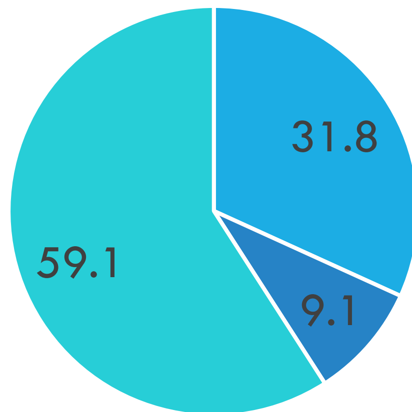
ANXIETY DISORDER DIAGNOSES AND COMORBIDITY

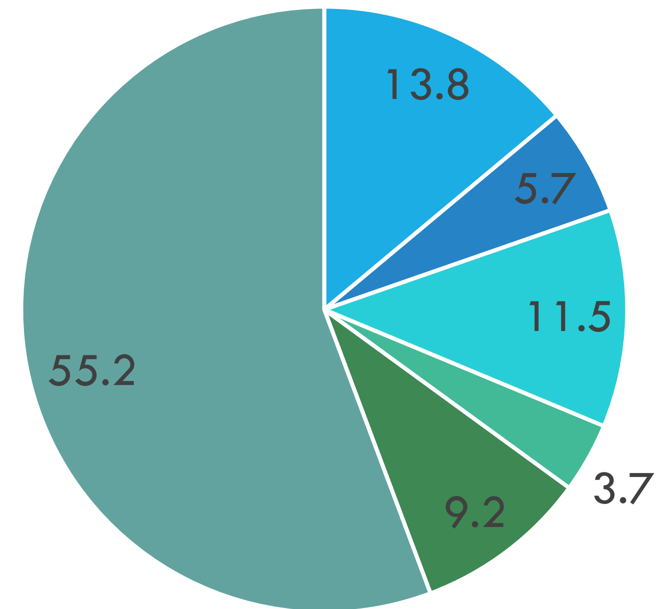


Mean number of anxiety disorder diagnoses = 2.42 (SD = 1.42)

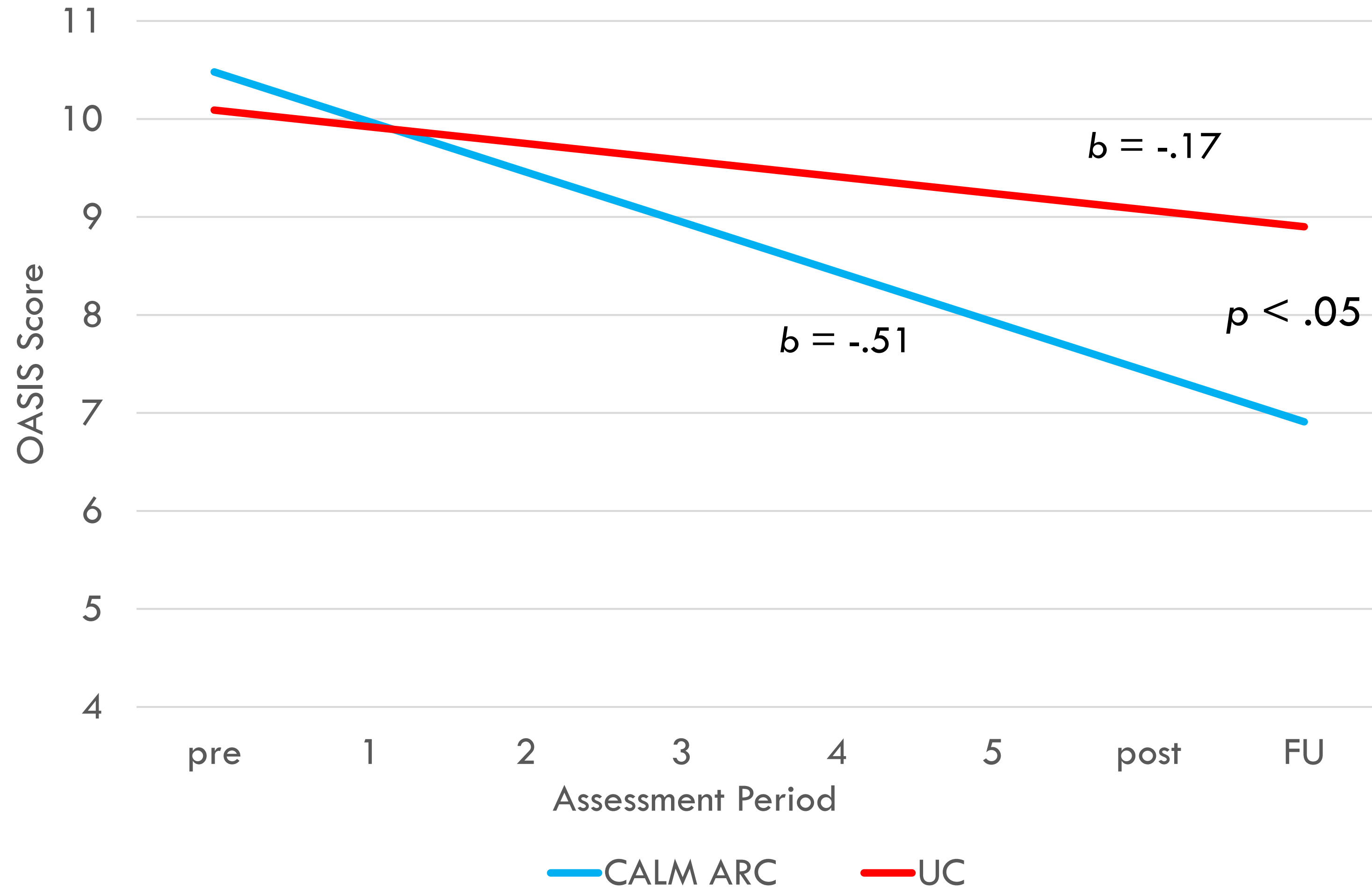
Comorbid *current* diagnoses:
Current MDE: 44.8%
Binge Eating Disorder: 19.5%
Bulimia Nervosa: 4.5%
Psychotic Symptoms: 1.1%
Anorexia Nervosa: 1.1%
Manic episode (past month): 2.3%

SUBSTANCE DIAGNOSES

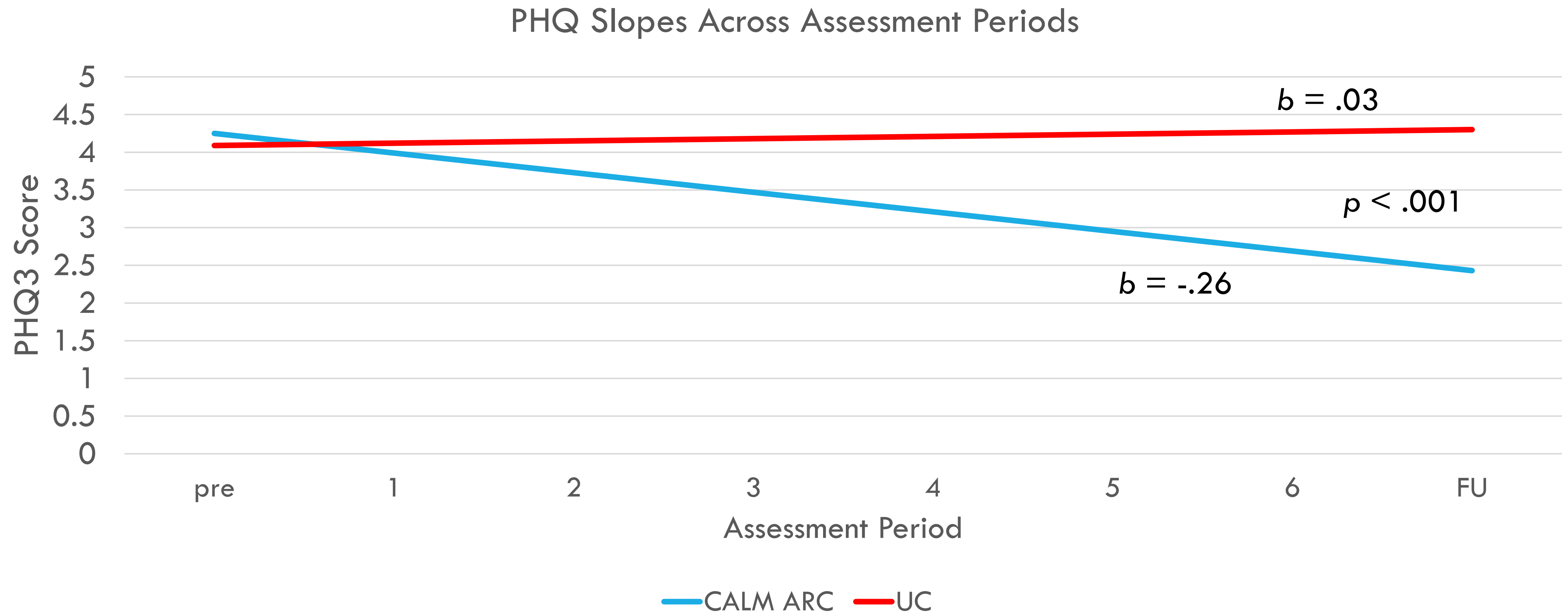




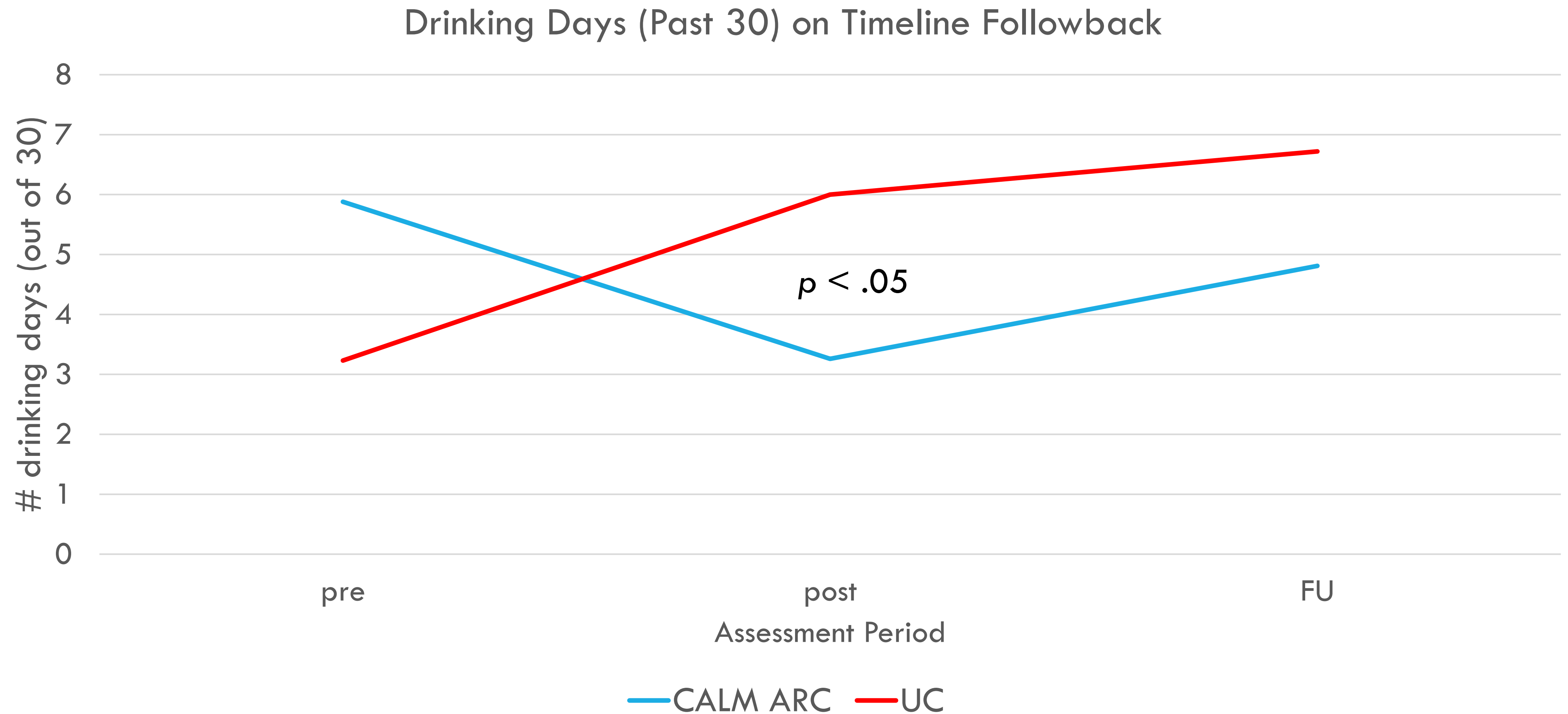
CHANGE IN ANXIETY SYMPTOMS OVER TIME



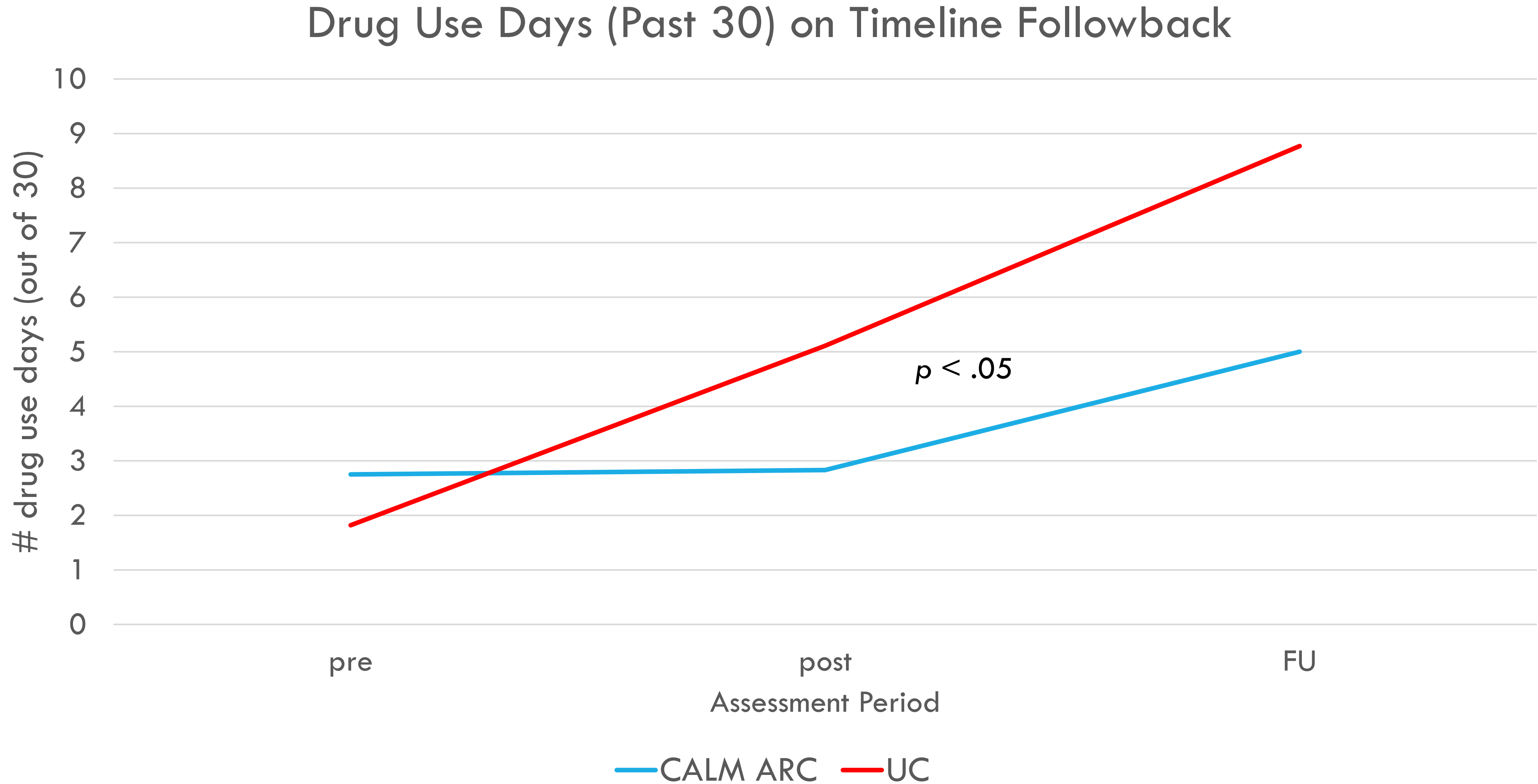
CHANGE IN DEPRESSION SEVERITY OVER TIME



SUBSTANCE USE OUTCOMES: DRINKING DAYS



SUBSTANCE USE OUTCOMES: DRUG USE DAYS



SUMMARY AND TAKE-HOME MESSAGE

- Feasible for addiction counselors to learn this treatment with this delivery method and to show high levels of adherence and competency
- Findings suggest a VERY BRIEF treatment, even with moderate engagement, improves anxiety outcomes and substance use outcomes
- CALM ARC outperformed UC on substance use variables

NEXT STEPS: ADDRESSING CHALLENGES AND IMPROVING INTEGRATION

HOW DO WE MAKE INTEGRATION ACTUALLY WORK IN OUR SYSTEMS OF CARE?

- We need to start at the beginning, with more integrated training of psychologists, psychiatrists, social workers, and masters' level clinicians
- System changes – hire people who can develop integrated programs, have this expertise, and can supervise clinicians to deliver this care
- Patients are already putting the demand on the system, we need to respond

FOR NOW, WHAT ARE SOME STRATEGIES YOU CAN USE

- Improve assessment/screening of psychiatric conditions in primary care and SUD settings, and do screening for SUD in mental health and primary care settings
- Once someone is identified as having comorbid SUD/mental health diagnoses, identify care:
  - Plan A is to find a fully integrated program (these are rare) that provides evidence-based treatment
  - Plan B is to find two concurrent programs that can coordinate with each other (this is more burdensome for the patient but more likely to be possible)
  - Not indicated: the “one at a time” approach
- Clinicians can also fill their own training gaps and apply these integrated skills to patients in individual therapy

FREQUENTLY ASKED QUESTIONS (FAQS)

1. Which of the following adaptations to typical anxiety care should be considered for successful integration in a SUD specialty clinic:

a. using a group format

b. making sure that patients understand what stimuli to approach vs. avoid

c. clear training protocols for clinicians

d. all of the above

2. Once a person has anxiety/depression and SUD, it doesn't matter which started first, they create a vicious cycle that should be addressed simultaneously.

True / False

FAQS

3. Which of the following is arguably the most effective component of CBT for anxiety disorders?

a. cognitive restructuring

b. breathing retraining

c. exposure to objectively safe, feared/avoided situations

d. psychoeducation

4. Name one limitation of current models of care with regard to treating co-occurring disorders.

ACCEPTABLE ANSWERS: mental health care does not include SUD care; SUD care does not assess or treat underlying anxiety/depression; people who are referred to get SUD care before getting mental health care usually do not end up getting the treatment they need/don't finish SUD care/don't come back to get mental health care; clinician training is siloed so people have expertise in mental health or SUD but not both; there are seemingly discrepant ways of viewing approach v. avoidance of cues that trigger fear/anxiety in the mental health world v. SUD world.

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