Title Treating Co-Occurring Disorders in Young Adults
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Moderator: Hello, everybody, and welcome to today's webinar, treating co-occurring disorders in young adults. Today's webinar is paid for by Newport Healthcare. Newport Healthcare is the national leader in teen and young adult behavioral health treatment providing sustainable healing for mental health and co-occurring disorders. Some important points before we get started.

Dr. Michael Roeske, the presenter for today's webinar, is a senior director at the Newport Healthcare Center for Research and Innovation. As such, he has both a financial and intellectual interest in the content. The purpose of this presentation is to provide a balanced view on co-occurring disorders in young adults. APA does not endorse any products or services. The content was created by Newport Healthcare and does not reflect the views of APA nor its editorial staff.

Please email advertising@apa.org if you would like to learn more. Next, this program does not offer CE. However, we will email everyone watching live today a certificate of attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes. A recording of this presentation will be emailed to everyone within the next two weeks. That email will also include a copy of today's presentation slides.

During our time together you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. If you have a question for our presenters, please type them in using that box located at the bottom of your screen. With that, I would like to introduce today's presenter Dr. Michael Roeske. He's a senior director at the Newport Healthcare Center for Research and Innovation.

As a licensed clinical psychologist, Dr. Roeske has worked and studied in a variety of treatment settings since 2003, including adult substance use disorder and adolescent mental health programs, community-based psychological services, and inpatient psychiatric hospitals. He is trained as a full battery assessor of children to older adults and has functioned as a supervisor, clinical director, educator, presenter, and operator. Welcome, Dr. Roeske.

Dr. Michael Roeske: Thank you. The things we're going to talk about today, we'll start with who we're talking about, why we're talking about them. Then we'll get into what I called common issues. It was a little long for the title to put in traditional behavioral health and substance use disorder treatment, but that's going to be primarily what I talk about is what happens in a lot of those environments.

It still happens in what we call integrated care, but it's a little bit more in a little bit more-- Handled a little better, I think, in that particular environment, but they still exist. The origins of this, in 2003, I was-- My first work in behavioral healthcare, and I was working with a young man who had been adjudicated to treatment as a condition of probation. He had a long history of pretty significant cocaine use and major depressive disorder.

One day, he just didn't show up to the appointment, and a couple of days later I got contacted to let me know that he had been arrested trying to purchase cocaine, I

guess the Friday evening before, and had managed to hang himself while in the holding cell over the weekend. Being a young clinician, you're sensitive to the risk component, and it just flooded me with a lot of questions.

Had I not assessed properly the suicidality? Was he at greater risk? Was he not disclosing any mood issues? Was he using- It's not uncommon for people to share information about how to beat drug testing. -or was it impulsive? The same thing with the suicide event. Was it just the situation where he was in the moment and felt really desperate and just doing?

In the time since, I've worked with young adults with co-occurring disorders in a lot of those environments that were described in the beginning, and the same questions that emerged in that early treatment experience I saw happen with colleagues in-- Then from an institutional or clinic perspective threw out. This emerges from that clinical experience and then my effort to understand whether or not these things are also being discussed by other people being identified.

Then treatment considerations, I'll try to tie it back into more concrete understanding about how you address these things, how I address these things, and then we'll end it with a case study. Young adults, the research typically defines that as 18 to 25-year-old. Obviously, we know, maturationally, a 30-year-old might get that, if we think about it developmentally. The case study I'm going to discuss as a 26-year-old in co-occurring disorders.

This is where you have a diagnosable DSM mental health disorder that is completely independent from a diagnosable substance use disorder. It's not simply a constellation of symptoms that might come from a substance use disorder. They're independent, and they have substances use disorder. All the substances have their own specific criteria, but they're pretty much the same across the 11 criteria, pretty much the same across all the substances.

The important point here is that this American Psychiatric Association then recognizes the chan-- The differences in severity. That's an important piece in my estimation, both from a treatment perspective and prognosis perspective. Then substance-induced mental disorders. These are, basically, what look like mental disorders that are the direct result of intoxication, taking the substance in, or from withdrawal.

It doesn't mean that there's not co-occurring disorders within there. It's just that at any particular time with what you're looking at, it is best explained as being the result of the substance. Fortunately, within a few hours or days, these disorders typically resolve themselves, remit. There are some outliers on there. I worked in the Bay Area where methamphetamine was a pretty concerning issue and so sometimes you have things like psychosis that don't really dissipate and can last for a couple years.

Then there's any mental illness. This is any diagnosable DSM disorder with the exception of developmental disorders or substance use disorders in the last 12 months. Then severe mental illness. This is where you have profound functional impairment. Each state has their own criteria that defines what SMI is. Often around

duration, diagnosis, severity. Some places include substance use disorder diagnosis, some places don't.

Why is this important? Well, you can just look at it from an epidemiological perspective. Anytime you have 4.5 million of anything in a particular population, it's something to pay attention to, so this is not an outlier group. These are people that many of us are in contact with. Probably within our own families. Certainly with friends of families. Lots of us have this experience with people that have these struggles.

Then you can see when it comes to even the more concerning, which is the severe mental illness, you can see it still almost occupies nearly two million people in the country per SAMHSA estimates. Which, again, is a fairly large population. When you have both of them together, and this is pretty intuitive, you end up with more profound functional impairment, higher morbidity, mortality, greater risk of completed suicides, greater risk of homelessness, incarceration, things like that.

Why else is this important? Well, one of them is they're just difficult to engage in treatment. Some people are young adult whisperers. They just really know this population and can really connect with them fairly easily. Generally speaking though, they can be difficult to connect with. They're also less likely to receive services than older adults. Then, perhaps, most concerning among any age group, they're the least likely to be insured, have a primary care physician, or receive any sort of preventative care.

The first issue, they're complex. Now, I know a lot of you are going to say, well, what patient isn't complex? I can name a dozen other populations that are really strikingly complex. Me saying that is the same as, maybe, saying water is wet or it's more light out during the day. What's the benefit of even saying that? My experience is, having worked a lot of different populations in different environments is, really, that maybe these are, let's stick to that, maybe wetter than most, maybe brighter than most.

One of the primary reasons is, when we think about diagnosis, we try to understand from a temporal perspective where this emerged, what's primary, what did we see and when. That helps us understand exactly what is happening and how to approach it from a treatment perspective. You can often tell. Sometimes it's very clear that the mental health condition preceded the substance use disorder. Other times, it's very clear that the substance use disorder preceded the mental health condition.

A lot of times, like in the case study that we're going to take a look at, it's not as clear the mental health was-- There weren't any periods of sobriety. The mental health coincided with the substance use. Then the other reason, and in part for the temporal issues, the bi-directional nature and other influences. Sometimes you have a mental health condition that helps initiate or exacerbates a substance use disorder or substance misuse, or the opposite of that, where you have substance misuse and it, ultimately, leads to mental health condi-- The initiation, the emergence, or the exacerbation of a mental health condition.

I think of, for example, also in the Bay Area at the time, with marijuana and psychotic disorders that were emerging in people that had no prodromal symptoms. They

weren't like schizotypal type of personalities prior to it and, next thing, you have this florid psychosis. Then they're not typically equal in severity, so a lot of times, one's more prominent than the other.

The challenge with that, the reason it creates complexity, is, especially if someone has a serious mental illness like psychosis or they're floridly manic, it really pushes the other one to the background, and you may not pay attention to it, you may not diagnose it. Then, in the same vein, different populations are more likely in different settings. You have biases about what you're looking for.

Obviously, if you're in an inpatient setting, you're more likely to see severe mental illness with a mild or moderate substance use disorder versus if you're in a primary SUD environment, you're more likely to see severe substance use disorders and then a mild or moderate mental health condition. To make matters a little more problematic, a lot of times, our diagnosis is based on what we see and what the client is telling us.

It seems most times, again, depending on the patient, they're fairly reliable historians, they will tell you what's happening. The problem is substance use disorders, as I mentioned, can appear the same as independent source, and that runs the gamut with mania, psychosis, depression, anxiety. In this sense, history, actually, is more important. Obviously, we still want to collect information from the patient.

If we could collateral information, that's great as well, in terms of what's currently happening, but a lot of times, what you do is you start to collect information. Do they have a previous diagnosis, have they had treatment experience before this? If you find a valid diagnosis, you do a presumptive-- You take the diagnosis as presumptively valid, and you consider what treatments were in place to help stabilize that person or that were helpful for them and you gather that information.

There are times, though, when there's no clear history. The person doesn't really have a lot of background information. They're, maybe, not a great historian, doesn't have a great memory with things, or there's, often the case with this population, you have multiple diagnoses that end up confusing the picture. You're not really sure what's going to be relied upon or thought about.

Then you have other things. You have physical diseases, hypothyroidism, commonly can come across as like depressive symptoms or great depression. Then you have just basic others social determinants. Stress is probably the biggest factor outside of-- I mean just in terms of the exacerbation of mental health in general, stress is certainly the primary one, and we know that's going to be the case for many types of established mental health diagnoses. You really struggle here with that.

Then what we do know, when it comes to co-occurring disorders, even with younger **[unintelligible 00:14:27]**, is it largely comes from research on White populations, people who look like myself. We really don't know a lot of other populations in terms of prevalence and how treatment approaches are. We estimate that it's less common, least common, among the major racial ethnic groups in Asian Americans,

but there's also indication or suspicion that we just, maybe, don't really have the data on it.

Based on this, there's gaps in behavioral health service, access, utilization, and completion among this group. You have basic challenges with language, fear of stigma. People have different appreciations for levels of trust when it comes to health care and Western medicine. How you communicate disease processes, how you attribute the origin of it, how you consider treatment, all those things. Then you have, certainly, shame can be part of it as well within certain ethnic or racial groups.

Ultimately, we think that, basically, it's under-assessed, underdiagnosed, and under-referred, so the literature is skewed in part because we just don't have the data for it. Even though, again, we think it's less prevalent in Asian Americans, we really don't know just because Whites are more commonly ones to approach treatment and have been involved in so many studies.

Given the complexity, how do you diagnose? I want to avoid as best I can, and as the moderator said in the beginning, have a balanced conversation. This is my opinion, this is also SAMHSA opinion. It's almost impossible to diagnose with ongoing user. The reason I say I don't have a balanced position, I certainly have a great deal of respect for harm reduction advocates, people that- We'll talk about harm reduction a little later. -but really recognize that there are a lot of people who will not participate in treatment, abstinence-based treatment, which is fairly common in the community.

What's better? To have some point of contact with somebody to help treat them versus not. Just, in my experience, and based upon looking at other people's expert opinions about it, it seems to be the case that you just aren't going to be able to tell exactly what's going on if the person's continuing to use, and so you do need a period of abstinence.

Now, certainly, what I said was historical data is important, so if you do have a person with a period of sobriety in the past, that is very helpful to help distinguish did the mental health symptoms continue, did they mitigate, did they increase. Certainly, I've mentioned in the beginning that original case for me that startled me and thrust me into really try to pay attention to this population, client safety is the most important one.

We use the Columbia. A lot of people use the Columbia. Just paying attention around suicidality. There's all sorts of screeners for this. I just picked some just as examples. Past our present mental health disorders and mental health screening form. The CAGE. Cut down, annoyed, guilty, eye-openers. It's also adapt for drugs. Trauma, primary care, PTSD 5. Functional impairment.

The standard of care, though, is the biopsychosocial model. Going with this idea, it really is this interplay of biological, sociological, psychological factors that contribute to the person's issues that result in their being in front of you in the office. It really is not only an assessment approach where you take consideration of all those particular factors, it's also an approach to care.

What I mean by that is, you have multiple voices in here. This is the the idea of the true treatment team where you have someone that can speak from the psychiatric perspective, someone that can speak from the psychological perspective, the addictions counseling perspective, dietary perspective. Regardless of what it is that's emerging.

I do want to make space here too from the important from the collateral perspective.

I put family history here. Obviously, that's a little more relevant for young adults, but there-- We certainly have young adults in our program that are married, have spouses, and so you need to shift a little bit from the family therapy perspective or the family history perspective. Maybe spousal as opposed to parents. Back here, going back to the diagnosis perspective, understanding heritage, history, experience, beliefs, ways of communicating, factors important to racial, ethnic, sexual, and gender identity groups.

I mentioned having been in the Bay Area for a while, and one of the things that I saw there in the gay male community was this interesting- I say interesting in that sort of of non-common definition, more psychology definition, sort of capture your attention as opposed to

something that you are looking forward to seeing. -there was an interplay between methamphetamine use and body image issues and depression that played in there. It was important for me to understand the role of exercise and fashion and different things that played into some peoples' interest in methamphetamine, which is an appetite suppressor, and then, conversely, the people that were involved in those behaviors tended to be somewhat familiar with each other. It was important for me to understand the relevance of all those things and how they interplayed together to be able to sit with one of those-- With a client like that and not come across as not-- To engage and connect with him.

Then the next one is a important one. I put in here Thomas Kuhn. You probably all heard of the paradigm shift. He is the one that popularized that term. I won't get into his whole philosophy of science. I just referenced it in there to-- Around his term of incommensurability. Basically, it can come from different paradigms. Let's say you come from a primary SUD environment.

That's where you did all your training, that's how you entered into the field, spent a lot of time there, versus primary mental health, you're going to see these things in entirely different lights and not realize you're talking about different-- You think you're talking about the same things, but in fact, the terms are different. There's a way in which you actually can't speak to someone very well that's coming from a different paradigm.

Probably the most common one is substance misuse is the primary issue. While there may be something else going on, we're not going to know until we stabilize them. They need to get into recovery and then we can see what remains. In the continuum of things, I could probably lean or skew over towards that direction versus the person who comes from the more primary mental health, less exposure to SUDs or severe SUDs.

Substance misuse is a mental health condition, and we need to address what is feeding the compulsion to use, what's leading to the behavior to begin with. We can't expect them to stabilize until then. Both of those are correct, both of those are going to emerge in these various environments as you work with colleagues. [silence] Then to make things even more confusing for people, there's three distinct models of care that come with this population.

The first one is the, historically, most common one and the one that I started out with which is sequential or serial treatment. You pick your path, you choose one. Okay, I'm going to treat the substance use disorder, going back to those differences of opinion that I just gave towards those two colleagues. I'm going to pick my path. I'm going to treat the substance use disorder knowing I need to stabilize that first.

Part of the idea here, like if I think about the high incidence of trauma or the high correlation of trauma, especially in severe substance use disorders, and you think about treating the trauma, most trauma treatments, as we know, is some form of exposure therapy where you end up with the potential for affect dysregulation. Here you have a person who is, potentially, using substances to regulate affect, that is using it to improve mood, and you're giving them a treatment that dysregulates them, that makes them feel unsafe, that impacts their move negatively.

The concern would be that they're going to use as a result, they're going to discontinue treatment, they're going to disengage in all those different ideas. On the other side of it, you have people that think the opposite of that. Hey, if I don't treat the trauma, I'm not too worried about the SUD. My expectation is that if I treat the trauma, if the SUD is still prevalent there at the end, we can treat that afterwards, or we can send them out to specialized treatment.

Then there's simultaneous or parallel treatment. I've been in these environments as well. This is where you have a particular model that you have at your clinic or location or facility, but then you partner, let's say, with someone in the community. This is also fairly common where I worked. I was a clinical director and primary residential for SUDs, but they were co-occurring, but we didn't have an on-staff psychiatrist, and so, if it really was clear that they needed a referral, we had to refer out.

We would send them out. We had a relationship with a couple of psychiatric providers in the community. We'd send them out there, they would assess, we would collaborate, and then they'd make a medication recommendation or not. Then the last one, it really has become what the- Back to the bio-psychosocial. - kind of the desired standard of care, which is an integrated approach. I've also worked there.

When I think about my company, I think we identify as an integrated model of care. We have staff psychiatrist. Typically, master's level, like LPC, LMFT. Not as many psychologists on staff. Then dieticians and nursing and various participants, and they all seem to work pretty well together. We still skew a little bit closer to the primary mental health side but, again, we have all the people that are there. SUD treatment, various things.

This has demonstrated superiority both in terms of cost of care, patient satisfaction, and then other outcomes. The question becomes, well, what if you're working at a place that doesn't have integrated care? Go back to that original place where I worked which was it didn't have integrated care. I think back, should I have referred him out? Should he have been at a different place? Had I not been clearly aware of what his needs were?

Well, the fact is, and I know this is a 2011 reference-- I probably should try to find something more relevant, because it may have changed. I say that because, when we get to the case study at the end, this is, again, early on. You have this young adult co-occurring disorders, it really-- There weren't a lot of options. It was an inpatient environment. There weren't a lot of options for a step-down environment. Typically, SUD was the most common one available.

Certainly, at the time that Sterling was writing this, it was just not-- Rarely within one system where everything is contained where you have one service delivery with all the different people. Ultimately, as SAMHSA points out, there's no wrong door. Really, the important thing is the engagement. Ultimately, it was appropriate that that young man was in my office, and I could try to assess and help them.

Really, that's kind of the idea about it. Doesn't really matter if, again, you're integrated, if you're sequential, if you're either of the three. Whatever the environment is, pyro practice, there's really no wrong door to it. You can help them. One of the primary reasons that you can make that claim, and this is not an issue. It's kind of cliche at this point.

It's a lot about the relationship independent of whether or not you're primary mental health or primary SUD or integrated care or if you're motivational enhancement therapy or CBT adherent or psychodynamic, a lot of the variable in terms of how you're going to be helpful is about the relationship. SAMHSA puts it out there as fairly clear. It's the cornerstone of care. How do you connect? Do they trust you? Do you trust them? How do you communicate when there's the breakdown in that?

He said, really, again from the Kelly-- Example of the Kelly Review, strong essential factor in supporting recovery. It just, again, more verification of this different study here by Dison. He saw improved symptoms and functioning, engagement, satisfaction in quality of life indicators when you had a strong therapeutic alliance. Now, one of the questions that emerges is, considering the concordance with trauma histories, well, what about people with PTSD? Is there a barrier to developing a strong alliance with that population?

Obviously, many of them have trust issues, and rightly so. They can get affectively dysregulated like I mentioned, or they can be affectively flat. Regardless, it can be difficult for them to connect to people, especially authority figures, where they have to be vulnerable. It's not an egalitarian relationship, and so this meta-analysis by Howard from last year took a look at that.

They used the Working Alliance Inventory, the same one we use, and found that not only was it relevant for outcomes like it finds in other populations, it actually was vitally important and people could develop strong therapeutic alliances with people

with PTSD. Then I put a couple of links in here for guidance. You have Division 12 that provides evidence-based approaches for-- You can look up for trauma treatments and PTSD.

Then APA has explicit guidelines for PTSD. If you do download the slide deck, you'll have access to that, or you can just go online to the APA website and take a look at it. The other common issue that I've experienced, and again, SAMHSA recognized, was that these clients can make you uncomfortable. A lot of this, in my belief, is based on where you work, your training, your biases, what brought you into the field in the same way the severity of disorders.

I did two years of clinical training in psychiatric hospitals, and I remember very quickly, myself and my peers, you knew very quickly whether or not,` people with severe mental illness, those were your people or not. It can be really disorganizing. You can be very uncomfortable. Especially when people are floridly psychotic or just really rampantly manic. It can be disorienting.

In my explanation, you have to be comfortable with your own psychotic parts of self at times. You have to be able to identify with some of it, and I think that can be a bit threatening for some people. I liked working that population. Again, there are people who were like, no, give me your more neurotic-level client. I prefer working on insight and more of a collaborative relationship.

What you want to do is you want to invite those feelings in of discomfort and reluctance. One of the things that I do that-- When I supervise, I work in the research arm right now, and I've had for a couple of years, but I still supervise psych associates that work in these environments, and I invite them to bring in transference and counter-transference. Those are psychoanalytic terms, but most of us, those are commonly used in the field.

Maybe a little more comfortable or more familiar with attachment theory and internal working models. The primary idea is that our early attachment relationship figures could transfer it onto the therapist is the transference. Then the counter-transference is, well, I have my own experiences with attachment figures and what I expect people to behave like and who I tend to gravitate toward, and they're asking me to play a particular role in this transference, and now I'm going to react in kind.

Racker, some of you may be familiar with his-- Again, I find it useful clinically to help you respond to treatment, to help guide you as you do evidence-based therapies. Concordant is where you experience the client in the same way that they experienced the early caregiver. For them, you've kind of empathically. Let's say, for example, they had a very strict demanding father, biological father. They didn't give a lot of praise, they had tended to be critical, they had really high expectations.

They were disappointed, and so the result was the client tended to avoid engagement with the father. They tended to feel shame, felt shut down, didn't talk a whole lot. Chose not to go into certain vocations or whatever the result. That is important for me to understand. As I'm feeling that, let's say during the course of treatment the patient starts to-- I start to experience the client's being critical of me

and that I feel like I'm not doing enough, that I'm not being helpful enough, that they're judging me.

Again, it might just be that that's true. Maybe I'm not doing enough, and it's not a transference response. There's certainly some people who talk about those reality-based responses. My experiences is still filtered in there. Anyway, it's important for me because that helps me to empathize with the client to understand what it was like for them in their early years, and it helps me also look for pitfalls that are, potentially, in the treatment.

Then complementary, this is unemphatically from the client. This is where going back to that same withholding demanding father figure. Let's say for example, I start to get irritated with the client where I feel like they're not trying hard enough, they're not really listening to what I'm saying, they just are shrinking in all this, and I feel this increasing desire to be critical. Again, that's very, very helpful.

What I do experience is you have to be alert to these actors in a role that you get pulled into. People may have different levels of comfort with the idea of transference and counter-transference, but certainly, the literature, for example, going back to internal working models, when we look at attachment theory and attachment styles and then our choice of romantic partners, or if you think about your own experiences with how you've--

A common cliche would be you can go into a room of 50 people that are strangers with the intent of finding a romantic partner. By the end of the night, you find this exact same replica of the person you just got out of a have a relationship with. It happens, and it helps you respond and know your role. Additionally, these clients may be dishonest.

Those of you that have worked a lot with primary SUD or people with personality disorders or personality disorder features, you're more comfortable or more expecting dishonesty or evasion or denial or minimization or maximization. Any of the various ways in which you're left with a sense of, I'm not really sure what's truth or not truth or if they're being honest.

That can be really uncomfortable for people, and the way that I work with supervisees is, really, just to normalize it and it's just information. Just to view it as a symptom of CODs, and an expectation of CODs. That they're going to engage in those type of things not because they're not interested in therapy, though that could be the case, or not because they're incapable of therapy, but because it tends to come along with the constellation of syn-- It's more syndromy than a very, maybe, narrow diagnostic perspective of which dishonesty, minimization and things emerge.

How do you deal with that? I think a lot of times, particularly early career clinicians in my experience, they're so focused, They know the importance of the therapy alliance, so they're so focused on being empathic that they don't want to rupture that. They don't want to do or say things that are going to, potentially, create somebody that doesn't come to treatment anymore or stops engaging in treatment, or doesn't like them.

Part of it is that a lot of us have a familiarity with confrontation that are depicted as aggressive. I think it's like Nar-Anon was a common-- Or therapeutic communities. Look what you've done to your family, or interventions that list out complaints about the person's behavior and they need to change. What we typically know is that that's not terribly helpful.

Obviously, it's intuitive, and this is Bill Miller that I'm referencing here, the found-- Co-model developer of motivational interviewing and motivational enhancement therapy, breakdown therapy. What I do want to point us back to, and those of you that, again, worked in the primary SUD world, but you know confrontation is needed, and this Polcin article talked about how it can be recast as a supportive honest approach.

Again, not an aggressive confrontational style of, you're going to listen to what I say and you're going to adopt my view of your life, but from the perspective of, if things don't make sense, if you have an intuitive sense that there's just not something adding up-- I say this to families all the time, with caretakers. If your radar is suspecting something's off, 9 times out of 10 you're right.

In fact, going back to this idea of impatient and really disorganized people, it actually does-- Like with- I'm a parent. - or with a child, if you don't provide clear guidance and structure, it actually can make a child feel worse or more fearful or the young adult in this case, so it actually is really important to be able to speak to those things. Hey, I get it, but here's what's not added up for me. It actually, in my estimation, is important to do.

Going back to that initial case where I had, that's probably something where I probably would've done something differently. Again, I didn't necessarily see in the postmortem on that that there were a lot of indications, but I think I was fairly trusting in terms of what he was telling me in a way that I learned subsequent to that that I probably shouldn't have been.

Then I go into humor here. I could have put this in other parts of here, but I just think humor's underrated, undiscussed, it's understudied. Now, there are particular humor interventions. I know that there are some studies that I've looked at. Just in general, and most of us know how to do this. I think you're either humorous or you're not. It's hard to pick up a humorous bone. I often use humor. Particularly when there's a need for confrontation.

Those of you that have ever attended an open 12-step meeting or a closed 12-step meeting, and if you identify as being in recovery, a lot of times people are just confused at how people can laugh at tragic events and conversations. Now, it's not that you're going to belittle or trivialize really tragic things, but it's important to be able to display humor, to talk about humor, and it is a way to disarm people and get people to share.

An example of that would be I might share examples of really crazy things that people have done to maintain their use. I had an example. It was before my time at that outpatient clinic. I talked about where I had a-- There was a physician that used to catheterize himself, put in clean urine prior to submitting the urinary analysis. The

only way they found it was they suspected he was using, they couldn't figure it out. They would watch the urine come out.

They found a substance, they did a larger lab analysis, and they found petroleum jelly. The lubricant or whatever it is that lubricates for a catheter, they found that in there, made that-- Then talked to him about that and he acknowledged it. The other piece in here is just I do Colombo a lot. Let me get this straight. Again, it has a lot to do with your personality and how comfortable you are with that, but I have found those things very, very useful. Especially when I'm concerned, or I think something's off.

Than another issue is the position of substance use is often driven by policy. I got into working with the most severe substance users, and so I ignored a lot of the natural remission, natural recovery, spontaneous remission literature. People would send me these articles by the Sobells who were doing stuff in Canada, have these very large titles. People get sober from disorders without treatment.

They had a lot of good evidence for it. Like 75% of people were not having problematic drinking without treatment, and were moderately drinking. Now, the challenge is, when you get into the lit, one, it self-report. I mentioned they're not great reporters. The other piece, when get into it, though, then they hit-- I think it's in the limitation section, but there's a small subset of people for whom that are more severe.

They didn't assess for a severity that are chronic in relapsing, and they probably do need treatment. It's like, well, that's-- Yes, that's what the literature says. Harm reduction advocacy. This started to emerge in the '90s, in the '80s with HIV. The primary idea on this is that it matches young people's positive views of substances and abstinence-based programs don't. Again, going back to this idea, again, a lot of times, though, it's controlled by policies controlled by your clinic.

This is more flexible if you have private practice, but even then you run into problems when it comes to referral. SUDs, though, ultimately, when you look at larger windows, like three-year timetables, this a longitudinal study by Fleury, people, they too tend to be more chronic than acute. When you do have more severe in certain adolescence, they tend not to transition out like this. Looked at studies from adolescents to 35 to 50. Just something to think about when it comes to treatment approaches.

I want to move to a case study here so that we have some time to Q&A a little bit and get through it. This was a client I had at-- While I was an inpatient. He lived with his parents. He was a 26-year-old white male, grew up in affluent neighborhood, went to boarding school, did one year of college, lived with his parents. Described his father and being able to handle his use. He had to comfort his mother when she was-- He felt like she was brittle.

Again, important information. What kind of therapist was I going to be? Was I going to be the one who was knowing or was I going to be the one who gets excited or concerned about the things he tells me? No known family history of mental health around substance use disorders, but they were hyper-religious, so there was some

suspicion about a grandfather possibly having a drinking issue and possibly aunt that may have committed suicide.

There were hush conversations. He was young. No one ever talked about it. The father was implicated an embezzlement scheme at the age of eight, and so now I'm also thinking, am I the knowing collaborative therapist, but I also have a secret, or I might disappoint him in any moment? He began using at the age of 12. Few periods of abstinence since. He also learned that he could get-- If he was liked, he was very charming, he could get away with misbehavior.

Again, very informative to me in terms of how to conduct a therapy. Will he try to charm me, will I be charmed, will I try to not confront him with his behavior because this is what he will pull people to do? In fact, that was the case. I liked him, the medical director liked him. He would go through really long periods of feeling depressed. Wouldn't go to bed for days at a time, just miserable.

Reason for referral. This was his second hospitalization for danger to self. He had tried to commit suicide about six months earlier by OD. The problem was when he was drinking heavily, he would become suicidal, and then he was afraid that he was going to try to OD on heroin again. This was long before fentanyl was so prevalent in the community, but he was not using heroin very often, so he didn't have much tolerance for it, so it was a real risk.

The question a medical would have for me is like, is this true major depressive disorder or is it substance induced? He was given a recommendation for PHP and meds. He was non-compliant with both of them previous to that. He was given the MDD diagnosis and polysubstance dependence. No temporal clarity like I spoke about. What he said prior to this is, "I did well for a while, and I started looking for a job. I had his relationship and we started drinking, and ever since then, I've been drinking daily and using heroin off and on."

Then the week come up, he just has real intense desire to die. He was afraid when he was drinking he was going to shoot up and try to kill himself. Nothing remarkable in the medical history. Normal labs. When I met with him, very pleasant, very engaging, good eye contact, oriented times four. No report of HI or SI, cognitively, he appeared better than average. Good recall. No evidence of hallucinations or delusions.

I reviewed the med records, gave a clinical interview, discussed it with the treatment team. I gave him the trail-making test for rote memory and executive functioning. I gave him the WRAT3 just to get a sense of-- Only did one year of college. Maybe he didn't really try in high school. Maybe he wasn't very good at basic reading and writing. Gave him the Beck for depression. I gave him the aggression questionnaire and then the MMPI and the Rorschach.

Cognitive measures, he was. He was I think two standard deviations better on the WAIS, so he had like a 133 IQ or something like that. I can't remember quite hand. Clinical measures. Major depressive disorder, recurrent. Moderate alcohol use disorder, severe. Abuse disorder, mild. On projective measures, he saw things the

way other people do. Insight, inappropriate and appropriate behavior which is, again, what we want from somebody.

Helpful. Again, we can develop that observing ego about who he is and how he's being experienced. On various measures, though, he just had a lot of problems adjusting to conventional expectations. There was also a lot of indication that he just might come across, again, and he said this, more friendly than he is. He might actually not really connect. He might get dysregulated, he might be distrustful, and all those things.

If we were in a, maybe, a live environment, this is where I would have a separate slide where I say, okay, what do you think? Obviously, this is just a case study with not enough information, and you don't have the person in front of you, but do you think MDD, do you think substance induced? Would you recommend abstinence for this person? What kind of treatment environment? How would you engage with this person?

What kind of polls do you think you would have? What kind of affective response would you-- Do you think you would have with him? I, ultimately, gave him a substance use mood disorder, I think if I were to do it again I probably would give MDD, but the problem was I was sitting with him, across from him, and he didn't look-- He came across as not depressed even though he endorsed a lot of the indicators, but again, he had the ability to hide.

Actually, I think that's incorrect. I think it would've been AUD dependence. This is DSM-IV. Tend to externalize and intellectualize, so you want to provide a clearly defined and well-structured therapy. Here's what it is, here's what we're going to do. Over efforts at rapport-building you're going to fail. I can't also try to be too cool. I was close in age to him at the time, I looked like him, I liked him, so it really still favored straightforward conversation.

I said things like this. Like, "It seems like you're doing well." That concerns me though because I don't know that you would tell me if it's the other way around. Maybe you think I can help and that's probably fair, I'm a doctoral student. How much am I really going to be able to impact all of this? I say risky because I do think talking about the relationship directly, a lot of clients can do really well with that. Some clients, it blows them out of the room. Again, with this guy, with the trustworthiness, how would he respond to that?

I liked him. There was a pull not to address certain things with him. I just wanted him, primarily, I want to get him to the next treatment experience. Additional recommendations and thoughts. With him based on his history and what appeared to be likely family history and the trauma experience, harm reduction's unlikely to work.

I do think he's someone that needs to be stable, yes, abstinent.

He's not going to do well with efforts at moderation. If he does, it's going to be for a short period of time. Also would benefit from a step-down treatment. At the time there were-- His real option for residential care was a primary SUD. There are more. There weren't a lot of places like what we have now, or we certainly see it on the

landscape more and more of these co-occurring and primary mental health residential programs for young adults, but it really wasn't a lot back then.

He would do well in mutual health group, like 12-step fits. Even Celebrate or LifeRing or different-- If there's secular or non-12-step based programs, he probably do really well with those, even with the mental health issues. Then I definitely think he would just thrive in a sober living environment where he is just around other people with structure. The expectation to go to work and do different things.

Then mentors, positive adult figures, and you're like, but that's true for everybody, but certainly for someone like this, really with him, monitoring and getting people in his life that are going to, again, be positive and mentors. He's going to need ongoing support. This is not an acute condition with him. This is a chronic condition. He's going to be susceptible to resuming with the substance use. He's probably going to have recurrent depressive episodes or the potential for depressive episodes.

In the end, this is a client, and I've seen it over the years that really can flourish and exceed all expectations. Really, kind of an interesting character. I realize we're running out of time here. Just, again, as a summation here, really important population. Difficult, confusing, lot of common challenges that exist within our different environments. I recommend keeping the treatment considerations very simple. Ultimately each case is unique. Just really, the person in front of you, it's important that they're there, and just do your best.

I think this is where we go to the Q&A page. I don't know if it's at the end here.

Moderator: Yes. Thank you so much, Dr. Roeske. We do have a few questions that have come in. One being, what is the best way for families to find a suitable treatment facility for young adults with co-occurring disorders?

Dr. Roeske: That's a great question. As we know, like everything else, what do we do? We go to Google and you try to look at reviews, and you get a sense of different things. It really is very, very difficult. My feeling, it's the same as trying to find an individual therapist or maybe going with the idea of dating. If you have word of mouth, if you have people that you're familiar with, if you have colleagues that you trust, if you have experiences, that's generally going to be the best approach.

There are a lot more options for people at this point. It's very, very difficult for families, though. Again, they're young adults. It gets really kind of conflicting in terms of what they're-- A lot of difference in terms of how involved they are, how dependent the young adults are to them financially, emotionally, and otherwise, but it is very difficult.

Moderator: Thank you. Are there any treatment modalities that are considered more effective with co-occurring disorders?

Dr. Roeske: Yes and no. It goes back to a little bit of the common factors when it comes to the treatment. Certainly, when it comes to the substance use disorder piece, trying to amplify a conflict with people who have at motivational enhancement

therapy. Then, from the mental health side, the things that you're likely doing or you know work.

Like for example, we have a heavy emphasis in EMDR for adverse life experience and people with adverse life experiences, and so that would be an appropriate modality. Obviously, things with DBT and CBT that help with affect regulation. ACT is a really good one to get to the relational piece to negative thoughts and experiences. Going back to that, though, it really comes down to the relationship and not as much about the particular treatment approach.

Moderator: Kind of piggybacking off of that, how do you best prioritize your treatment goals for co-occurring disorders outside of, perhaps, the most obvious forerunner?

Dr. Roeske: Yes, that's a great question. Like with anything it's- Like with my client I talked about from 2003. -you start with the safety-- Wait, could we do this on anybody? Do over the safety piece. That also helps guide the treatment recommendation. One of the primary reasons that you send someone to resi-- Inpatient, in particular, is because you're just really concerned about what they're going to do if they're not in a really structured, constantly supervised environment, and so you take a look at that. What kind of level of supervision do they need? Are they able to be on their own in a particular environment, or how do you think they would do in various intensities of service? Then, I do look at it from the perspective knowing that they are disproportionately severe typically. I do typically look at it from that perspective, so if the substance use is forward, if it's really like a primary thing, that will be an intervention for me.

I typically do put out the biggest fire first. Obviously, integrated care was talked about. Then you kind of go down the scale from there. Again, if someone is floridly manic, I can't do anything around the substance use until a psychiatrist comes in and hits them with Zydis, and then it gets them on Depakote to get them stabilized.

Moderator: We had a question come in that was based on the case study you shared. Do you ever see a correlation between patients with higher IQs and if they do seem to test better? How does that play into treatment?

Dr. Roeske: Test better in terms of like with respect to the psychopathology?

Moderator: All it says is, do they seem to test better? Whatever you think. That's the question there.

Dr. Roeske: I can say in general that higher IQ clients tend to fit into the more difficult range. In part because a lot of them do have trauma histories, so they tend to be somewhat suspect of authority figures of which IE or EG the therapist occupies, and so they tend to outthink, overthink, try to guess the game when it comes to assessments. This is where I use motivational enhancement therapy. I roll with it.

If they need to be the smartest person in the room, I let them be that, and I'll talk about that piece of it, about that pull on it. They do tend to be more difficult and, at

times, exacerbating. Potentially great, because if they focus in the right direction, they can really get the insight and be motivated for change.

Moderator: All right, well I think that was our last question. It's all we have time for today, unfortunately. Thank you so much for joining us, Dr. Roeske, and thank you to all of our listeners for your participation today. We'd like to thank Newport Healthcare for making this webinar possible. As we mentioned at the beginning, a recording of today's presentation will be emailed to everyone within the next two weeks, and that email will also include a copy of the presentation slide.

As soon as the webinar has ended, a short survey will appear on your screen, and we ask that you take that survey and give us your feedback to inform our future programs.

With that, thank you again for your attention, and we hope you have a wonderful rest of your day.

Dr. Roeske: Thank you.

[00:58:42] [END OF AUDIO]