

How to Recognize Eating Disorder Behaviors in the Substance Abuse Population and Integrated Treatment



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CO-OCCURRING STATISTICS

- Approximately 50% of individuals with an Eating Disorder (ED) are abusing prescription or over-the-counter medications, illicit drugs, and/or alcohol, which is 5 times the abuse rates seen in the general population (The National Center on Addiction and Substance Abuse).
- People with Substance Use Disorder (SUD) are 10x more likely to have an ED.
- Lifetime rates of any SUD in the various ED subgroups were as follows:
 - Anorexia Nervosa (AN), 27.0%
 - Bulimia Nervosa (BN), 36.8%
 - Binge Eating Disorder (BED) 35%(National Comorbidity Survey Replication Hudson, Hiripi, Pope, & Kessler, 2007)

CO-OCCURRING STATISTICS (CONT'D)

- Both have high Standardized Mortality Ratios (SMRs) due to medical complications and suicide.
 - Can be difficult to treat when they occur
- As eating disorder symptoms become more severe the number of different substances used increases (Prian & Robinson, 2006).
- Up to 30 million people of all ages and genders suffer from an eating disorder within the USA.
- OSFED (but not AN or BN) was significantly more common in people with SUD than without SUD.
- Eating Disorders have the highest mortality rate out of any mental health issues
- AN and SUD comorbidity have a higher suicide rate.

EATING DISORDER TREATMENT DISPARITY

2,913 acute care hospital beds for every one million U.S. residents.

2913

1,400 psychiatric beds available for every one million people diagnosed with a psychiatric disorder.

1400

Only 224 eating disorder beds available for every one million people diagnosed with an eating disorder.

224

Accute Beds / One Million US Residents

Psych Beds / One Million Psych Population

E.D. Beds / One Million E.D. Population

EATING DISORDERS DIAGNOSES

- **Anorexia Nervosa:** Characterized by self-starvation and excessive weight loss. AN is divided into two diagnostic categories, restrictive anorexia and binge/purge anorexia.
- **Bulimia Nervosa:** Characterized by a cycle of bingeing and compensatory behaviors, such as self-induced vomiting, laxative abuse or exercising, designed to compensate for the effects of binge eating.
- **Binge Eating Disorder:** Characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.
- **Other Specified Feeding or Eating Disorder (OSFED):** Refers to abnormal eating or feeding without all the symptoms needed to be diagnosed with anorexia, bulimia or binge eating disorder. EG. Night eating syndrome.
- **Avoidant/Restrictive Food Intake Disorder (ARFID):** Usually found in childhood or infancy but can also be found in adults.

BEHAVIORS THAT MAY BE INDICATIVE OF EATING DISORDERS

- Consistently leaving the table within ten minutes after eating a meal
- Stirring or playing with food rather than eating
- Skipping meals consistently
- Skipping a meal then over-eating at another meal
- Consistently tired or fatigued
- Consistently setting and communicating goals around getting physically “healthy”
- Exercising despite physical injuries
- Exercising more than 1.5 hours a day more than 4-5 days a week
- Restricting foods or food groups
- Talking about particular foods as “good” or “bad”
- Expressing concerns about being or becoming fat
- Gaining weight in treatment
- Inordinate amounts of conversation about food, weight, the body, and calorie intake
- Rigid eating patterns

STUDIES SUGGEST

“...that it is important for clinicians to consider and screen for subthreshold levels of Eating Disorders in addition to formal Eating Disorder diagnoses. Moreover, assessment of co-occurring subthreshold eating problems may facilitate earlier intervention to prevent later development of the full-blown disorder.”

<http://pubs.niaaa.nih.gov/publications/arh26-2/151-160.htm#.VA4QNdegjcs.email>

EATING DISORDERS CAN HIDE BEHIND SUBSTANCE ABUSE DISORDERS

- Many patients who suffer from substance abuse exhibit eating disorder behaviors that can often remain **undetected by his or her treatment team.**
- Initially substance abuse may **mask** eating disorder behaviors, or be utilized as part of the eating disorder pattern.
- As individuals with addictions and/or compulsive tendencies enter into abstinence, they may reach toward other **numbing mechanisms** such as eating disorder behaviors to help them cope with the unwanted thoughts, feelings and memories that emerge.

UNDERLYING PERSONALITY CHARACTERISTICS

Co-occurring population tends to be characterized by:

- **High Harm avoidance:**
 - Self-consciousness and hypersensitive
 - Result: anxiety management
- **Low Self-directedness:**
 - Strong feelings of insecurity, inadequacy, fragile ego
 - Result: uncertainty, disconnect with values
- **High Novelty seeking:**
 - Higher among SUD population; seen with BN
 - Result: boredom, quick with emotions

SCREENING: SCOFF QUESTIONNAIRE

The SCOFF Questionnaire has been validated in primary care practices and is a good tool given the short time it takes and ease of application.

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14 lb) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

Note: Free SUD book from SAMHSA with ED Assessment “EAT-26”

“TIP 45: Detoxification and Substance Abuse Treatment”

or go to: <http://www.eat-26.com/>



WHAT TO SAY AND WHAT NOT TO SAY

DO:

- What do you think about your body?
- Do you diet or attempt to lose weight in other ways?
- Do worries about eating or your body affect your day to day life?
- Do you ever try to make up for or “spend” calories after eating to keep from gaining weight?
- Do you ever feel out of control when eating or eating for reasons other than being physically hungry?

DON'T:

- You don't look like you have an eating disorder
- I could stand to lose some weight myself
- You look good
- You look healthy
- Just eat healthier foods
- You don't look fat
- You are too skinny

SIMILARITIES

- ED and SUD both typically begin in adolescence or early adulthood, include behaviors which may function to maintain the disorder despite harmful consequences, have a high tendency to relapse, and alter the way the individual relates to others (Goodman, 2008)
- High mortality rates - life-threatening disorders
- Long-term illnesses
- Moral issue- Why don't they just eat? or Why don't they just stop using?
- Denial, secrecy and shame
- Comorbidity such as anxiety, depression, and bipolar

SIMILARITIES

- Behavioral symptoms:
 - difficulty managing tension, impulsivity, compulsivity and preoccupation with behavior
- Neurobiology –
 - Similarities in brain circuitry and the reward path-limbic system
- Both disorders involve disruption in appetite and satiation, obsessive-compulsive behavior, self-destructive behavior and severe medical consequences. (APA 1994)

SIMILARITIES

Progression

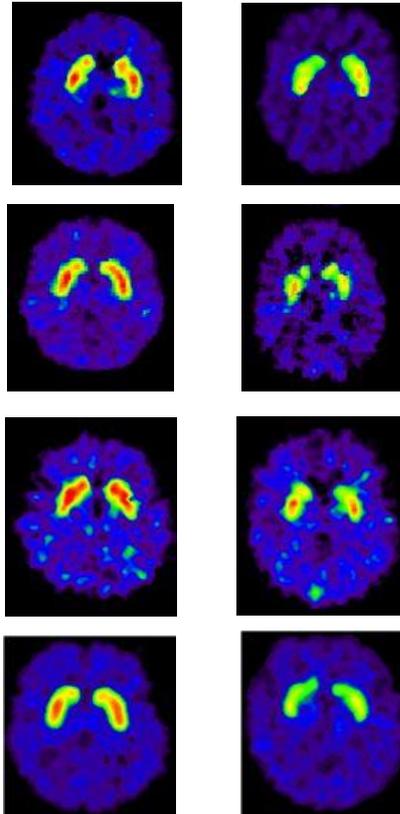
- Loss of control
- Resistant to treatment
- Continuing to use despite negative consequences
- Progressive illness- increased amounts of substance or behavior is needed to achieve the same result
- Frequent relapses

Risk Factors

- Family history
- Genetic history
- History of trauma
- Lack of social supports

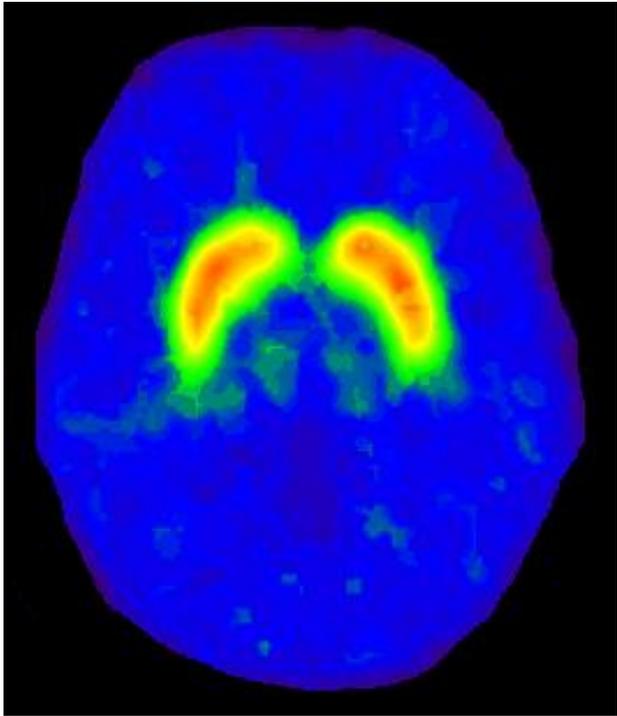
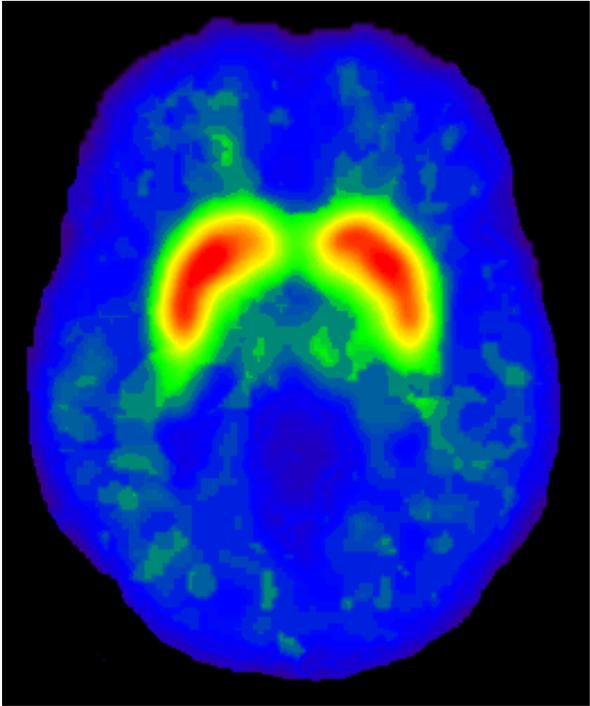
FUNCTIONALLY...

Dopamine D2 Receptors are Decreased by Addiction



DOPAMINE RECEPTORS

[¹¹C]raclopride



DIFFERENCES

- Substances have tolerance, physical dependence and withdrawal not applicable to eating disorder.
- The goal for substance abuse treatment is abstinence.
- Goal for eating disorders is to normalize eating behaviors versus **abstinence** from food.

CURRENT TREATMENT APPROACHES

- Sequential treatment - Focuses on the most acute disorder first. Treatment is delivered by different providers in different locations.
- Parallel treatment - Both disorders addressed at the same time but with different providers or different locations.
- Currently no evidence-based integrated treatment for treating co-occurring substance abuse and eating disorders.

INTEGRATED TREATMENT APPROACH

- Comprehensive screening for both eating disorders and substance abuse
- Co-occurring psychiatric disorders
- Medical conditions and lab test
- Comprehensive drug testing
- Understanding the independent and combined medical complications of these disorders is crucial in treatment planning and implementation, as evidenced by their prominence in guidelines from the American Psychiatric Association (Yager et al., 2006), the American Society of Addiction Medicine (Mee-Lee & Schulman, 2001), and the National Institute of Clinical Excellence, (2004)
- Comprehensive individual treatment plan that encompass co-occurring psychiatric disorders
 - Source: Chapter 21 integrated treatment principle strategies for patients with eating disorder substance abuse and addictions - Dennis, Pryor, Brewerton



INTEGRATED TREATMENT

- Treatment teams that are trained in evidence-based treatments:
 - Motivational interviewing
 - Motivating people to reduce their substance use (i.e., harm reduction versus abstinence)
 - Stages of change treatment interventions
 - Acceptance and Commitment Therapy (ACT)
 - DBT
 - Exposure Response Prevention
 - Prolonged Exposure
 - Cognitive Behavioral Therapy
 - Family Treatment
 - Medications that integrate psychosocial interventions with eating disorders and substance abuse
- Services provided in the same location with the same providers in a stepwise integrative fashion

INTEGRATED TREATMENT IS ASSOCIATED WITH THE FOLLOWING POSITIVE OUTCOMES:

- Reduced substance use
- Improvement in psychiatric symptoms and functioning
- Decreased hospitalization, taking meds as Rxd
- Increased coping skills
- Increased job performance, reentry to workforce
- Improved quality of life

CHALLENGES WITH INTEGRATED TREATMENT

- Facility set up
- Medical needs
- Sobriety monitoring
- Sober living communities
- Family resistance

INTEGRATED TREATMENT RECOVERY MODEL

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

GUIDELINES FOR EFFECTIVE TREATMENT -NIDA (ADAPTED WITH EATING DISORDER)

1. Eating disorders, substance abuse, and addictions are complex but treatable conditions that affect brain functioning and behavior
2. No single treatment is appropriate for individuals
3. Treatment needs to be readily available
 - Individuals with eating disorder and substance abuse are often reluctant to seek treatment and prevention is important
4. Effective treatment tends to multiple needs of the individual not just the eating disorder or substance use disorder

GUIDELINES – CONT.

5. Remaining in treatment for an adequate period of time is crucial for treatment effectiveness.
6. Group, individual and family counseling, nutritional, and other behavior therapies are critical components of effective treatment for both disorders.
 - Family support and intervention
7. Medications are important element of treatment for many patients especially when combined with counseling and other behavioral therapies.
 - This is where relapse prevention medicine is very critical
8. An individual's treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.

GUIDELINES – CONT.

9. Medical detoxification is the first stage of addiction treatment and by itself does not change long-term drug use. Likewise, weight restoration, the normalization of eating patterns and the elimination of compensatory behavior is only the first stage of recovery from ED.
10. Treatment does not need to be voluntary to be effective
11. ED-related behaviors and drug use during treatment must be monitored continuously.
12. Patient should be tested for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases and targeted risk – reduction counseling should be provided.

Source: Chapter 21 integrated treatment principle strategies for patients with eating disorder substance abuse and addictions- Dennis, Pryor, Brewerton

