Co-Occurring Eating Disorders and Addiction: Implications for Recovery

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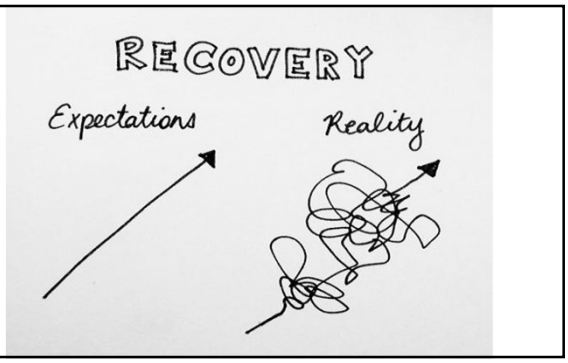
We'll try to talk about …

- ★ Eating Disorders and their relationship to Substance Use Disorders
- ★ The similarities **and** key differences between Eating Disorders and Substance Use Disorders (and how they can complicate treatment/recovery)
- ★ Treatment options and mutual aid groups for clients who have co-occurring Eating Disorders
- ★ Triggers



"This desire to 'switch the witch for the bitch' was always there. Just because I was making inroads to recovery didn't mean I didn't have a deep desire to numb my feelings. Drinking alcohol often took the place of my disordered eating in times when my food was 'under control.'
It became the thing I used to numb myself so as not to feel my emotions. So I had to say no to that, too."

Making Peace with Your Plate (p. 29)

What are we really talking about here?

Substance Use Disorder (SUD): a medical condition in which the use of one or more substances leads to a clinically significant impairment characterized by an array of mental, physical, emotional and behavioral symptoms that cause problems such as loss of control, strain on one's interpersonal life, hazardous use, tolerance, and withdrawal. Drugs usually involved in SUD include alcohol, opioids, stimulants, hallucinogens, dissociative anesthetics, inhalants, sedatives and tobacco.

What are we really talking about here? (continued …)

Eating Disorder (ED): a disorder defined by abnormal eating habits that negatively affect a person's physical and/or mental health. Anxiety disorders, depression and substance use disorders are common among people with eating disorders.

Substance Use Disorders

➔ Substance Abuse
➔ Substance Dependence
➔ Addiction

Eating Disorder Diagnoses

Anorexia Nervosa (AN): Characterized by self-starvation, and excessive weight loss. Anorexia Nervosa is divided into the diagnostic categories – Restrictive Anorexia and Binge/Purge Anorexia.

Bulimia Nervosa (BN): Characterized by a cycle of bingeing and compensatory behaviors, such as self-induced vomiting, laxative abuse or exercising, that are designed to compensate for the effects of binge eating.

Eating Disorder Diagnoses (continued …)

Binge Eating Disorder (BED): Characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.

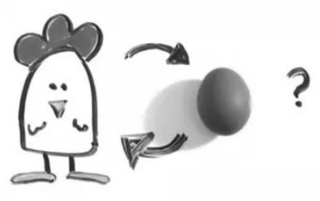
Other Specified Feeding or Eating Disorder (OSFED): Refers to abnormal eating or feeding without all the symptoms needed to be diagnosed with anorexia, bulimia or binge eating disorder.

Let's dispel some myths

- Most people with AN do not JUST restrict
  - **And not all people with AN (or any ED) are low weight!**
- Malnutrition can occur at any weight
- Not all people with ED have the goal of weight loss or have an issue with body image
  - Avoidant Restrictive Food Intake Disorder - limits the type/amount of certain foods
  - Orthorexia - being obsessed with clean eating or restricting certain food types
  - PICA - eating objects with no nutritional value

Let's dispel some myths (continued …)

- Eating disorders are NOT a choice - they are complex medical and psychiatric illnesses with several bio-psycho-social contributing factors (much like SUD's!)
- Eating Disorders are not "women only" illnesses
  - A 2007 study by the Centers for Disease Control and Prevention found that up to ***one-third of all eating disorder sufferers are male***
  - A 2015 study of US undergraduate students found that ***transgender men and women and nonbinary students were the group most likely to have been diagnosed with an ED in the past year*** (Diemer, 2015).



Some Co-Occurring Statistics

- Up to 30 million individuals in the US of all genders and ages meet criteria for an Eating Disorder
- Up to 35% of individuals who abuse or are dependent on alcohol or other drugs also meet criteria for ED - compared to only 3% of the general population (that's more than 10X more likely than the gen pop!)

Some Co-Occurring Statistics (continued …)

- OSFED (Other Specified Feeding or Eating Disorder) is significantly more common in people with Substance Use Disorders.
- Eating disorders have the highest mortality rate of any mental illness.
  - "Every 62 minutes, one person dies of an Eating Disorder"
  - 40% BN patients report self-injuring or addictive behavior

A Few More Co-Occurring Stats..

- Lifetime rates of Substance Use Disorder in the various Eating Disorder subgroups are:
  - Anorexia Nervosa – 27.0%
  - Bulimia Nervosa – 36.8%
  - Binge Eating Disorder – 35%

A Few More Co-Occurring Stats.. (continued)

- Women with Anorexia Nervosa are 19 times more likely to die from a Substance Use Disorder than the general population.
- Approximately 57% of males with Binge Eating Disorder will also experience a Substance Use Disorder.
- Individuals who undergo bariatric surgery are at higher risk for developing a Substance Use Disorder.

Common Personality Characteristics of the Co-Occurring Population:

- Harm avoidance
  - Hypersensitivity and self-consciousness
  - Common result: need for anxiety management (ie: wanting to numb)
- Self-Directedness
  - Connects values to behaviors
  - Strong feelings of insecurity, inadequacy
  - Common result: disconnect from values, uncertainty about future, feeling stuck

Common Personality Characteristics of the Co-Occurring Population: (continued …)

- Novelty Seeking
  - Higher among SUD population; seen with Bulimia Nervosa particularly
  - Result: boredom, quick with emotions – difficulty following rules

Similarities in Eating Disorders and Substance Use Disorders

- Increase in behaviors needed for some effect to separate from current reality
- Behaviors used to regulate emotions
- Coping does not involve social supports
- Avoidant behaviors that perpetuate and intensify negative emotions and isolation
- Both ED and SUD usually require long-term, intensive treatment

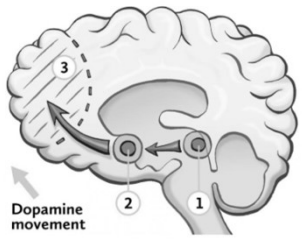
Similarities in Eating Disorders and Substance Use Disorders (continued …)

- Onset *usually* in youth - thus need for early intervention
- Chronic, progressive, and fatal if left untreated
  - Often escalates in frequency and intensity over time
- Stress as a trigger
- Social supports are key in recovery maintenance **

Similarities (cont.)

- Research suggests a strong genetic component to both
- Links to certain chemical processes in the brain (dopamine, glutamate, etc.)
- Onset and course influenced by social pressures, **media messages**, environmental triggers, family dynamics, emotional trauma
- Presence of cravings, continued use/engagement in behavior despite negative consequences, inability to cut back or stop despite repeated attempts, sacrifice of other interests (family, work, hobbies, etc.)

Eating Disorders and Substance Use Disorders are COMPLEX illnesses



Neurotransmitters play a key role in both ED and SUD

Dopamine - a chemical released by neurons to send signals to other nerve cells. It produces pleasure through the "reward system" of the brain. It also serves functions like controlling movement and regulating hormonal responses important to cognition and emotion. Substances give the brain MUCH higher dopamine spikes than "normal" pleasurable activities.

Neurotransmitters play a key role in both ED and SUD (continued …)

Glutamate - most abundant neurotransmitter that is used by every major excitatory function in the brain. It is the neurotransmitter which regulates learning and memory. *When someone is malnourished, they have lower glutamate levels which negatively impacts learning and memory.*

Serotonin - neurotransmitter whose complex function includes modulating cognition, reward, memory and numerous physiological processes like sleep, sensory perception and controlling emotional states such as anxiety and depression. *Sleep disturbance is common among binge eaters who are particularly susceptible to Serotonin.*

Important Differences that Impact Recovery

- Abstinence and relationship to triggers
  - A person cannot abstain from all food in ED recovery like a person can abstain from all substances in SUD recovery
- Addiction to product vs addiction to the process/ritual
- Physiological dependence vs psychological learned behavior

Important Differences that Impact Recovery (continued …)

- Food is part of culture, family, social relationships - difficulty in avoiding triggers
- Difference in stigma
- Insurance coverage / treatment availability
  - Both resources are scarce, but SUD treatment is more prevalent today

Eating Disorders can be masked by Substance Use Disorders (*and vice versa*)

- Disordered eating patterns often go undetected by SUD treatment team
  - *Very few inpatient facilities supervise food consumption closely*
  - *Often unsure of what constitutes a "red flag" for disordered eating*
  - *Many individuals with ED become very good at hiding their symptoms*
  - *Even harder to detect at lower levels of SUD treatment (like OP)*

Eating Disorders can be masked by Substance Use Disorders (*and vice versa*) (continued …)

- Substance use might mask ED behaviors or be used as part of ED related rituals
- As someone enters into abstinence from drugs and alcohol, they might reach for alternative numbing mechanisms or behaviors such as food/disordered eating to cope with re-emerging emotions

So, what IS a red flag for ED in SUD treatment?

-leaving the table within ten minutes of eating a meal

-Stirring or playing with food rather than eating it

-Skipping meals consistently

-Skipping a meal, then overeating at another meal

-Consistently setting and communicating goals around getting physically "healthy"

-Exercising despite physical injuries

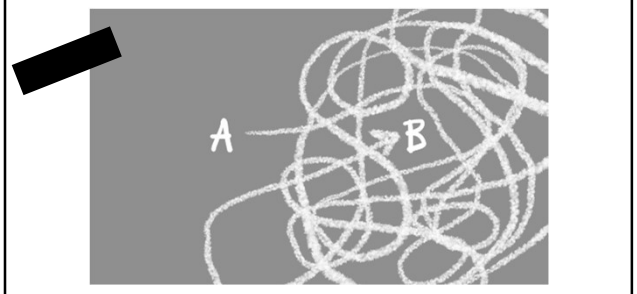
-Hoarding

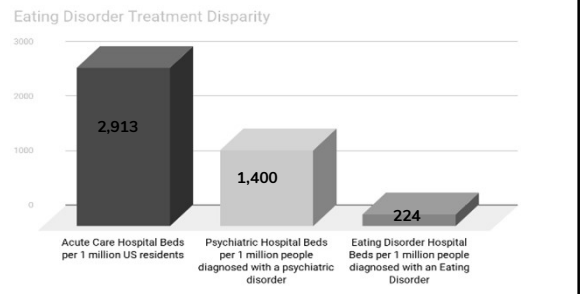
So, what IS a red flag for ED in SUD treatment? (continued …)

- Rigid eating patterns
- Repeatedly expressing concerns about being "fat" or losing weight
- Excessive weight gain or loss while in treatment

If noticed/displayed/reported, a clinician should:

- Don't assume ED
- Use as a "gentle red flag"
- Do a 24 hour food recall
- Keep personal opinions on food or body image to yourself!
- Seek advice from an ED specialist if concerned





Co-occuring Treatment Approaches

- **Sequential treatment:** Focuses on the most acute or severe disorder first. Treatment delivered by separate providers at separate locations
- **Parallel treatment:** Both disorders are addressed at the same time but with different providers, and potentially, different locations
- **Dual-Diagnosis treatment:** Both disorders are treated simultaneously within the same facility and by an integrated treatment team

Currently there is no evidence-based integrated treatment model for treating co-occurring Substance Use and Eating Disorders.

Dual-Diagnosis Treatment

- ➔ Ideal - But surprisingly difficult to find because most addiction-focused treatment centers are not equipped to address ED (no meal-time support, little/no access to ED specialists, no access to intensive medical monitoring)
  - *Vise versa - most ED-focused treatment centers are not equipped in treating addiction*
- ➔ Nonetheless - research shows that some sort of integrated treatment model is essential to stable, long-term recovery from both disorders.
- ➔ Sometimes medical intervention for ED stabilization is needed before concurrent or SUD focused treatment can begin
  - *Re-feeding sometimes necessary (risk for re-feeding syndrome - shock to internal organs)*
  - *Rapid weight gain*

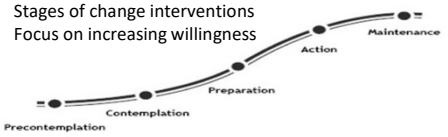
Integrated Treatment and Recovery

- ★ **Hope** is critical
  - 12-step programs and other mutual aid groups can nurture hope
  - Unconditional positive regard and respect
  - Long-term engagement
- ★ Services and treatment goals should be client-driven!
  - The more autonomy over treatment level/intensity/goals the better with SUD and ED
- ★ Integrated treatment team
  - Treatment specialists responsible for engaging individuals and supporting their recovery
  - Connection with a broad range of clinicians outside of one's own specialty

Behavioral Models for Treatment/Approach to Recovery

Motivational Interviewing

- Motivating individuals to move towards change to reduce their substance use and/or ED behavior (harm reduction vs abstinence)
- Stages of change interventions
- Focus on increasing willingness



Behavioral Models for Treatment/ Approach to Recovery (continued …)

Acceptance and Commitment Therapy

- Connection to values
  - Develop goals in line w/ those values
- Values/goals drive behavior

Cognitive Behavior Therapy

- Relatively short, system-oriented
- Focus on beliefs, values, and thought processes
- Modify distorted beliefs and attitudes
- Self -monitoring, problem solving, coping mechanisms, mindfulness, maintenance/relapse prevention

Dialectical Behavior Therapy

- Focuses on mindfulness
- Largely skills based
- Emotion regulation, Distress Tolerance, Interpersonal Effectiveness
- Reducing unhealthy coping by replacing with healthy/equally effective coping
- Reduce impulsivity, under-control

RO-DBT

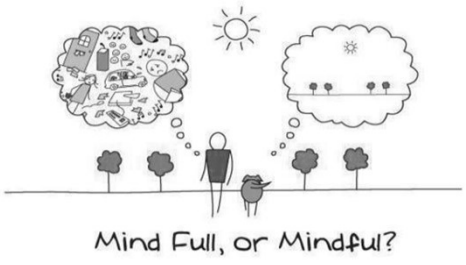
- Radically Open DBT
- Targets disorders of "overcontrol" (ie: AN, OCD, Autism Spectrum Disorder)
- With AN in particular - focus on urge surfing, identifying goals and values not directly linked to food

Maudsley Approach or Family Based Treatment (FBT)

- ★ Home based
- ★ One of the most effective ED treatment model for adolescents
- ★ parents /guardians/close supports play a KEY role
- ★ Focus is on refeeding, weight restoration, and interrupting compensatory behaviors first then focuses on secondary issues related the the ED such as root cause and maintenance
- ★ Phased treatment, with each phase giving the adolescent more control over their own eating

Mindfulness Based Approaches

- **Mindfulness Based Stress Reduction** (MBSR) teaches mindfulness via formal meditation
- **Mindfulness Based Therapeutic Community (MBTC)** is a long-term, residential program where individuals practice meditations daily and discuss the usefulness of meditation and mindfulness in recovery
- **Mindfulness Oriented Recovery Enhancement (MORE) a**ddresses stress-precipitated AOD relapses via ten session program
- **DBT** & **ACT** are existing programs with a mindfulness component already built in
- Mindfulness is always helpful in recovery in from SUD, ED, and to promote general well-being



Essentials for effective treatment and recovery initiation

- ED's and SUD's are complex but treatable illnesses that affect the brain and behavior (and do not indicate moral weakness)
- No single treatment method is appropriate for all individuals
- Treatment readily available when willingness occurs (People with SUD's and ED's are often reluctant to seek treatment at first)

Essentials for effective treatment and recovery initiation (continued …)

- Must address the whole individual and his/her multiple needs rather than JUST the SUD/ED behavior
- Adequate length, intensity and quality of treatment
- Support/intervention for family/friends
- Individual and group counseling and other behavioral therapies available
- Nutritional didactics

Essentials for effective treatment and recovery initiation (cont.)

- Detoxification and stabilization are the essential first stages of recovery but likely NOT enough to achieve maintain long-term stable recovery and abstinence from substances. Similarly, weight restoration/medical stabilization and normalized eating patterns are only the beginning stages of ED recovery
- Both Eating Disordered behaviors AND any AOD use need to be monitored continuously throughout treatment
- Clients should be tested for HIV/AIDS, Hep B and C, TB, other infectious diseases or medical issues and given targeted risk reduction counseling (ie: informed consent for opioid users, medical risks for active AN and BN behaviors, etc)

Self-help and Mutual Aid Groups

- **Alcoholics Anonymous (AA) and Narcotics Anonymous (NA)** - views alcoholism/addiction as a disease with moral, spiritual, and physical components and suggests a 12-step program of change. Key components are spirituality, sponsorship, consistent meeting attendance, service, etc.
  - See also: MA, CA, CMA, HA,
- **Overeaters Anonymous (OA)** - 54,000 members, 7,000 meetings, 80 countries - Only requirement for membership is the desire to stop compulsive eating. 12-step program adapted from AA
- **Eating Disorders Anonymous (EDA)** - they define recovery as "to live without obsessing over food, weight, or body image". Goal of the program is to "achieve balance".

- **Anorexics and Bulimics Anonymous (ABA)** - Open to individuals with AN, BN, other disordered eating, binge eating, excessive exercising, etc. Focus is on helping members feel *in control* of food, body image, and weight.
- **SMART Recovery** - Non-12-step - goal is abstinence from addiction (behavioral or substance). Focus is on building and maintaining motivation, coping with urges, management of thoughts/feelings/behaviors, and living a balanced life

- **Refuge Recovery -** Buddhist path to recovery - Peer-led meetings that practice, educate, and provide Buddhist-inspired guidance and meditations for anyone seeking recovery from addiction
- **Celebrate Recovery (CR)** - Christian 12 step recovery program for "anyone struggling with hurt, pain or addiction of any kind"
- **Lifering** - Secular - defines themselves as an "organization of people who share practical experiences and sobriety support". Individualized and self-directed

Recovery is not rare and it is not random

Local Resources

- **Center for Eating Disorders** - 734-712-5750 - Non-profit treatment, professional training, and education facility in Ann Arbor, Michigan.
  - Outpatient team treatment of ED in children, teens, adults, and their families.
  - Assessments and ongoing treatment
  - BED specialized groups: *Hungerwise* and *Bodywise*
- **St. Joseph Mercy Hospital -** 734-712-5750 **-** *Adolescent Partial Hospitalization Program (ages 12-18)* - team includes individuals with expertise in child and adolescent psychiatry, social work, nursing, education, chemical dependency and activity therapy

Local Resources (continued …)

- **Michigan Medicine Comprehensive Eating Disorders program -** call 877-475-MOTT (877-475-6688) *and ask to be directed to the Comprehensive Eating Disorders Program.*
  - **Partial Hospitalization Program (PHP)**
  - **Intensive Outpatient Program (IOP)**
  - **Outpatient Program**
  - **Inpatient Medical Hospitalization**
  - **Inpatient Psychiatric Hospitalization**
- **Dawn Farm -** 734-669-8265 - A community of abstinence-based SUD treatment programs. OP, inpatient, detox, sober living, recovery support services, psychiatric evaluations
- **Home of New Vision** - 734-975-1602 - SUD treatment offering OP, inpatient, detox, sober living, recovery support, engagement services, mental health/psychiatric services

More resources

- BodyWise www.thebodywiseprogram.com (734)-668-8585
- www.HVAI.org to find local AA meetings
- www.na.org/meetingsearch to find local NA meetings
- https://oa.org/find-a-meeting/ for OA meetings in person and online or **http://www.a2oa.org/** or call 1-505-891-2664
- National Eating Disorders Association Helpline: 1-800-931-2237
- **Suicide Hotline - 800-273-8255**

Check out these cool books!

- Making Peace with Your Plate: Eating Disorder Recovery by *Espra Andrus and Robyn Cruze*
- Life without Ed by *Jenni Schaefer*
- Goodbye Ed, Hello Me by *Jenni Schaefer*
- Overcoming Binge Eating by Dr. Christopher Fairburn
- Anorexics and Bulimics Anonymous
- Alcoholics Anonymous (or Big Book), Basic Text of Narcotics Anonymous
- Refuge Recovery

Questions?

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