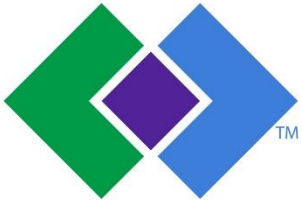

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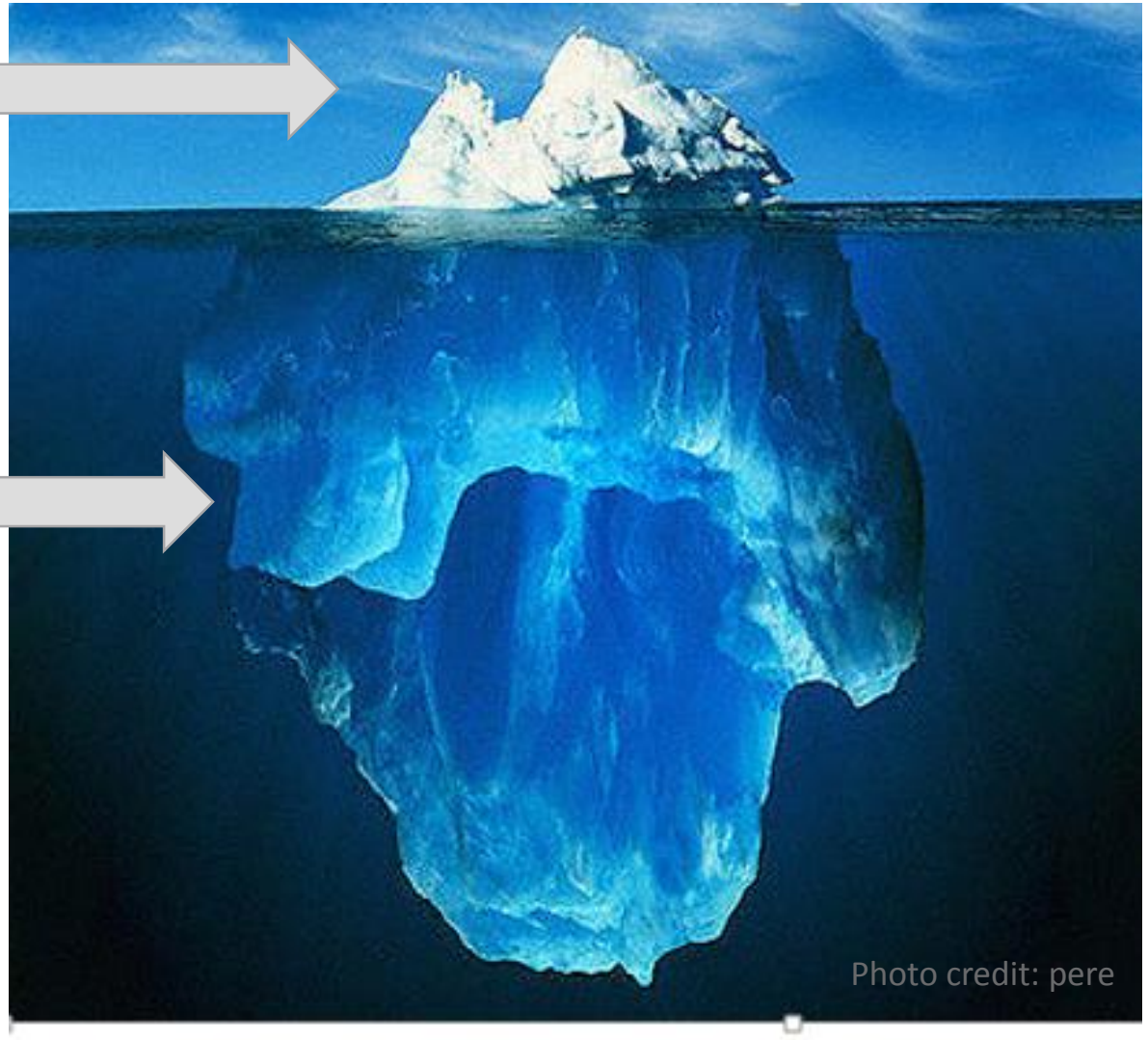
Co-occurring Eating Disorders and Substance Use Disorder

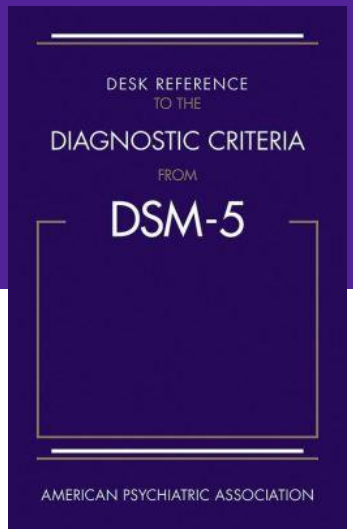
Andrea Zuellig, PhD, LP and Alison Sharpe-Havill, PsyD, LP
Melrose Center Psychologists

What we see

What we *don't* SEE



Feeding and Eating Disorders



Anorexia Nervosa

Bulimia Nervosa

Binge-Eating Disorder

Other Specified Feeding or Eating Disorder

Unspecified Feeding or Eating Disorder

Avoidant/Restrictive Food Intake Disorder

Rumination Disorder

Pica

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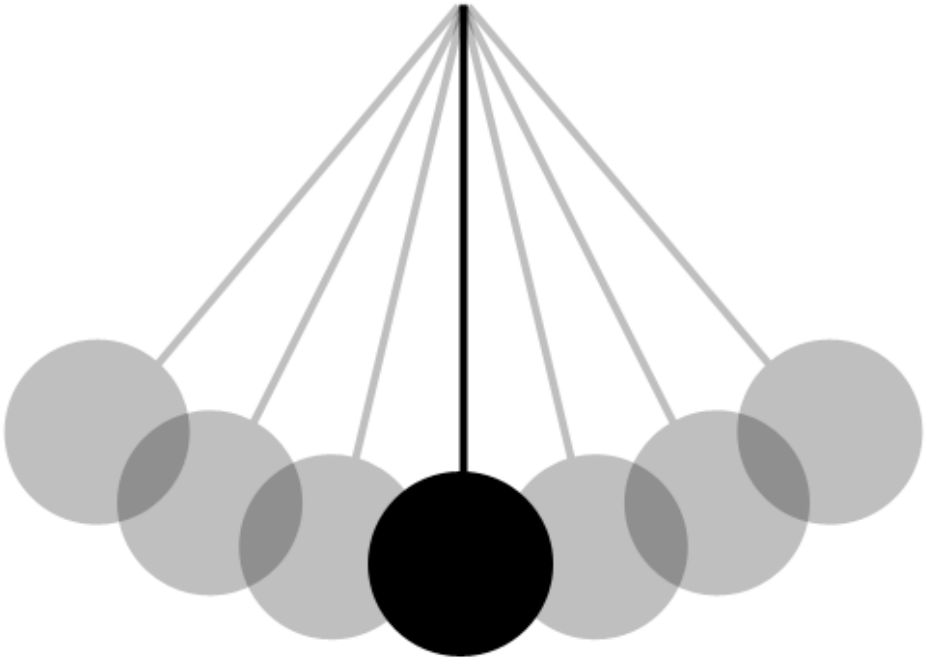
Eating Behaviors Continuum



Dieting, Restricting

Normal Eating

Excessive or Binge Eating

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SCOFF QUESTIONNAIRE

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

A score of 2 or more indicates possible risk for eating disorder and warrants further assessment

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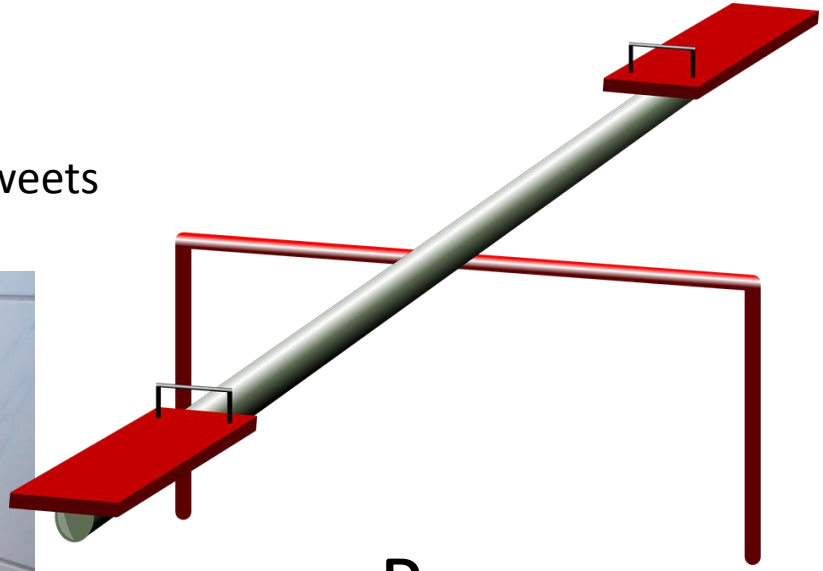
Binge - Purge

Binge

Could be any food but patients often talk about sweets

PC: Kevin Botto



Purge

- Self-induced vomiting
- Abuse of laxatives, diuretics
- Restricting
- Over-exercising

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Addiction Transference

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Eating Disorder

Research had found that up to **50%** diagnosed with an eating disorder will struggle with substance abuse, whereas only 9% of the general population is diagnosed with SUD.

Substance Abuse

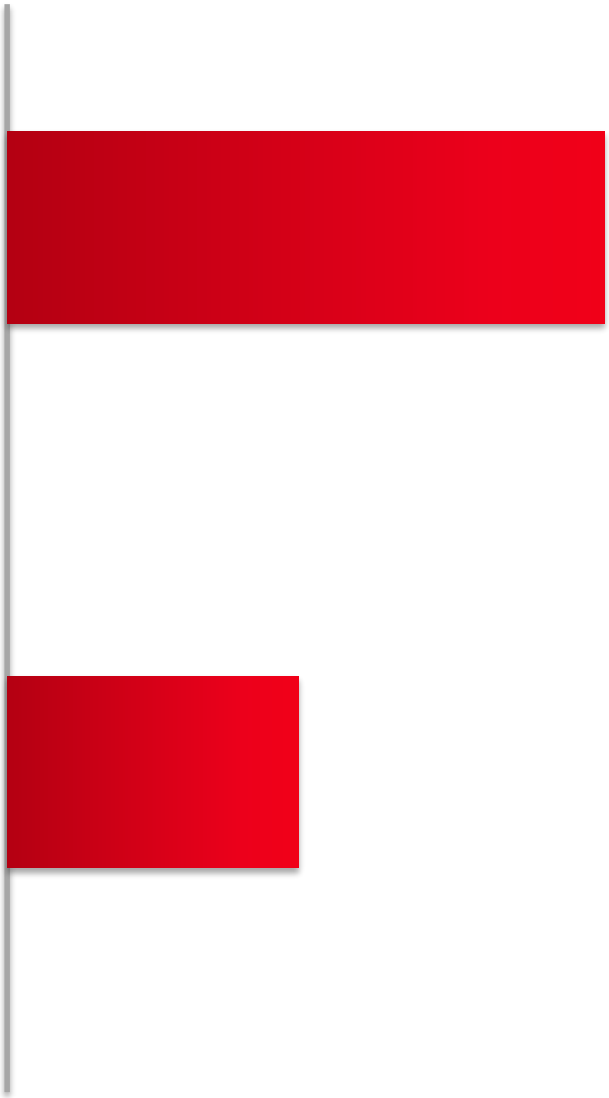
Conversely, **35%** of those who abuse substances have been found to have an eating disorder compared to 3% of the general population diagnosed with ED

11x

Person with SUD is 11x more likely to have an eating disorder.

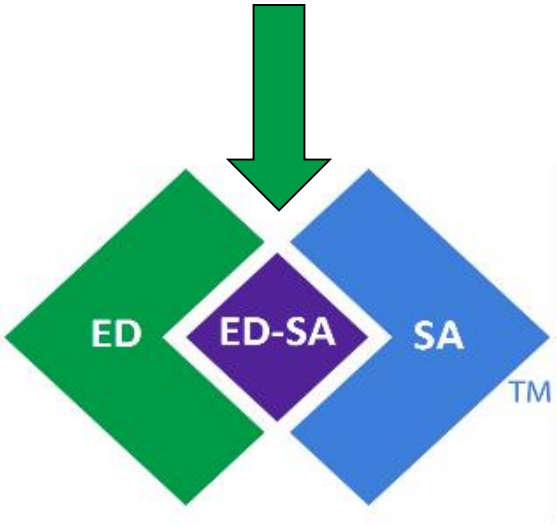
5x

Person with ED is 5x more likely to abuse drugs and alcohol than a person without an eating disorder.



Prevalence of ED-SA

At least 25% of our patients at Melrose Center struggle with substance abuse



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Shared Traits

- Lack of control over urges and behaviors
- Impulsive nature of symptom use
- Symptoms used as an unhealthy way to escape or regulate emotions

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Other factors to consider and rule out

- Eating to cope with stress, emotions or trauma/abuse
- Food deprivation/starvation
- Food Insecurity

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Risk Factors

- Eating Disorders have highest mortality rate of any psychiatric disorder; increases with co-occurrence of SUD
- Individuals with AN are 19x more likely to die from SUD, mainly AUD
- Complex relationship ED and SA; most often get worse together

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Risk factors

- Research has found that ED often comes first
- Early dieting is a key risk factor for not only eating disorders but also substance use disorders
- Restriction and drive for thinness in substance abuse treatment predicts early drop-out

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How Patients Experience the Connection

Attempts to cope with the eating disorder:

"I use pot so I can eat during family dinners"
"Pot helps me eat and not purge after meals"
"Alcohol allows me to have a break from following the rules of the ED"

Attempts to engage more in the eating disorder:

"I work out for hours and take pain meds to deal with the pain"
"Drinking makes me feel full and then it's easier not to eat"
"Drinking the night before helps me purge the next day"

ED and SUD get worse together (dysregulation model):

"When I drink alcohol, my awareness of food goes down and I tend to overeat"
"If I drink, I won't eat because it's too many calories"
"I binge eat really bad when I smoke pot"

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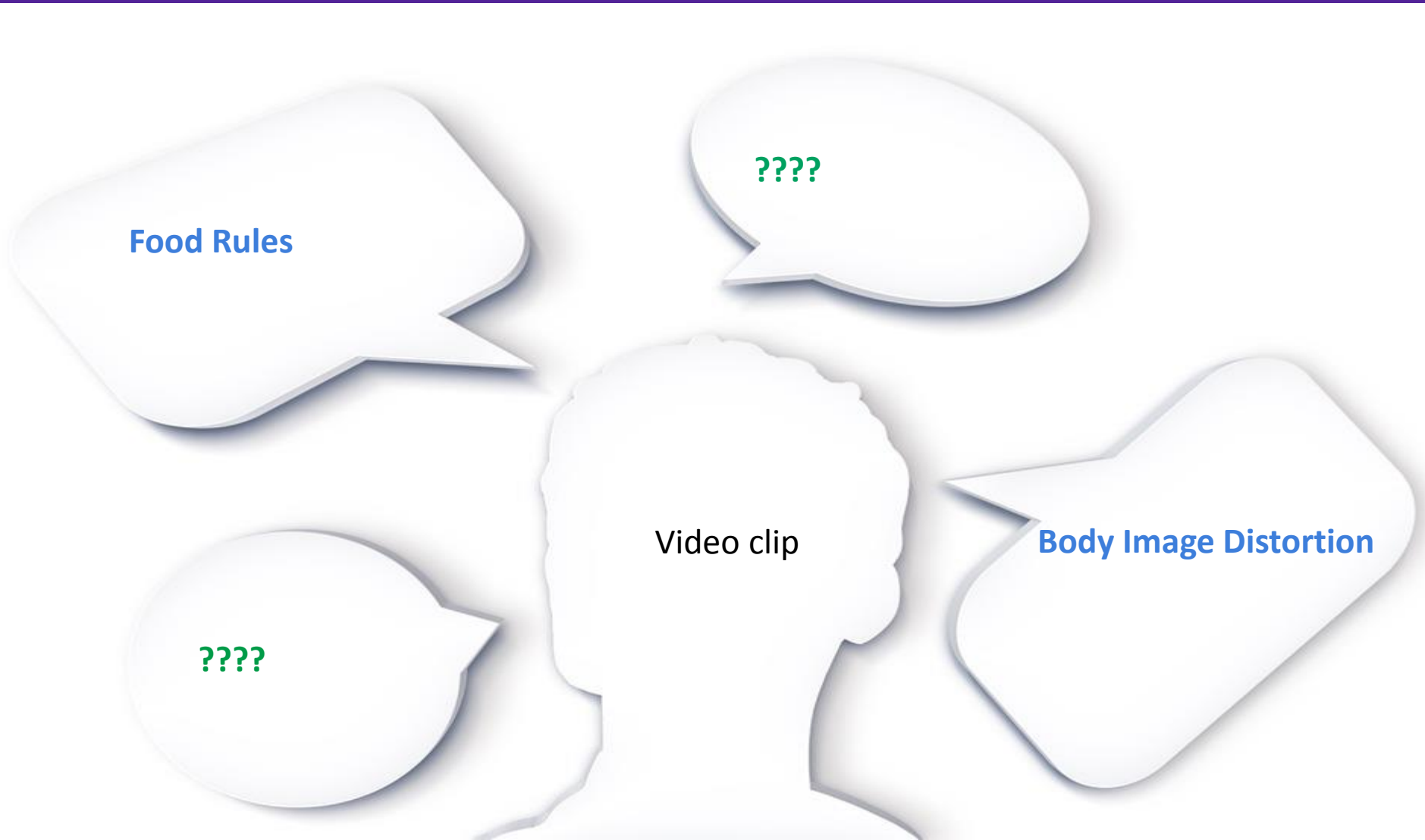
The Voice of the Eating Disorder vs. Addiction



Quieting the Voice of ED and SUD

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Starting the Conversation

- Approach in a concerned, non-judgmental manner
- Don’t be vague, ask specific questions
- Use “I” statements rather than “you” statements
- Avoid placing shame, blame or guilt on the person regarding their actions or attitudes
- Avoid giving simple solutions
- Consider getting some collateral information from parents or other support people who may be with them

Abstinence vs. Truce

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I wish I had known

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Support Structure?

Treatment for ED-SA

Integrated, concurrent treatment of co-occurring disorder

Cross-trained staff and cross-organizational partnering

Need to address underlying issues

trauma, anxiety/depression,
relational/interpersonal factors,
developmental factors,
neurobiological factors

Longer and more complicated treatment

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Treatment for ED-SA

Detox and weight restoration (not enough!)

Increase understanding of the connection between substance use and current functioning/quality of life (**Psychoeducation**)

Enhance **motivation** to change (MI, ACT)

Develop capacity to regulate **emotions** (DBT, CBT)

Encourage development of **healthy relationships** and consistent involvement in recovery community (12-step, mentoring)

Strengthen **relapse prevention skills** (CBT; medication management)

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Melrose EDSA
Intensive Outpatient Programs

Melrose Center - St Louis Park

Mon & Weds 9:30 – 4:00

Tues & Thurs 9:30 – 4:00

Evening Program:

Monday and Thursday 4:00 – 7:00

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Melrose Center Dedicated Provider Line

952-993-5864 8:30 am- 5 pm

- Ask questions about patient signs/symptoms from knowledgeable Care Managers OR for urgent admissions
- Patient questions about insurance
- Make the call for Initial Assessment with the patient, if possible
- If patient is reluctant, give them brochure with Scheduling line: 952-993-6200

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Check our website: Melroseheals.com

Find us on

Call Melrose Outreach Services

952-993-6555