Eating Disorders: An Addictive or Psychiatric Illness?

Prepared for Cigna by Milestones Eating Disorders Program
Part I: The Addiction Viewpoint...

- The case for looking at an eating disorder as an addictive disease – a checklist to consider
- Does this apply to Anorexia, Bulimia, Binge Eating?
- How can Food be Addictive?
- What related problems frequently accompany an eating disorder?
- Psychiatric Treatment or Addiction Treatment?
Tolerance
Withdrawal [Physical / Psychological]
More For Longer Periods Than Intended
Unsuccessful Effort To Cut Back Or Control
Significant Time To Obtain Or Recover From Effects
Decreased Activities Due To Dependency [Isolation]
Continuation Despite Consequences

Question: How Many Of The Above Criteria Need To Be Met To Qualify As Dependency –Aka Addiction?
Answer: 3, 4, 5, 6, Or All?
How Can Food or Dieting be Addictive?

- Nature of Substance + Nature of Person - Amounts and Length of Time
- Brain Chemistry differences with Eating Disorders - Reward Circuits in the Eating Disordered brain
- Junk Foods [sugar, flour, processed foods] and the overeating disorders [bulimia, binge eating]
- Restricting – Can that be addictive too?
Part II: The Physical Aspect of Addiction - Brain Chemistry

- Physical Addiction with Eating Disorders - What the research is showing us with recent advances in brain mapping
- What are the “offending” substances with Bulimia and Binge Eating – the role of sugar, refined flours, and volume
- Is there a genetic link that makes someone more likely to develop an eating disorder?
THE ADDICTED BRAIN

BRAIN REWARD CENTER

What do the colors mean?

RED
high dopamine
normal pleasure and interest

YELLOW
medium dopamine
difficulty feeling joy or pleasure

GREEN
low dopamine
lack of pleasure

Normal brain

Brain of an obese person

Brain of a cocaine user

Brain of an alcoholic
Functionally...

Dopamine D2 Receptors are Decreased by Addiction
The cycle of declining dopamine receptors leading to addiction

- Bingeing
- Numbened pleasure response
- Cravings
- Bingeing escalates
- Even less pleasure response
- Stronger cravings
- Bingeing

Dopamine receptors (D2)
## Part III: Emotional Aspects of Eating Disorders- Frequently Related Issues

<table>
<thead>
<tr>
<th>MOST FREQUENT</th>
<th>HOW COMMON</th>
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<tbody>
<tr>
<td><strong>MOOD DISORDERS</strong> [Depression, Anxiety, Bi-Polar]</td>
<td>Estimates 70-90%</td>
</tr>
<tr>
<td><strong>SUBSTANCE ABUSE</strong> [alcohol, drugs]</td>
<td>Estimates 40-60%</td>
</tr>
<tr>
<td><strong>PAST TRAUMA – PTSD</strong> [Post Traumatic Stress]</td>
<td>Estimates 20-40%</td>
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<tr>
<td><strong>ATTENTION DEFICIT</strong></td>
<td>Estimates 20-30%</td>
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<tr>
<td><strong>PERSONALITY DISORDERS</strong> [borderline, compulsive]</td>
<td>Estimates 20-40%</td>
</tr>
<tr>
<td><strong>PROCESS ADDICTIONS</strong> [behavioral – e.g. spending, gambling, sex addiction]</td>
<td>Estimates 20-40%</td>
</tr>
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Co-Existing Addictions

- Adderal and ADD / ADHD Medications [Abused For Appetite Depressant Properties]
- Tranquilizers - Xanax, Ativan, Klonopin / Opiates – Pain Pills [Abused for appetite suppressant]
- Laxatives - Correctol, Ducolax, Etc./ Ipecac [To Induce vomiting] / Exercise
- Street Drugs – Cocaine, Marijuana, Heroin
- Alcohol, Tobacco Products
PART IV: A BLENDED ADDICTION TREATMENT MODEL

- Assumes ED is an addictive process with physical, emotional, and spiritual [existential] components

- Assumes “disease” [pre-disposition] is life-long with periods of prolonged remission and often punctuated by relapses followed by continued recovery

- May incorporate traditional therapies, nutritional therapies, psychiatric medications, and relevant 12-step community based support groups when indicated
TREATMENT SETTING: LEVELS OF CARE

“One Size Does Not Fit All”

- Inpatient (Hospital Based)
- Residential (Non-Hospital Based)
- Partial Hospital (Day Treatment)
- Intensive Outpatient (Half-Day Treatment)
- Outpatient (Therapist, Dietitian, etc.)
TREATMENT COMPONENTS WITH BLENDED MODEL APPROACH

- Structured Food Plan – eliminates “trigger” foods
- Cognitive Behavioral Therapies + Harm Reduction
- Constructive Living Model – Responsibility for Recovery with less emphasis on “feelings” more on behaviors
- Treatment of Dual and Tri-Diagnoses [multiple issues / disorders]
- Therapeutic Environment – [Inpatient / Residential]
- Use of Community based support groups
- Role of Medication
- Mindful Eating Model
- Daily Living Skills [meal preparation, shopping, etc.]
- Individualized Family Therapy*
STRUCTURED FOOD PLANS

- Prescribed by a dietitian familiar with eating disorders and addiction model
- Often involves weighing, measuring and monitoring amounts
- Schedule of eating 3 to 5 times daily
- Limits or eliminates junk food
- Focus on “mindful eating”
- Blind weights monitored by dietitian
ESSENTIAL ELEMENTS OF RECOVERY
LIFESTYLE

S.E.R.F. – Components
- S = Spirituality
- E = Exercise
- R = Rest
- F = Food Plan

Individual Rx for each of these components depending on ED specifics
CONCERNS ABOUT THE ADDICTION MODEL

- Does not offer a “cure” and requires a long-term commitment to recovery

- Usually involves a structured food plan which limits or eliminates “binge foods” / addictive behaviors [rituals]

- May not be suitable for “Restricting Anorexics” with no history of addictive relationship with binge eating or purging

* Usually involves a need to treat cross-addictions and “dual and tri-diagnoses” at the same time as the eating disorder.
RESOURCES

- MILESTONESPROGRAM.ORG - 800 347. 2364
- ED Support Group PA, NY, FLA [800-347-2364]
- OA (Overeaters Anonymous) OA.ORG
- ABA (Anorexics and Bulimics Anonymous)
- ANAD Support Groups
- EDREFERRAL.COM

*Access through iPad Device
TREATING EATING DISORDERS

milestones
in recovery

800 347-2364