

Co-Occurring Disorders: When Eating Disorders and Substance Abuse Collide

Kim Dennis, MD
CEO/Medical Director
Timberline Knolls, Lemont, IL

www.timberlineknolls.com



TIMBERLINE  KNOLLS

Making a real life difference.

A residential treatment center located on 43 beautiful acres just outside Chicago, offering a nurturing environment of recovery for women ages 12 and older struggling to overcome eating disorders, substance abuse, mood disorders, trauma and co-occurring disorders.

www.timberlineknolls.com

| 1.877.257.9611

Definition

- *Comorbidity*: Two disorders or illnesses occur simultaneously in the same person, also known as a dual diagnosis or co-occurring disorders
- WHY? the research indicates:
 - Overlapping genetic vulnerabilities
 - Common genetic factors
 - Overlapping environmental triggers
 - Stress, trauma, neglect, early drug exposure
 - Involvement of similar brain regions
 - Areas: reward pathways, stress responses (limbic lobes), prefrontal cortex
 - Drug abuse and eating disorders are developmental disorders
 - Begin in adolescence or childhood when brain is developing

Eating Disorder (ED) & Substance Abuse (SA) Demographics

Food for Thought - Substance Abuse and Eating Disorders: a 73-page report by the National Center on Addiction and Substance Abuse (CASA) at Columbia University

- The first comprehensive examination of the link between substance abuse and eating disorders.
- Reveals that up to 50% of individuals with eating disorders also abuse alcohol or illicit drugs, compared to 9% of the general population.
- The study was released by CASA president and former U.S. Secretary of Health, Education and Welfare, Joseph A. Califano, Jr.

ED & SA Demographics

- Up to 35 % of alcohol or illicit drug abusers have eating disorders compared to 3% of the general population.
- Califano: "This lethal link between substance abuse and eating disorders sends a signal to parents, teachers and health professionals -- where you see the smoke of eating disorders, look for the fire of substance abuse and vice versa."
- Especially in girls and women

ED & SA

- Bulimia Nervosa (BN), purging type
 - Most commonly linked to substance abuse
 - Also high in Anorexia Nervosa (AN), binge-purge type, and Binge Eating Disorder (BED)
- Substances include:
 - Alcohol, amphetamines, cocaine, benzodiazepines (ex., Ativan, Klonopin, Xanax), heroin, caffeine, tobacco, diuretics, and laxatives
 - Used to self-medicate negative emotions and obsessive thoughts (body concerns), to suppress appetite, to increase metabolism
- Health professionals often overlook the link between substance abuse and eating disorders
- Integrated treatment options are almost nonexistent

Other Findings

- Advertisers put children at greater risk of developing an eating disorder through the portrayal of unrealistic body images.
- The average American woman is 5'4" tall and weighs approximately 140 pounds, but the average model is 5'11" and weighs 117 pounds.
- The report found that women's magazines contain more than ten times more ads and articles related to weight loss than men's magazines, which is the same gender ratio reported for eating disorders.

Other Findings

- The report finds that only 15 percent of girls are overweight.
- However, 40 percent of girls in grades one through five and 62 percent of teenage girls are trying to lose weight.
- These girls are especially vulnerable to eating disorders and related substance abuse problems.

Other Findings

- Middle school girls (10 – 14 year olds) who diet more than once a week are nearly 4 times more likely to become smokers.
- Girls with eating disorder symptoms are almost 4 times more likely to use inhalants and cocaine.
- 12.6 percent of female high school students take diet pills, powders or liquids to control their weight without a doctor's advice.

Other Findings

- Women with bulimia who are alcohol dependent compared with those who are not report higher rates of:
 - suicide attempts
 - anxiety
 - personality disorders
 - conduct disorders
 - other drug dependence
- As many as one million men and boys suffer from an eating disorder; gay and bisexual males are at increased risk of such disorders.

Other Findings

Shared Risk Factors SA and ED:

- Occur in times of transition or stress
- Common brain chemistry
- Common family history
- Low self esteem
- Depression, anxiety, impulsivity
- History of sexual abuse, physical abuse and/or neglect
- Unhealthy parental behaviors and low monitoring of children's activities
- Unhealthy peer norms and social pressures
- Susceptibility to messages from media

Other Findings

Shared Characteristics SA and ED:

- Obsessive preoccupation, craving, compulsive behavior, secretiveness, rituals
- Experience mood altering effects, social isolation
- Linked to other psychiatric disorders, suicide
- Linked to medical complications
- Difficult to treat
- Potentially fatal
- Chronic diseases with high relapse rates
- Require intensive therapy

The Disease Concept: Eating Disorders as Addiction Spectrum Disorders

“...a PRIMARY, CHRONIC DISEASE with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often PROGRESSIVE and FATAL.

It is characterized by continuous or periodic: IMPAIRED CONTROL over [binging/starving, cutting], PREOCCUPATION with [E.D. thoughts/behaviors, self-injury], use despite ADVERSE CONSEQUENCES, and distortions in thinking, most notably DENIAL.”

Definition approved by the Boards of Directors of the National Council on Alcoholism and Drug Dependence, Inc. (February 3, 1990) and the American Society of Addiction Medicine (February 25, 1990).

The Disease Concept: Applied to Eating Disorders

- Primary, progressive, chronic disease
- Family disease
- Dependence and withdrawal symptoms
- Complex etiology: bio-psycho-social-spiritual
- Relapsing course is common
- Some effects of the disease are irreversible (osteoporosis, scarring)
- **Potentially Fatal--significant morbidity/mortality: AN mortality rate of 5% per decade of illness, with 50% of deaths occurring by suicide (Sullivan 1995)**
- Full and sustained recovery is real and possible for the patient and the family

Similarities--Behavioral

- Loss of control
- Unsuccessful attempts to cut down or stop the behavior
- Great deal of time spent thinking about or engaging in the behavior
- Continuing despite consequences related to the behavior

Similarities--Behavioral

- Withdrawal symptoms including hallucinations (HA), irritability, restlessness, insomnia, depressed mood, suicidal ideation
- Need for increased amounts of the substance or behavior
- Negative impact on social, occupational or recreational activities (diseases of isolation)

Differences from Substance Abuse

- Definition of abstinence requires a high level of clinical sophistication—we all need to eat
- Individualized and flexible definition of abstinence from eating disordered behaviors
- Individualized boundaries around food behaviors, food types, meal plans
- Body image distortions more extreme
- More of an impact of media/culture of development of eating disorders
- Greater female to male prevalence ratio for eating disorders than substance abuse

Differences, cont.

- More stigma, particularly for the obese and for males
- Less recognition of EDs as brain diseases with genetic and biochemical components: “They just need to eat,” “They just need to stop eating so much,” “They just need to stop throwing up.”
- Different physical signs and symptoms (but multi-organ impairments in each)
- Less availability of 12 step support groups for ED

12 Step Myths

- **It's a cult**
 - Members can leave at any time
- **Members are told they will never be fully recovered**
 - The message of recovery is that full and happy living is possible.
- **Members are forced to stay in a position of powerlessness**
 - Admitting powerlessness over having a disease opens people up to the power of recovery, to live empowered lives
- **Members are told they cannot trust themselves/self-confidence is a liability**
 - Recovery is learning to trust oneself in the context of the loving support of a recovery community
- **An addiction model attributes appetites and desires to “the disease”**
 - Recovery encourages attention to the body's wisdom, a reconnection to hunger and satiety signals, development of body trust
- **Members are discouraged from having therapists, doctors, and other sources of support**
 - “We have no opinion on outside issues.”

12 Step Myths

- Members are discouraged from taking medication
 - 12step groups have no opinion on medication or any other outside issues
- It's a religious program
 - Members are free to develop their own understanding of a Higher Power or God; members can belong to any outside organized religion or none at all
- It doesn't work for eating disorders because people can't abstain from food/eating
 - 12-step model for EDs encourages each person to define what food behaviors or foods constitutes abstinence from her/his disease; abstaining from “alcohol foods” or “alcoholic food behaviors”
- 12-step groups like Over-eaters Anonymous (OA) and Eating Disorders Anonymous (EDA) won't work for anorexics or bulimics because there are overweight members
 - The only requirement for membership is a desire to stop eating compulsively
- OA members aren't supposed to eat sugar or white flour
 - False, each person develops her own definition of abstinence (usually with the help of an ED professional)

Tools of Recovery

- Literature:
 - The basics: Big Book of Alcoholics Anonymous; 12 Steps and 12 Traditions of AA
 - ED focused: 12&12 of OA; Brown Book of Overeaters Anonymous; Anorexics and Bulimics Anonymous, daily meditation books (i.e. For Today, Voices of Recovery), pamphlets addressing special populations and many more.
- Meetings
- Sponsorship
- Service
- Anonymity (humility—being right-sized)
- Writing/journaling
- Phone calls
- Plan of eating/definition of abstinence

Defining Abstinence

Abstinence means waking up every day and dedicating myself to recovery— to taking care of my body, mind, and soul.

For my **body**, abstinence is eating nutritious foods to fuel my body in a healthy way.

For my **mind**, abstinence means actively censoring my thoughts and effectively using my coping skills to manage stress and relieve anxiety.

For my **soul**, abstinence means truly being happy. It means that I make decisions that are consistent with my morals and values and take full responsibility for my own choices.

--former Timberline Knolls resident

Eating Disorders and Drug Use

- Most common abused drugs
 - Amphetamines
 - Appetite suppressant
 - Cocaine
 - Appetite suppressant
 - Marijuana

Emotional Eating and Substance Use Disorders (SUD)

- Individuals with both involve the use of maladaptive behaviors to control or lessen negative or undesired affect
- Eating is used for this purpose
- Early research: emotional eaters had pervasive sense of interpersonal distrust, high levels of perfectionism, paralyzing sense of ineffectiveness, difficulty identifying emotions, difficulty identifying hunger cues, and decreased ability to communicate feelings.

Emotional Eating and SUDs

- Coniglio (1990) indicated up to half of women who misuse substances also suffer from an eating disorder such as Bulimia or Binge Eating Disorder
- People with SUD eat more after substance intake is reduced and report “food cravings” (Garvey 1989)
- Adolescents with ED who purge use substances to relieve emotions and “get away” from problems (Stock 2002)
- Individuals with SUD and ED use food to regulate emotions (Granner, 2002)

Treatment

- Ongoing medical care
- Education
- 12 step facilitation
- Dialectical behavioral therapy (DBT)
- Family therapy and support
- Nutrition therapy
- Individual and group therapy
- Expressive therapies, i.e., art, equine, dance/movement, yoga, canine
- Trauma work

Treatment (Physical)

- Abstinence from alcohol and drugs
- Treat medical complications (safe detox, liver failure, nutritional deficiencies, anemias, etc.)
- Re-feeding: food as medicine
- “Normalization” of eating process
- Body image/distortions (physical, mental and emotional work)
- Medication: anti-craving meds, SSRIs high dose for Bulimia, topirimate for Binge Eating, atypical antipsychotics for Anorexia; treat co-occurring psychiatric disorders

Treatment (Soul)

- Healing trauma: exposure therapy, story-telling, somatic/alternative therapies, expressive therapy
- Chronic illnesses require long-term care: ongoing therapy, ongoing practice of 12-step recovery and DBT skills
- Restoration of a life enhancing relationship with food and body, self and others, Higher Power/God
- Relapse: forward or backwards?

Summary

- Addictions and eating disorders are genuine diseases--progressive, chronic and potentially fatal; and are FAMILY diseases.
- Patients with eating disorders frequently have a family history of alcoholism or addiction.
- Clinical similarities between substance and behavioral addictions include common underlying cognitive, emotional, relational, and spiritual problems.
- There appear to be similar biological brain pathways associated with addictive food behaviors and substance addictions.
- Addictive behaviors are powerfully re-enforced at a biochemical level, and at the level of emotional and body memory.

Summary (cont.)

- Experiential therapies are powerful tools to access
- 12-step facilitation as an integral part of treatment increases the likelihood of long-term recovery for those with eating disorders, alcoholism and the family aspects of the disease:
 - AA, OA, EDA, ABA, Families Anonymous, Alanon, ACOA



TIMBERLINE  KNOLLS

Making a real life difference.

A residential treatment center located on 43 beautiful acres just outside Chicago, offering a nurturing environment of recovery for women ages 12 and older struggling to overcome eating disorders, substance abuse, mood disorders, trauma and co-occurring disorders.

www.timberlineknolls.com

| 1.877.257.9611