ROGERS
Behavioral Health

The intersection of eating disorders and substance use disorders: Assessment and intervention

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Disclosures

Michelle L. Maloney, PhD, NCSE, LPC, CAADC, CRPS, and Nicole Stettler, PhD, have declared that they do not, nor do their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Identify at least two ways to assess eating and/or substance use problems in patients
2. Recognize at least two ways to adapt evidence-based interventions to address co-occurring eating and substance use disorder symptoms
3. Describe at least two perspectives on at least one emerging and/or controversial topic in the field

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What will be covered in this webinar

- Eating and substance use: Co-occurring presentations
- Assessment of eating and substance use behaviors
- Adapting evidence-based interventions for co-occurring symptoms
- Emerging or controversial topics

Please note:

Our focus for the content of this program is on the healthcare professional who is practicing in a clinical setting.

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Presenter subjectivities

Michelle L. Maloney

Professional identities

- Executive director of Addiction Services
- Licensed in both mental health and substance use
- Thirty years of experience in SUD

Personal identities

- She/her/hers
- White, Heterosexual, married, middle-aged, middle class, Gen X
- Wife, Sister, Daughter, Veteran

Nicole Stettler

Professional identities

- Executive director of Eating Disorder Recovery Services
- PhD in Clinical Psychology
- Seven years of experience in ED

Personal identities

- She/her/hers
- White, cisgender, able-bodied, thin privilege, upper-middle class, Millennial
- Spouse, Daughter

We acknowledge that our experience, intersectionality, privilege – and lack thereof – informs what we each bring to our research, clinical practice, and teaching

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Eating and substance use: Co-occurring presentations

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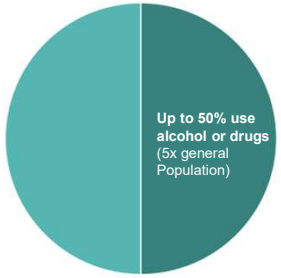
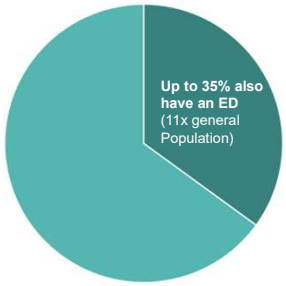
Co-occurrence

Individuals with eating disorders (ED):



Individuals with alcohol or drug dependence:



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Co-occurring presentation #1:

Use of appetite-reducing drugs

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Stimulants overview

- Psychoactive substance that provides temporary improvements in physical or mental functioning
- Temporarily elevates mood and increases feelings of well-being, energy, and alertness
- Widely used as both illicit recreational substances as well as prescribed.
- For prescriptions, typically prescribed for ADHD, depression, narcolepsy, and/or weight loss
- Some of the ***most addictive*** substances known

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Types of stimulants

- Cocaine
- Amphetamines
- Methamphetamine
- Prescription
- Ephedrine
- Pseudoephedrine
- Caffeine
- Nicotine

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Stimulants: Effects

- Euphoria changing to depression
- Anxiety/nervousness
- Irritability
- Tightness of muscles
- Paranoia
- Hallucinations
- Impulsive behavior
- Rapid speech
- Sweating
- Increase in blood pressure
- Weight loss
- Loss of appetite
- Increased temperature
- Strokes
- Seizures
- Nausea/abdominal pain
- Heart attack

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Restrictive eating disorders and use of stimulants

Prevalence of use among people with anorexia nervosa:

- Caffeine (37%)
- Tobacco/nicotine (25%)
- Prescription stimulant medications (14%)
- Amphetamines (3%)
- Cocaine (1%)

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Use of stimulants: Impact on ED

Use may be an ***intentional*** weight control strategy for some individuals

- Some evidence this motivation is gender-specific

Even if not intentional to control weight, clinical concern for negative impact on ED treatment outcomes

- May undermine goal of regular (mechanical) eating
- May disrupt natural hunger and fullness cues

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Co-occurring presentation #2:

"Drunkorexia"

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Alcohol use and disordered eating: "Drunkorexia"

- What is it?
  - Restriction of caloric intake
  - Excessive physical exercise
  - Alcohol-related use disorder
- Estimated to affect:
  - 14% to 46% of people
  - More prevalent among
    - Women
    - People between 10 and 19 years old
    - Caucasian individuals

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Drunkorexia: Common behaviors

- Restricts food to control weight
- Exercises 2+ hours daily to compensate for calories consumed from drinking (before or after)
- Uses stimulants to control weight
- Uses laxatives or diuretics to control weight
- Induces vomiting during or after drinking
- Drinks large amounts with the intention of vomiting
- Restricts calories before or during alcohol use to intensity intoxication or become intoxicated more quickly

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Drunkorexia: Current state

- Lack of robust published research
- Impact of COVID
- Assessment and evaluation
  - Alcohol use – including patterns, amounts
  - Disordered eating patterns and behaviors
  - Nutritional and medical evaluation
- Treatment requires
  - Comprehensive approach – target emotion dysregulation and teach skills to manage and tolerate emotions
  - Multi-disciplinary team

These patients have higher impulsivity, increased difficulty in engaging in goal-directed behavior, and difficulty engaging in emotion regulation strategies

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Co-occurring presentation #3:

Substance use and binge eating

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Substance use and risk of binge eating

Substance use can be a self-reported trigger for binge eating

- Disinhibition hypothesis
  - Not well-supported by EMA studies and longitudinal research, even for substances with purported appetite-stimulating effects (e.g., cannabis)
  - May be a post hoc explanation
- Expectancy effects?
  - Cannabis users with ED symptoms report expecting use to increase binge-eating behaviors

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Substance use and risk of binge eating

Shared vulnerabilities or mechanisms:

- Impulsive personality traits
- Impairments in executive functioning (set-shifting, decision-making)
- Negative mood state
- Positive expectancies

Lisdexamfetamine (brand name: Vyvanse) is FDA-approved for treatment of moderate-to-severe binge eating disorders in adults

- Seems to alter neural networks associated with self-referential processing, executive function, and reward

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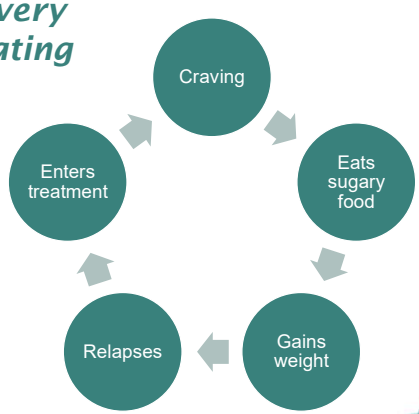
Substance use recovery and risk of binge eating



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Assessment of eating and substance use behaviors

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Validated screening and assessment tools: Eating Disorders

SCOFF

- Available as part of SBIRT for ED at www.eatingdisorderscreener.org
- Short but sensitive to AN and BN among young women

EDE-Q

- https://www.cbte.co/for-professionals/measures/
- Longer, but more sensitive to symptoms of other EDs (except ARFID)

NIAS

- Limited validation, but short and specific to ARFID
- Should be used in conjunction with EDE-Q

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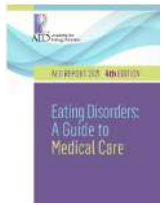
Assessment of eating disorders

In addition to behavioral information, medical information is also critical in the assessment of an ED

- Temperature
- Resting heart rate
- Blood pressure
- Orthostatic pulse and blood pressure
- Current height, weight, and BMI (or percentile for youth)
- Physical signs of malnutrition or purging
- Laboratory assessment, including CBC and comprehensive metabolic panel
- Electrocardiogram in patients with restrictive ED, severe purging behavior, and/or taking medications known to prolong QTc intervals



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Validated screening and assessment tools: Substance Use Disorders

Alcohol Use Disorders Identification Test (AUDIT) - https://nida.nih.gov or https://www.samhsa.gov

Drug Abuse Screening Test (DAST) – https://cde.nida.nih.gov/

Adolescent screening tool – Alcohol and brief intervention https://www.niaaa.nih.gov/sites/default/files/publications/NIAAA_Alcohol_Screening_Youth_Guide

Adolescent screening tool - CRAFFT - https://crafft.org/

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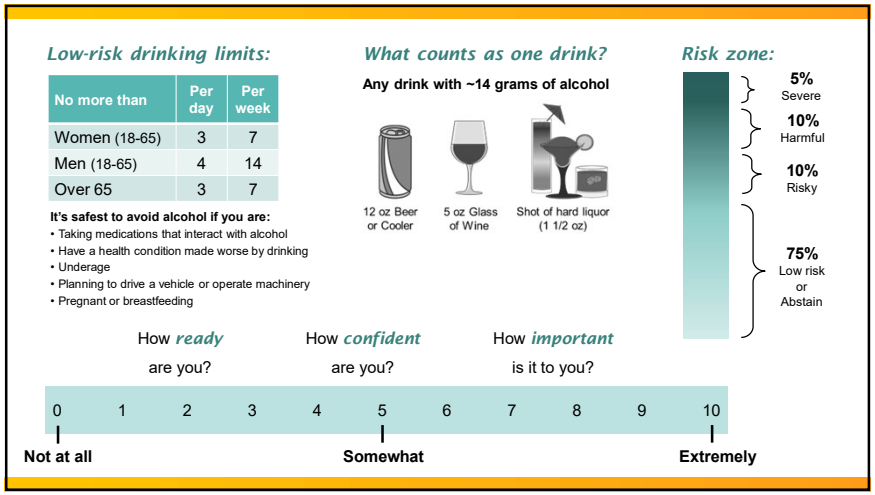

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Now what?

- Once the presence of ED and SUD symptoms is identified, integrated treatment is ideal
- However, no RCTs or evidence-based treatment manuals for this population exist
- Clinical judgment and case conceptualization must be used to identify a treatment plan

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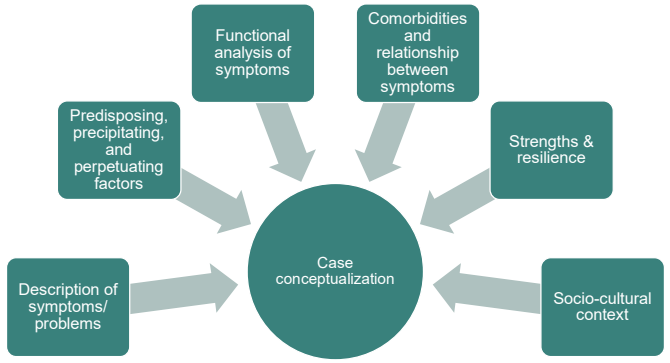
Using case conceptualization to identify treatment plan



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Case example: Terry

A 31-year-old male presented for treatment with a history of restrictive eating and significant alcohol use since adolescence. He reported consuming only one meal per day, followed by 10-20 standard alcoholic drinks. He was restricting eating as a way to look more slim/toned. He stated that this occurred starting at age 17 and continued for about 7 years. This pattern led to inadequate nutritional intake and significant alcohol use disorder. He then entered treatment for alcohol use. After completing treatment, he remained in recovery for about 2 years, although eating patterns remained chaotic. For the past 4 years, he has restricted during the day and binge eats at night. He denies significant body dissatisfaction but reports often feeling nauseous and not very hungry during the day. He has continued with his alcohol use and reports that his binge eating is tied to nightly edible use (up to 100 mg nightly).

Age and generation: 31

Diagnosis status: AUD, CUD, BED, MDD

Disability & physical health status: Able-bodied, malnourishment but no major medical problems as a result

Religion and spirituality: Believes in God; No active religion

Ethnicity and race: Pacific Islander, and Caucasian (Identifies as white)

Sexual orientation: Bi-sexual; Multiple partners

Socioeconomic status: Middle SES, well educated, currently unemployed and has been unable to maintain employment – family has been supporting him

Indigenous heritage: Non-native

National origin: U.S. born

Gender identity: Cisgender (he/him)

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Case example: Assessment

- Social Services assessment
- ASAM assessment with level of care considerations
- Extensive substance use history, AUDIT, and relapse mapping
- Multidisciplinary ED assessment
  - Behaviors
  - Medical status
  - Nutritional status

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Case example: Case conceptualization

Predisposing social context: Typical among family and peers to be concerned about weight and engage in dieting practices

Precipitating factors: Initial restriction (dieting) and alcohol use precipitated by attempts to fit in with peers as an older adolescent

Current maintaining factors:

- Alcohol & edible use typical among peers
- Alcohol use, edibles, and binge eating all functioning to soothe/numb painful emotions and pass the time (possible boredom, loneliness, lack of meaning in life)
- Learned associations with nighttime, bedroom, peer group and alcohol and binge eating
- Binge eating further exacerbated by physiological pressure to eat due to long-standing undernourishment and skipping meals
- Behaviors lead to feelings of guilt, shame, hopelessness that exacerbate depression

Strengths: intelligence and education, family's material support, previous history of recovery, well-liked by others

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Level of care considerations: ASAM (2024)

Determining the least restrictive care to appropriately treat the patient while taking into account patient-specific requirements

Questions to consider:

1. Is the patient experiencing any withdrawal symptoms?
2. Is the patient experiencing any medical conditions?
3. Does the patient have any psychiatric or cognitive conditions, and what level of support do they need to manage?
4. What is the risk level associated with their substance use-related behaviors?
5. What is the patient's current recovery environment?
6. What are the patient-specific considerations?

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Level of care considerations:
APA (2023) and SAHM (2022)

Factors* supporting hospitalization (medical or specialized ED unit)

Factor	Adults	Adolescents
Heart rate (resting / orthostatic)	<50 bpm / sustained increase of >30bpm	<50 bpm / sustained increase of >40 bpm
Blood pressure (resting / orthostatic)	<90/60mmHg / >20mmHg drop in sBP	<90/45 mmHG / >20mmHg drop in sBP
Low blood glucose	<60 mg/dL	
Hypothermia	<96.8 degrees F	
Low BMI	<15	≤75% median BMI for age & sex
Rapidity of weight change	>10% weight loss in 6 months of >20% weight loss in 1 year	
EKG abnormalities	Prolonged QTc >450 or other sig abnormalities	
Electrolyte disturbance	Hypokalemia, hyponatremia, hypophosphatemia, hypomagnesemia	

* incomplete list; see practice guidelines

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Level of care considerations:
APA Practice Guideline (2023)

Determining the least restrictive care to appropriately treat the patient while taking into account patient-specific requirements

Questions to consider:

1. Does the patient have any factors suggesting ***significant medical instability*** that would require pediatric or medical admission?
2. Does the patient have ***co-occurring conditions*** that would significantly affect treatment needs and require higher level of care?
3. Has the patient had a trial of ***outpatient treatment*** that was not successful?
4. To what extent is patient ***able to control*** eating disorder and weight control behaviors?

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Level of care considerations:
APA Practice Guideline (2023)

Questions to consider:

5. What is the patient's ***level of motivation to recover,*** including insight and cooperation with treatment?
6. What is the patient's ***psychosocial context***, including level of stress and ability to access support systems?
7. To what extent is the patient's access to a level of care influenced by ***logistical factors*** (geography, financial or insurance concerns, access to transportation, childcare needs, etc.)?

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Case example: Treatment plan

Following detox for alcohol, the patient was referred to a co-occurring partial hospitalization program

Interventions indicated by case conceptualization:

- **Psychoeducation** on substance use, eating patterns, and connections between the two
- **Cognitive behavioral therapy** sessions, including focus on establishing regular eating to break restrict/binge cycles
- **Behavioral activation** for depression
- **Nutritional counseling**, including education on adequate variety and re-establishing hunger/fullness cues
- **Motivational interviewing**, focusing on ongoing engagement in treatment as he continued to struggle with regular attendance
- **Dialectical behavior therapy** skills for emotion regulation and impulse control
- **Recovery maintenance planning** to establish awareness of triggers, personal intervention strategies and developing a relapse map to assist in early intervention

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Adapting evidence-based interventions for co-occurring symptoms

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Considerations for psychoeducation about weight and weight changes

- Weight restoration is a key treatment goal for EDs where weight has been suppressed
- Substance use adds another layer of impact on metabolism, nutrient absorption, and body composition
- Weight gain common in substance use recovery
  - May be body attempting to re-establish homeostasis or may overshoot to protect again future states of "famine"
- Psychoeducation should be cautious not to reinforce weight stigma or fear of weight gain
  - Emphasize importance of stabilizing eating and substance use *behaviors*, and tolerating or accepting weight/shapes changes

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Case example

- Although not significantly underweight, Terry's weight likely suppressed due to years of skipping meals and chaotic eating patterns
- Support Terry in anticipating some weight recovery
- Help challenge negative thoughts, catch and reduce new weight control behaviors

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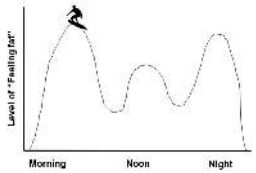
Use of urge surfing to manage urges

- Introduced by Alan Marlatt in early 1980s as part of "Mindfulness-based relapse prevention" for substance use
- Explicitly used for eating disorders in applications of DBT



Steps:

- Notice the urge
- Pay attention to associated sensations and thoughts
- Accept the experience rather than fighting or suppressing it
  - Visualize a wave, play the tape forward
- Allow the urge to naturally pass
  - In 12-step, call sponsor or recovery coach

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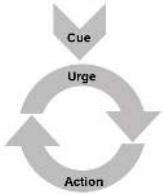
Use of urge surfing to manage urges

Cue exposure

- Exposure to situations, people, substances or food, etc., that might be associated with higher urges
- Prevent engaging in the behavior
- Learned association gradually extinguishes
- Not indicated for substance use
- Effective for reducing binge eating, but not purging



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Case example

- Clinician worked with Terry to identify triggers for alcohol use, cannabis use, and binge eating (places, people, items, physical sensations, time of day, etc.)
- Asked to practice urge surfing along with other coping skills when urges arise
- Able to practice cue exposure in treatment for specific binge foods

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Recovery maintenance planning

- Even highest quality ED and SUD treatment associated with large portion of partial symptom remission
- Relapse is common
- Recovery maintenance is a key part of treatment to help patient continue choosing adaptive behaviors vs maladaptive patterns over time
- Exit planning can be vital

Essential components:

- Identification and managing triggers
- Developing coping skills
- Building a support network
- Lifestyle changes
- Ongoing care and monitoring
- Mindfulness

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Case example

Terry's recovery maintenance plan included:

- Triggers for substance use, restriction, and binge eating
- Coping skills he found useful from CBT, DBT, mindfulness, and other parts of treatment
- People in his support network who promote recovery, including new peer groups he started to join
- Lifestyle changes, including applying to jobs to structure his time and building in time for meals and snacks
- Ongoing care and monitoring with outpatient therapist, dietitian, and primary care physician

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Emerging and/or controversial topics in the field

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Harm reduction approaches for SUD vs ED

Harm reduction: Interventions aimed at reducing negative effects of behaviors without necessarily eliminating the problematic behavior entirely

- Strong evidence for effectiveness of approaches in substance use field
- More emerging in ED field
  - Part of "dialectical abstinence" in DBT for BN for BED
    - Minimize harm of a lapse and re-commit to abstaining from behaviors
  - More controversial in the context of "severe and enduring eating disorders," especially anorexia nervosa

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Harm reduction approaches for SUD

- Improves quality of individual as well as the community life by reducing HIV, Hepatitis C, overdose
- Ensures that individuals must play a role in the creation of programs designed to serve them
- Users were the originators of syringe exchange, naloxone distribution, and the first methadone program
- Affirms that substance users are the primary agents of reducing the harms of their use
- Recognizes the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities effect people's vulnerability and capacity for effectively dealing with the harms of substance use

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Harm reduction approaches for SUD

Many patients with lower severity or length of use would prefer to reduce use

- Priorities of treatment were found to be
  - Staying alive
  - Improving quality of life
  - Reduction of substance use
  - Improvement of Mental health
  - Being able to meet their basic needs
  - Increasing self-efficacy
  - Increasing connection to support services

(National Council for Mental Wellbeing, 2022)

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Harm reduction approaches for SE-ED

Examples:

- May collaborate with patient on maintaining a lower weight than recommended
- May focus on enhancing quality of life vs symptom elimination

Clinical and ethical concerns:

- No research on how effective harm reduction approach is
- When and for whom? No clear criteria for "severe and enduring ED/AN"
- Does it "aid and abet" illness behavior?
- Does it allow ED clinicians and field to "give up on" striving to produce, offer, and increase access to high quality treatment?

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Food addiction

- Emerging area of research
  - Animal and human neurobiological systems
  - Behavior ratings based on substance use dependence criteria
  - Particular focus on addiction to "highly palatable" and/or "ultra-processed foods"
- Construct overlaps with BED, BN, and obesity, but does not fully overlap with any of these

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Approaches to addressing food addiction

- Limited research on food addiction interventions and outcomes
- Individual treatment approaches
  - Medication (naltrexone and bupropion, pexacerfont)
  - Bariatric surgery
  - Lifestyle modification, typically with nutrition plan
- Public health approaches (e.g., regulation of food products)

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Food addiction – abstinence in treatment?

- Muele (2019) – might concept of food addiction suggest effective treatment should include abstinence from some foods?
- Conflicts with gold-standard ED treatment approaches such as Enhanced CBT (CBT-E)
  - Reducing dietary restraint (avoidance or attempted avoidance of certain "forbidden" foods) is key part of this transdiagnostic treatment
  - One study to date supporting a theory that FA predicts restraint, rather than other way around
  - No studies examining CBT-E without dietary restraint element however
- On the other hand, abstinence has been a core part of some mutual-help support groups (e.g., Overeaters Anonymous), although low levels of evidence exist for these program's effectiveness

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Use of GLP-1 agonists for alcohol use disorder

- Glucagon-like peptide-1 (GLP-1) receptor agonists have shown potential in the treatment of substance use disorders
- GLP-1 receptor agonists like exendin-4 have been shown to reduce cocaine and heroin-seeking behavior in animal models
- For alcohol use disorder, GLP-1 receptor agonists have been shown to decrease alcohol intake and reduce the motivation to consume alcohol in both preclinical and clinical studies

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Use of GLP-1 agonists: Implications for EDs

- GLP-1 agonists act on receptors in appetite and reward areas of the brain
- Reduces appetite and "food noise," increase satiation
- Small pilot studies demonstrating potential to reduce binge eating in BED and BN
- Concerns:
  - Potential for misuse as a new "diet drug"
  - Use without appropriate screening for ED symptoms, especially for people in higher weight bodies
  - Potential conflict with ED treatment strategies that focus on reducing weight control behaviors

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Key take-home messages

1. Essential to complete a thorough assessment to understand patient's motivation, level of care, and current needs to address a comprehensive approach to treatment.
2. Conceptualization of functions of ED and SUD symptoms can help guide coordinated interventions to address overlapping and distinct maintaining mechanisms.
3. A multi-disciplinary team is vital. Teams should hold a patient-centered focus while maintaining safety and engagement.

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About the presenters

Nicole Stettler, PhD, is a licensed clinical psychologist and the executive clinical director of Eating Disorder Services

Michelle Maloney, PhD, NCSE, LPC, CAADC, CRPS, is a licensed professional counselor and substance use counselor and the executive clinical director of Addiction Services

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