Understanding the Link Between Alcohol Use Disorder and Eating Disorders and the Importance of Individualized Treatment in this Population

EDRDPRO

Eating Disorder Registered Dietitians & Professionals

ELEVATE YOUR SKILLS

Dr. Danielle Hagood, Psy.D.
Leigh-Ann Bamberg MS, RDN, LD

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Understanding the Importance

- The importance of Eating Disorder (ED) and Alcohol Use Disorder (AUD) education and provider alignment.
- Acuity of ED and SA individually and collectively
- Dual diagnosis for SUD and ED are currently on the rise
- The lack of awareness, understanding and evidenced based research of the link between eating disorders and Alcohol Use Disorder (AUD) has led to limited treatment options for those in need. Despite their high rates of co-occurrence, few treatment programs exist that address both eating disorders and Alcohol Use Disorder (AUD) simultaneously and effectively.
- Co-occurrence is more of a "rule" now than an exception
- Often, the symptoms of one disorder can mask and/or worsen the other disorder and vice versa
- One of the strongest and most consistent predictors of fatal outcomes with Anorexia was severity of alcohol abuse in follow-up studies.
- The highest rates of suicide attempts are reported among individuals with bulimia and co-occuring alcohol abuse. (54%).

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The DSM-V for Substance-related Disorders

The DSM-V recognizes substance-related disorders resulting from the use of 10 separate classes of drugs:

1. Alcohol
2. Caffeine
3. Cannabis
4. Hallucinogens (phencyclidine or similarly acting arylcyclohexylamines, and other hallucinogens, such as LSD)
5. Inhalants
6. Opioids
7. Sedatives
8. Hypnotics, or anxiolytics;
9. Stimulants (including amphetamine-type substances, cocaine, and other stimulants);
10. Tobacco and other or unknown substances

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DSM-V Criteria: Alcohol Use Disorder

DSM-V DIAGNOSTIC CRITERIA

- Consumed more alcohol or spent more time drinking than intended.
- Wants to limit or halt alcohol use, but hasn't succeeded.
- Spends an inordinate duration drinking, being ill, and undergoing the aftereffects of alcohol use.
- Has strong cravings for alcohol
- Consuming alcohol or becoming ill because of it has kept the person from properly attending to household duties and children, or resulted in difficulties performing on the job or at school.

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Continued Alcohol Use Disorder Diagnostic Criteria

- Has continued drinking in spite of it causing problems with family and loved ones.
- Has discontinued or is only sporadically involved with things that were once enjoyable or important to be able to drink.
- Has repeatedly been in situations during the consumption of alcohol that has increased the chance of being injured (using machinery, driving).
- Even though a person feels sad or distressed, or it affects an already existing health problem, the person continues to drink. Or, after episodes of forgetting or going blank about the events during drinking, the individual continues to use alcohol.
- Has to increase drinking to get the results he wants. (The usual amount of alcohol provides little results.)
- When the alcohol wears off, it causes symptoms like insomnia, difficulty staying asleep, aggravation, nervousness, sadness, stomach upset and nausea, and/or perspiring. Or, the person felt items were there, but they are actually not.

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DSM-V Feeding and Eating Disorders

DSM-V DIAGNOSTIC CRITERIA

The DSM-V defines feeding and eating disorders as characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning.

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Feeding and Eating Disorders

Pica: Persistent eating of nonnutritive, nonfood substances over the period of at least 1 month/ The eating of nonnutritive, nonfood substances the inappropriate to the developmental level of the individual.

Rumination Disorder: Repeated regurgitation of food over the period of at leas one month Regurgitated food may be re-chewed, re-swallowed, or spit out..

Night eating syndrome: Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal. There is awareness of recall of the eating. The night eating is not better explained by external influences such as changes in the individual's sleepwake cycle or by local social norms. The night eating causes significant distress and/or impairment in functioning. The disordered pattern of eating is not better explained by binge-eating disorder and or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication.

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Feeding and Eating Disorders

Avoidant/Restrictive Food Intake Disorder (ARFID)

Feeding or eating disturbance (e.g. lack of apparent interest in eating food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

1. Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).

2. Significant nutritional deficiency.

3. Dependence on enteral feeding or oral nutritional supplements.

4. Marked interference with psychosocial functioning.

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Anorexia Nervosa

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. Specify whether: Restricting type: During the last three months, the individual has not engaged in recurrent episodes of binge eating or purging behaviour (i.e. self-induced vomiting, or the misuse of laxatives, diuretics, or enemas).

Restricting type: During the last 3 months, the individual has not engaged in re- current episodes of binge eating or purging behavior (i.e., self-induced vomiting or the mis- use of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-eating/purging type: During the last three months the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e. self-induced vomiting, or the misuse of laxatives, diuretics, or enemas). Specify current severity: Mild: BMI more than 17 Moderate: BMI 16- 16.99 Severe: BMI 15-15.99 Extreme: BMI less than 15

**Atypical Anorexia Nervosa*: all of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.

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Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both: www.bodymatters.com.au 1. Eating in a discrete period of time (e.g. within any 2 hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances; 2. A sense of lack of control over eating during the episodes (e.g. a feeling that one cannot stop eating or control what or how much one is eating.

B. Recurrent inappropriate compensatory behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa. Specify current severity: Mild: An average of 1-3 episodes of inappropriate compensatory behaviours per week. Moderate: An average of 4-7 episodes of inappropriate compensatory behaviours per week. Severe: An average of 8-13 episodes of inappropriate compensatory behaviours per week. Extreme: An average of 14 or more episodes of inappropriate compensatory behaviours per week.

Bulimia Nervosa (of low frequency and/or limited duration): all of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.

Purging disorder: recurrent purging behavior to influence weight or shape (e.g. self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

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Binge-Eating Disorder

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both: 1. Eating in a discrete period of time (e.g. within any 2 hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances; 2. A sense of lack of control over eating during the episodes (e.g. a feeling that one cannot stop eating or control what or how much one is eating)

B. Binge eating episodes are associated with three or more of the following: 1. Eating much more rapidly than normal. 2. Eating until feeling uncomfortably full. 3. Eating large amounts of food when not feeling physically hungry. 4. Eating alone because of feeling embarrassed by how much one is eating. 5. Feeling disgusted with oneself, depressed, or very guilty afterwards.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa. Specify current severity: Mild: 1-3 binge eating episodes per week. www.bodymatters.com.au Moderate: 4-7 binge eating episodes per week. Severe: 8-13 binge eating episodes per week. Extreme: 14 or more binge eating episodes per week.

Binge-eating disorder (of low frequency and/or limited duration): all of the criteria for binge-eating disorder are met, except that the binge occurs, on average, less than once a week and/or for less than 3 months.

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Other Specified Feeding or Eating Disorder

a. Symptoms characteristic of a feeding or eating disorder that cause clinical distress or impairment in social, occupational, or other important areas of functioning; however DO NOT meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.
b. This category can also be used in situations to communicate the specific reason the presentation does not meet the criteria for a specific eating disorder.
c. This is done by recording "other specified feeding or eating disorder" followed by the specific reason e.g. "bulimia nervosa- low frequency".

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Unspecified Feeding or Eating Disorder

A. Unspecified Feeding or Eating Disorder-Symptoms characteristic of a feeding and eating disorder & cause clinical significant distress or impairment in social, occupational or other important areas of functioning predominate.
B. However DO NOT meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class.
C. Used when the clinician chooses not to specify the reason that criteria are not met for a specific feeding and eating disorder.
D. This includes times when there is insufficient information to make a more specific diagnosis (e.g. in emergency room setting).

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Theories of Addiction relating to Alcohol Use Disorder (AUD)

1. Biological/disease Model
Biological predisposition, neurotransmitter imbalance
1. Psychodynamic Model
Self medicating, symptom of an underlying issue, maladaptive coping, issues addressed addiction will remit
1. Moral/Spiritual Model
Weak, sinful, poor character
1. Environmental/Social Model
Stress, peer pressure, observational learning lack of skills
1. Biopsychosocial Model: All may have some truth

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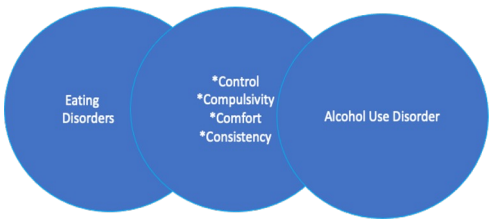

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Similar Characteristics Between Eating Disorders and Alcohol Use Disorder

1. Preoccupation with the behavior; drinking alcohol, substance use, food/bingeing, purging
2. Life Threatening
3. Relapsing Course
4. ED and AUD may produce mood altering effects
5. Require intensive , long term treatment
6. Secrecy, Rituals, engaging in compulsive Behaviors
7. Often begins with experimentation
8. Leads to compromised nutritional and medical complications
9. Increased severity over course of time when untreated

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Vulnerability Factors for AUD and ED

- The DSM 5 recognizes that people are not all automatically or equally vulnerable to developing substance related disorders and eating disorders.
- Eating disorders and alcohol use share a number of common risk factors, including brain chemistry, family history, low self-esteem, depression, anxiety, childhood trauma, undiagnosed MH issues, and social pressures. Other shared characteristics include compulsive behavior, social isolation, and risk for suicide.
- Many individuals with eating disorders describe eating-related symptoms similar to those endorsed by individuals with AUD, specifically cravings and patterns of compulsiveness.

- **Brain chemistry:**
  - Both BED and AUD have been associated with reduced activity in the orbitofrontal and prefrontal cortex areas, which are associated with self-control.[3]
  - A deficiency in the dopamine D4 receptor signaling could increase the susceptibility to the development of Alcohol Use Disorder (AUD) or ED and related comorbidities.[2]

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Vulnerability Factors for AUD and ED- Continued

- Addiction is a three-stage cycle starting with binge and intoxication, then withdrawal and negative effect, and preoccupation and anticipation. The cycle becomes more severe over time with continued use and abuse of the substance. Dramatic changes in brain function lesson an individual's ability to control their substance use.
- Euphoric feelings motivate people to continue to use the substance despite the risks.
- Continued misuse of substances cause progressive changes in the structure and function of the brain, these are called neuroadaptations leading to abuse.
- Anxiety has proven to be another vulnerability factor. In some individuals, starvation, or food restriction reportedly may actually reduce anxiety; this may occur because of reduced serotonin activity in individuals with over activity in this neurotransmitter system. Alcohol is a depressant and the effects are similar in reducing anxiety.

- **Family History:**
  - Family history of AUD and/or ED potentially increases the likelihood that an individual may be predisposed to developing a disorder.
  - Moderate to Highly Heritable Disorders
  - Family dynamic and environment may play an important role

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Vulnerability Factors for AUD and ED- Continued

- **Low Self-Esteem:**
  - Self-esteem, defined as an evaluation of self-worth and importance, is a central construct in psychology. It encompasses the extent to which individuals' value, approve of, appreciate, or like themselves
  - In ED, approximately 7 in 10 women and girls report a decline in body confidence and increase in beauty and appearance anxiety, which they say is driven by the pressure for perfection from media and advertising unrealistic standard of beauty.
- **Depression and Anxiety:**
  - A study of more than 2400 individuals hospitalized for an eating disorder found that 97% had one or more co-occurring conditions, including:
    - 94% had co-occurring mood disorders, mostly major depression
    - 56% were diagnosed with anxiety disorders
    - 22% had an alcohol or substance use disorder

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Prevalence and Comorbidity

- According to the National Center on Addiction and Substance Abuse, up to 50% of individuals with eating disorders abused alcohol, a rate five times higher than the general population.
- Up to 35% of individuals who abused or were dependent on alcohol or other drugs have also had eating disorders, a rate 11 times greater than the general population.

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Common Addictive Substances

- The DSM-5 recognizes 10 separate classes of drugs, among which there are several commonly abused in individuals with ED:
  - Alcohol
  - Stimulants
  - Cannabis
  - Tobacco
- Dr. Gaudiani (*Sick Enough*) suggests that addictive substances such as alcohol can play a specific role for individuals with eating disorders. Specifically, it can:
  - Satisfy the individual's desire to "have a good time"
  - Act as a way to self-medicate by masking anxiety, depression, feelings of being overwhelmed, or other symptoms of co-occurring mental disorders
  - Often times can be used as a substitute for food; "drink calories"
- Treatment and sobriety must work to offer ways for these individuals to have their needs and desires met in alternative ways.

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Alcohol and ED Psychological Implications, Presentation and Assessment:

- Behavioral: lethargic, ADL's/self care tasks, slowed speech, motor retardation
- Interpersonal: isolating, conflict, motivation
- Psychological: depressed and/or anxious mood, impaired cognitive functioning, apathy

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The Importance of Multidisciplinary Assessment of ED and SA Clients

- Screening and Quantitative Assessment
- Eating Disorders: EDE-Q, DSED, BUILT-R, EAT, EDI-2, EDQ, QEWP
- Substance Use Disorders: SCOFF, CAGE, TWEAK, MAST, ADS, DAST, DSQ
- Assessment of Withdrawal: CIWA-Ar, COWS
- Labs: Urinalysis, Blood Chemistry, EKG, Stool Samples, Imaging
- Qualitative Assessment
- Assessment as a method to begin to explore function of ED and SUD
- Obtain collateral information when feasible

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Alcohol and ED-Continued

- **Nutritional Implications:**
  - Malnutrition in this population-Many individuals suffering from alcohol abuse are malnourished secondary to consumption of too few nutrients as well as the impact alcohol can have on metabolic processes. Alcohol abuse can impact the ability of the body to properly digest, absorb, and utilize nutrients.
    - Overlap of Alcohol Abuse/ED-"Drunkorexia"
      - Individuals who restrict calories or purge to avoid weight gain from drinking alcohol
        - Individuals engaging in this behavior are at increased risk for developing a SUD/ED
    - Key deficiencies in this population include vitamin A (may impact integrity of liver function) and Thiamine.
    - A well-balanced meal plan containing variety is useful for combating general malnutrition in this population.

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Social Overlap of Alcohol and Diet Culture

- Drastic increase in glorification of alcohol on social media among a variety of populations
  - Older men and women down to adolescents
  - Specific increase in "mom" population
    - Wine being glorified as a way to cope when overwhelmed
    - #WineWednesday
- Besides an increase in "drunkorexia" or "saving calories" to be used for increase in alcohol intake, we are seeing an increase in alcohol-specific subscription services and even alcohol-specific delivery services
  - Winc, Shaker and Spoon, Saucey, Minibar
- Increase in alcoholic beverages promoting disordered eating
  - "Skinnygirl Alcohol" products by Bethenny Frankel
  - Skinny Mixes/Syrups
- Additionally, we are seeing a cross-over of alcohol being improperly used in the self-care and recovery community

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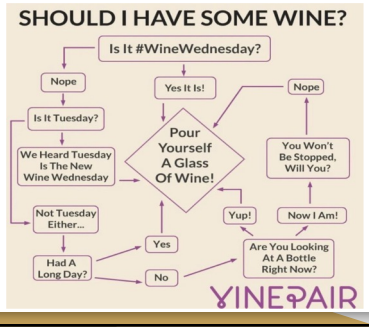

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BEAUTY COMES IN ALL SHAPES AND SIZES

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An empty bottle of wine
is better than a filled one.
It shows achievement.

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The Effects of COVID-19 on Eating Disorders and Alcohol Use

- Shifts in anxiety
- Environmental stress
- Increased Isolation
- Easier to engage in maladaptive behavior (food/alcohol), no one to monitor/accountability
- Virtual work and school / Employment and school changes
- Health and family anxiety
- Healthcare needs not being met
- Finances
- Jobs/School
- Health Care appointments

Treatment Options Limited

- Virtual telehealth phone advantages vs disadvantages
- Provides some connection and verbal outlet
- Accountability
- Recovery support groups

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Substances/Behaviors that may *feel* addictive

- Food
  - Sugar Specifically
    - There tends to be controversy around whether or not food is actually an addictive substance.
    - Most SUD/ED clients would argue that they have been addicted to food (sugar) and that is "why they may binge"
    - Most ED RDs would challenge the theory that food is addictive
      - Abstinence approach does not work in terms of ED treatment
      - Restriction perpetuates bingeing and other ED behaviors
    - There is ongoing research in this area
    - It is important to validate the client in that they may *feel* addicted to the food comparable to other addictions
- Laxatives
- Purging
- Exercise
  - This pattern of repetitive behavior is often termed as a *behavioral addiction*, but currently there is insufficient peer-reviewed evidence to establish diagnostic criteria needed to identify this behavior as a mental disorder.

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Substances/Behaviors that may feel addictive

- Nutrition Therapy for these areas::
  - Validate AUD impact on overall appetite-whether increased or decreased
    - Potential for increased "sweet" cravings or cravings in general when abstaining from drugs/alcohol/DOC
    - Anxiety secondary to abstinence from DOC leading to a decreased appetite
  - Importance of incorporating structured and consistent nutrition
    - Variety of food (and nutrients) can help with mood stabilization, decreased cravings, and relapse prevention
      - Abstaining from any food group (restriction) can lead to increased cravings and potentially prolonged malnutrition
  - Collaborating with the individual's medical team to ensure nutritional stabilization and rehabilitation is prioritized
    - With laxative abuse and purging, consistently monitoring lab values and adjusting the individual's care as needed
  - Ensuring the client is getting ENOUGH
    - Especially with SA clients, teaching them to distinguish between physical versus emotional hunger and how to honor both
    - Incorporating principles of mindfulness when eating
  - Normalizing body changes during recovery
    - Abdominal distention
    - Presence of edema
    - Potential of increase in weight following abstaining from DOC

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Examples of Client Distortions

- Attempts to use substances to cope with the eating disorder:
  - "Being under the influence of alcohol helps me eat and not feel anxious and purge after meals."
  - "When I'm drunk, it's easier to eat in social situations that would otherwise make me anxious."
- Attempts to use substances to engage more in the eating disorder:
  - "Alcohol has a lot of calories so if I drink, I restrict food intake."
  - "Drinking the night before helps me sleep and not eat as much the next day."
  - "Alcohol makes it easier to purge so that I feel more deserving to eat the next day."

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Treatment for Eating Disorders and Alcohol Use Disorder

Treatment of one disorder often leads to exacerbation of the other. For example, It is not uncommon for clients being treated for Bulimia to increase their use of alcohol or substances as they decrease bingeing and purging behavior. Likewise, clients may find it more difficult to curb binge eating behavior or restrictive eating after Alcohol Use Disorder (AUD) treatment.

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Treatment for Eating Disorders and Alcohol Use Disorder -Continued

- Longer and more complicated treatment
  - The difficulty of treating the neurological impact from the SA coupled with malnutrition from the ED
  - Differences in the recovery models for SA versus ED
    - Abstinence from substances versus moderation of all foods
- Integrated, concurrent treatment of co-occurring disorder
  - Individualized to the client
  - Typically, as one numbing tactic is taken away, the individual becomes more drawn to the other (See-saw)
- Need to address underlying issues:
  - Trauma
  - Anxiety/depression
  - Relational/interpersonal factors
  - Developmental factors
  - Neurobiological factors

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Treatment Approaches

- Detox and weight restoration (not enough!)
  - Must address the physical effects of withdrawal as well as potential nutrient deficiencies from prolonged Alcohol Abuse and ED behaviors
- Increase understanding of the connection between alcohol use/eating disorder 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, celebrate recovery)
- Strengthen relapse prevention skills (CBT; medication management)

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Treatment Approaches and Common Topics

- Cultivating and Sustaining Motivation (e.g. Pros and Cons, Connecting With Values)
- Maintaining Positive Changes
- Building and Maintaining Structure
- Addressing Current and Potential Challenges, Including Triggers and High Risk Situations
- Identifying Warning Signs
- Challenging Disordered Thinking
- Identifying and/or Creating a Support Network
- Addressing Lapses and Relapses
- Relapse Prevention Plans - Living document - Shared with multidisciplinary team and identified supports
  - Rates of relapse in this population tend to be increased

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Case Study

- 30 yo female w hx of severe bingeing/purging and alcohol abuse (1 L of Vodka per day) as well as abuse of vyvanse
- Presentation of sx: daily alcohol abuse often leading to black outs, calorie counting, constantly obsessing about next meal, bouts of excessive exercise as well as other compulsive bx (hiding, stealing food, etc.), self-harm, thoughts of suicide
- Interventions client tried on her own: keto diet (restricting carbohydrates, sugar specifically), abuse of vyvanse to help suppress appetite, abuse of coffee and other energy drinks (more than 50 oz per day) to try and function/attend work

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Case Study

- Interventions used with this client from her multidisciplinary team:
  - Therapy-discussion of contributing factors to the AUD/ED
    - Significant trauma/PTSD (childhood abuse, multiple sexual assaults)
    - Identified triggers and how to challenge these
  - Relational/family support-identifying her support persons
  - Medically-monitoring labs consistently, finding appropriate medications, teaching medication management
  - Nutritionally-
    - Initiation of meal plan including consistency in a variety of foods and food groups
    - Providing client the flexibility and autonomy to choose the foods she wanted within a structured approach
    - Not limiting binge foods, actually incorporating these consistently (habituation)
    - Teaching principles of mindfulness as well as intuitive eating (education versus implementation initially)

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