IS DRUNKOREXIA A THING?

A CLOSER LOOK AT CO-OCCURRING EATING DISORDERS AND SUBSTANCE USE DISORDERS

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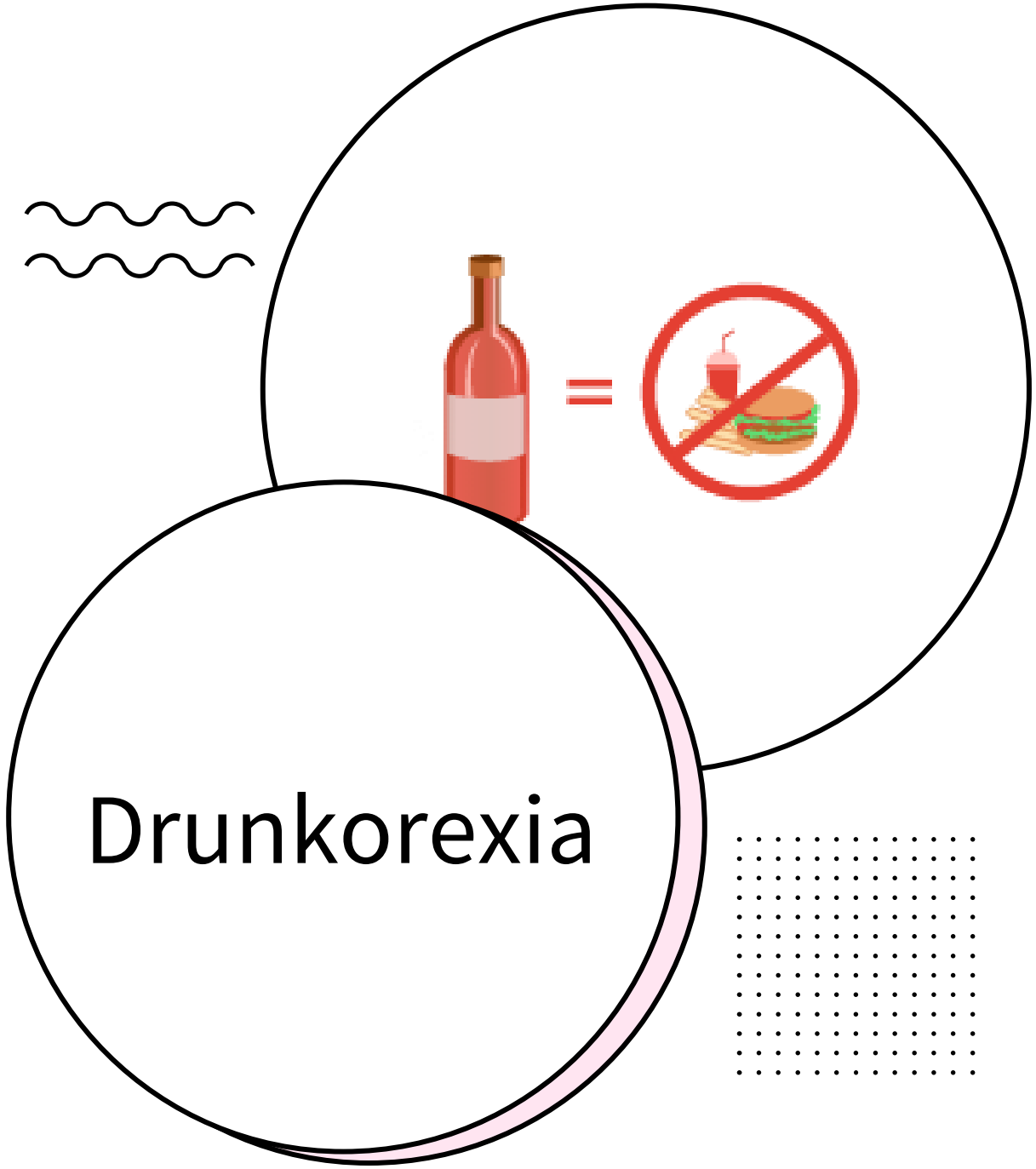


- Not a diagnosis.
- A slang term used to describe replacing meals with alcohol to make up for calorie consumption.
- This can lead to becoming intoxicated faster and have dangerous effects such as blackouts, alcohol poisoning, and hypoglycemia.
- In a study looking at calorie restriction prior to alcohol consumption in college freshmen, 14% of the subjects reported restriction calories, with 6% reporting the behavior to avoid weight gain and 10% to enhance alcohol's effect.

What is the co-occurrence of ED and SUD?

People with a substance use disorder are ten times more likely to have an eating disorder than the general population.

One in five people diagnosed with an eating disorder will develop a substance use disorder in their lifetime.

Up to 57% of men with Binge Eating Disorder also have a co-occurring substance abuse problem.

Percentage of Those With SUD

Anorexia

12%-27%

Binge Eating Disorder

25%-50%

Bulimia

30%-70%

Reasons for High Rates of Co-Occurrence

- Diet Culture / Weight Stigma
- Thin Ideal
- Heritability
- Early age of onset for both

Similarities of SUD and ED

Both create a lot of chaos in client's life.

ED can have a lot of time spent on the behaviors and food/weight instead of what is really going on in life.

Addiction too can be distracting in thinking about drinking/using, obtaining the substance, etc.

Both can involve a lot of secrecy.

High degrees of shame.

Highly identified with the eating disorder or the persona around substance use – "party girl" "wine time".

Impulsiveness – particularly with BN and BED.

- High levels of trauma and grief
- Common to see comorbid conditions
- High drop out rates for treatment
- Highest mortality rates for all mental health dx – 1)opiate addiction and 2)Anorexia Nervosa
- Co-occurring ED and SUD increases the risk of medical complications and death

Drugs Commonly Used

OTC – Nicotine, caffeine, laxatives, diuretics

Alcohol

Stimulants – Cocaine, ADHD meds, amphetamines

Opiates – Oxycodone, heroin, fentanyl, tramadol

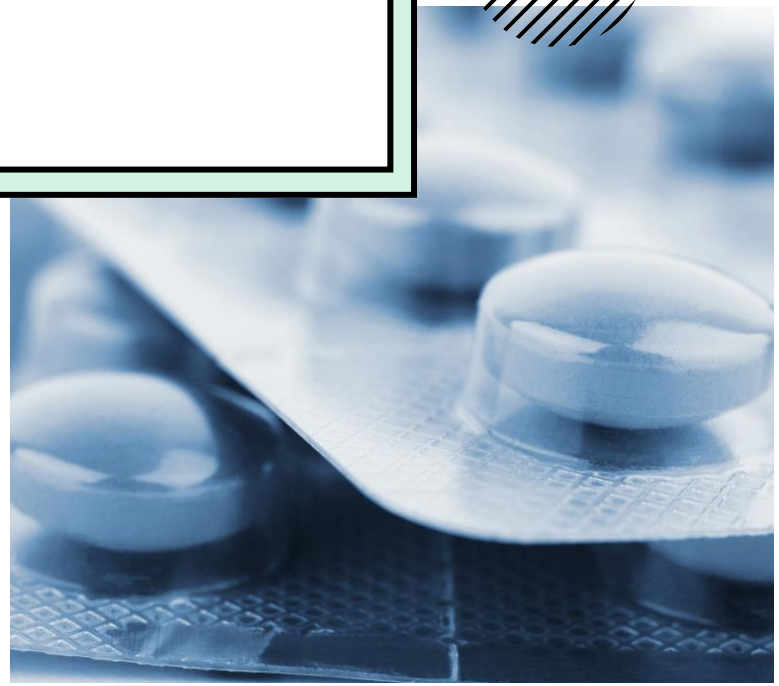
Sedative, Hypnotics, and Anxiolytics – benzodiazepines, sleeping pills

Cannabis

Inhalants

Hallucinogens- Ketamine, MDMA, LSD

Substance Use Disorders



Can begin before the eating disorder

One disorder may improve and the other pop up

During the eating disorder

After the eating disorder

Reasons For Under Reporting

- Therapeutic relationship
- Not motivated for treatment
- Lack of awareness of the problem
- Concerns about disappointing the therapist
- Shame about their behavior
- Past experiences of criticism about their behaviors
- Shame around weight and appearance

Assessing the client

- CAGE, CAGE-AID, AUDIT
- SCOFF – 5 Item tool for eating disorder. High sensitivity for AN and BN
- BED Scale
- Eat 26
- APA Guidelines list several tools available for various populations – ie adolescents, Spanish speaking, transgender and gender non-binary
- Semi-structured Interview

SCOFF Questions

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

CAGE-AID Questions

- Have you ever felt you ought to **cut down** on your drinking or drug use?
- Have people **annoyed** you by criticizing your drinking or drug use?
- Have you felt bad or **guilty** about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**eye-opener**)?

Scoring: Item responses on the CAGE are scored 0 for "no" and 1 for "yes" answers. Further assessment needed with any patient who scores a one or higher.

Quantify Substance Use and ED Behaviors

- What your client may be calling a “binge” may not be.
- Frequency, intensity, or time spent in behaviors.
- Dietary restriction, binge eating, purging or other compensatory behaviors?
- Frequency and amounts of alcohol or other drugs used.
- Level of distress for the client.
- Potential for harm to the client.
- What happens when you don’t drink or use?

Eating Disorder and SUD Treatment

Those dependent on alcohol or other drugs may require detox.

Those with severe eating disorder may need to be refed in order to have a nourished brain required for effective treatment of SUD.

Simultaneous treatment of both disorders offers the best outcomes.

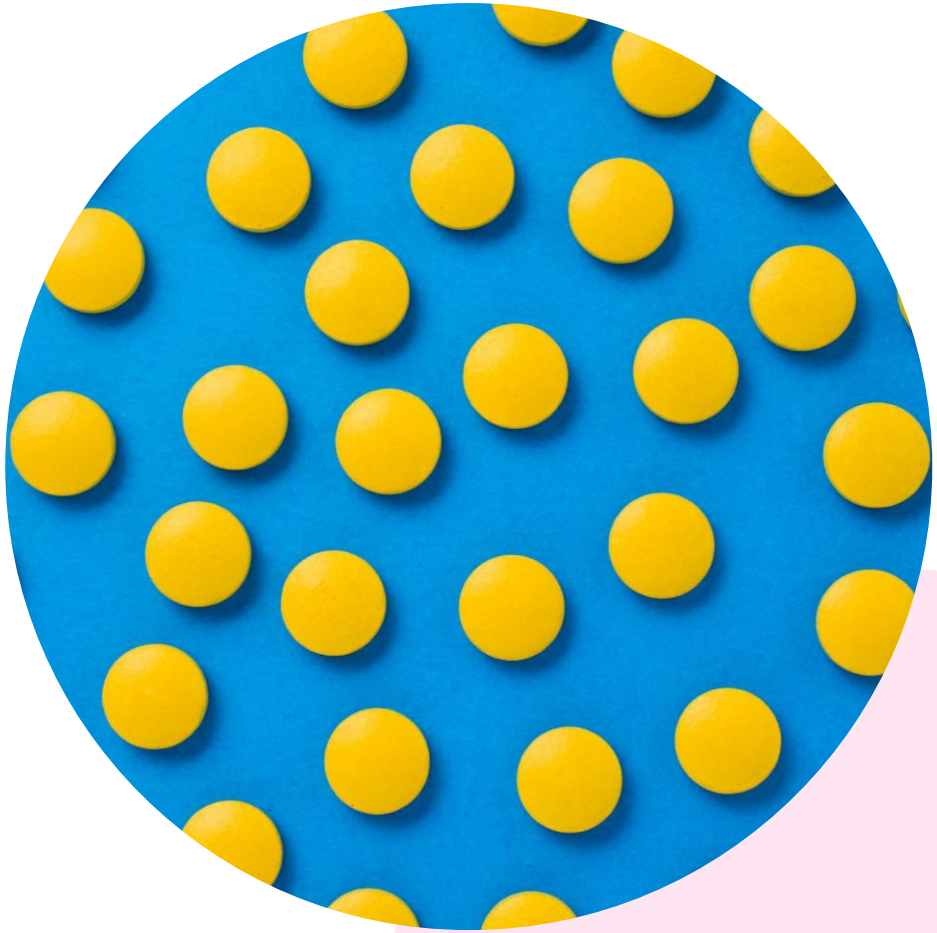
Challenges to simultaneous treatment

- Difficult to find treatment with expertise and equal emphasis on both disorders at all levels of care.
- Most facilities for residential SUD treatment do not tend to have the high level of expertise and monitoring to extinguish ED behaviors.
- Eating disorder focused treatment often has limited programing around the SUD recovery.


TEAMWORK
MAKES
THE
DREAM
WORK

Pharmacotherapy

- Moderate to Severe Alcohol Use Disorder
  - Acamprosate
  - Disulfiram
  - Naltrexone
- Opioid Use Disorder
  - Buprenorphine/naloxone – Subutex, Suboxone
  - Methadone



Case Study

Kara was a 23yo female at time of her first visit. Kara reported restricting food all day, coming home from work in the evening and bingeing and purging all evening on large quantities of food. Kara would also drink shots of alcohol and some beers during this time of bingeing and purging through vomiting.

Kara would exercise at least one hour a day but also walked to work and anywhere possible “to burn more calories”. She worked a job that required a lot of walking also.

Client had been to inpatient twice before for eating disorder treatment and for a psychiatric inpatient stay for bipolar depression. She reported depression that was intensified when drinking with suicidal ideation with no plan or intent reported at the time of assessment.

6 P’s Case Formulation

Problem

- Bulimia Nervosa – extreme severity
- Alcohol Use Disorder – severe
- Bipolar I Disorder
- Bulimia since age 16
- Presenting problem: bingeing, purging, compulsive exercise, alcohol abuse/dependence, bipolar
- Body image issues
- Increased suicidal ideation when drinking

Predisposing Factors

- Raised by single mother and never knew father
- Some estrangement and resentment from older siblings
- Sexually assaulted at 16yo
- Diet culture and focus on thin ideal
- Hx of addiction in family

Precipitating Factors

- Isolation
- Very little social or emotional support
- Bipolar depression not controlled
- “Good food” “bad food” with food elimination
- Hx of repeated relapse with intense shame
- Little prior focus on SUD in tx

Perpetuating factors

- Restriction
- Need for medical detox
- Malnourished brain
- Fear of weight gain
- Does not have medical dr or psychiatrist
- Little insight into the seriousness and medical instability of ED and SUD
- Isolating

Protective Factors

- Close relationship with mother
- Mother is very supportive of recovery
- Boyfriend concerned and encouraging/supportive

After Initial Assessment

Plan

- Referral for medical testing and labs
- Referral to medical detox and higher level of care for medical stabilization
- Once out of res and back to OKC will begin outpatient therapy
- Come out of tx with PCP, RD, Psychiatrist

Protective Factors After Returning to Outpatient Therapy

- Mother is very supportive of recovery
- Boyfriend concerned and encouraging/supportive
- Living in sober living
- Motivated for treatment
- Has a full team that she trusts

Once Inpatient, Res, & PHP completed

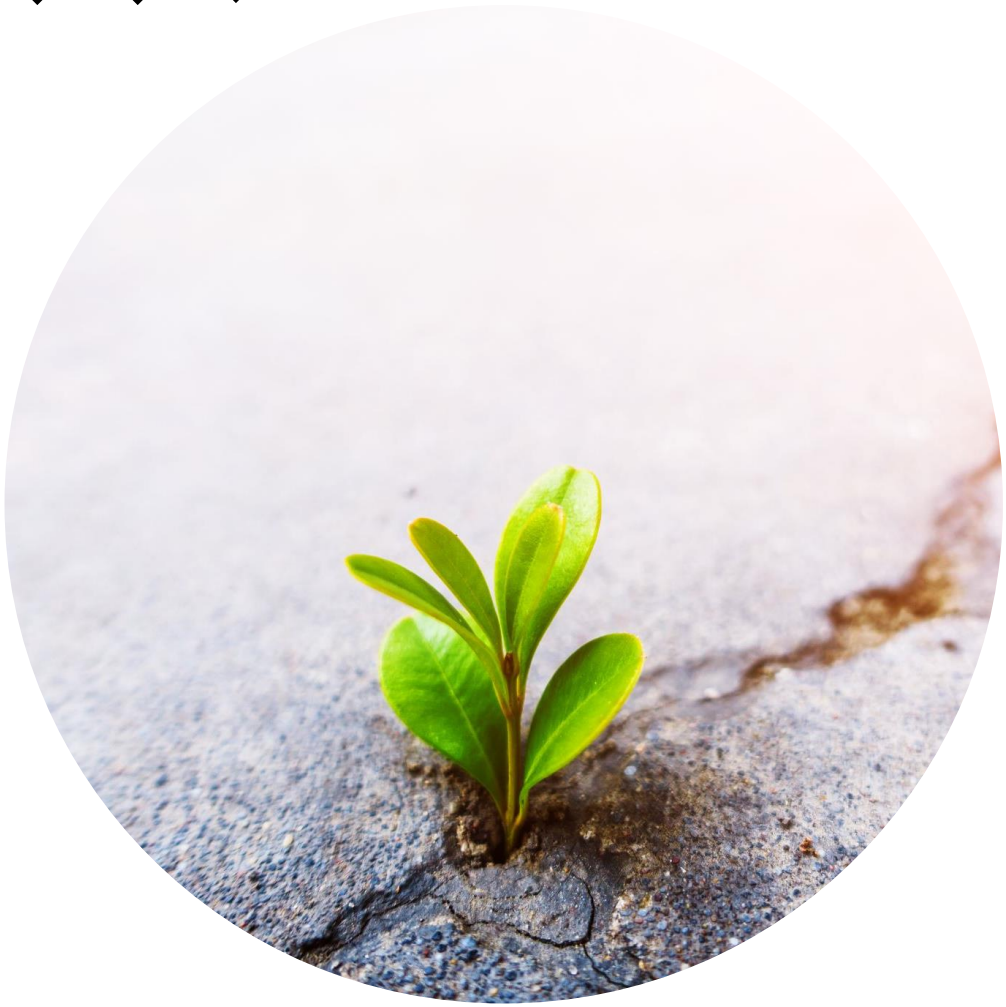
Plan

- Continued work on cognitive distortions around food, weight, body image
- Address perfectionism
- Referral to AA
- Recognition of triggers, thoughts, feelings, urges
- Relapse prevention
- Focus on values and goals instead of weight and size

Recovery Programs for SUD

- Alcoholics Anonymous
- Narcotics Anonymous
- Dharma Recovery
- Refuge Recovery
- SMART Recovery
- Celebrate Recovery

FEELINGS OF SHAME



Finding Motivation for Recovery

- Don’t get caught in the power struggle with you and the ED or the addiction.
- “It is perfectly okay if you want to keep your eating disorder” – Carolyn Costin
- Client voicing the reasons for change
- “Of course” “And”– finding compassion and validating

Contemplation Questions

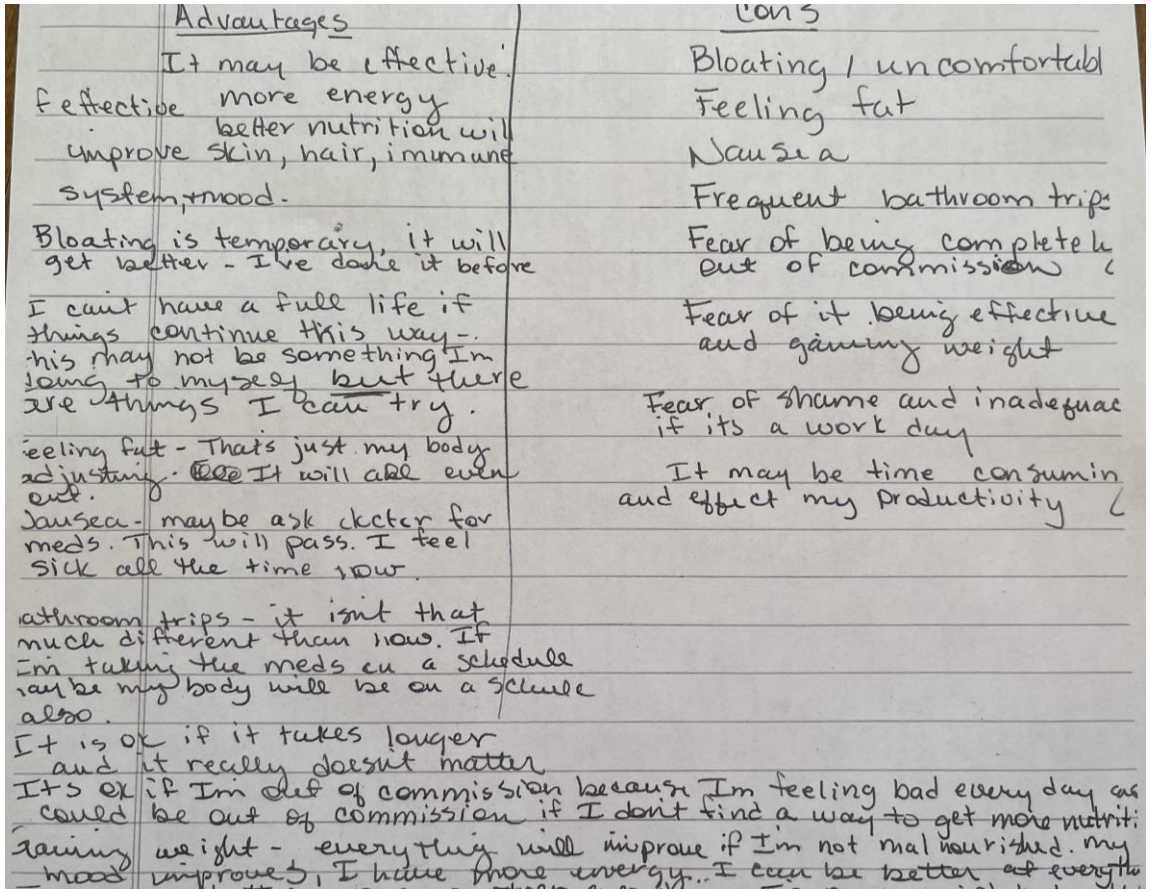
What are the pros and cons of staying the same vs. changing?

What will your future likely be if you do change and will it be like if you don’t?

How does continuing in your eating disorder/addiction help or hurt your health and happiness?

What are the risks to your relationship(s) if you stay the same and what are the risks to your relationship(s) if you recover?

KARA'S HOMEWORK



Advantages

It may be effective.
effective more energy
better nutrition will
improve skin, hair, immune
system, mood.

Bloating is temporary, it will get better - I've done it before

I can't have a full life if things continue this way - this may not be something Im doing to myself but there are things I can try.

feeling fat - That's just my body adjusting. It will all even out.

nausea - maybe ask doctor for meds. This will pass. I feel sick all the time now.

bathroom trips - it isn't that much different than now. If I'm taking the meds on a schedule maybe my body will be on a schedule also.

It is ok if it takes longer and it really doesn't matter

It's ok if Im out of commission because Im feeling bad every day as could be out of commission if I don't find a way to get more nutriti gaining weight - everything will improve if Im not malnourished. my mood improves, I have more energy.. I can be better at everyth

Cons

Bloating / uncomfortabl
Feeling fat
Nausea
Frequent bathroom trips
Fear of being completely out of commission
Fear of it being effective and gaining weight
Fear of shame and inadequac if it's a work day
It may be time consumin and effect my productivity

Possible Functions of the Eating Disorder and SUD

- Coping mechanism to deal with life
- A way to indirectly call out for help
- A way to keep oneself from expressing distress to others
- Survival strategy
- A way to deal with/avoid emotions (numbing)
- A way to cope with the lack of autonomy (this is the one thing I can control)
- A way to deal with unresolved trauma and/or deprivation
- A way to gain power and control
- Rebellion
- A way to try and get unmet needs met (comfort, soothing)
- A substitute for attachment, relationship, love
- A way to release emotions and cope with distress
- A way to push others away
- Manifestation of unresolved family conflict
- A way of avoiding growing up – tends to accompany a fear of responsibility

Dialogue With My ED or Addiction

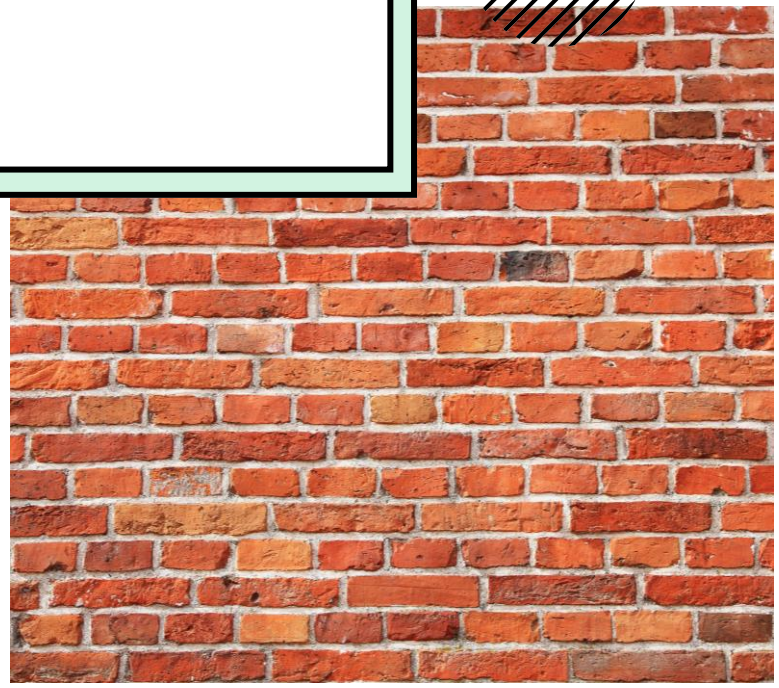
GOAL OF FINDING THE FUNCTIONS THE ED/SUD

LEARNING TO RECOGNIZE WHAT THE ED OR ADDICTION SAYS

FINDING OUT WHAT THE TRUE NEEDS ARE THAT THE ED/SUD IS TRYING TO MEET

FUEL VS. NEEDS

Invisible Wall



- Sometimes we feel motivated to make a change but when it comes time to make a different choice, we do what we have always done.
- This might be coming from a core belief that is driving a need to protect yourself in some way.
- This wall keeps getting in the way of the forward movement you are trying to make.
- What core beliefs might be creating an invisible wall in your life?

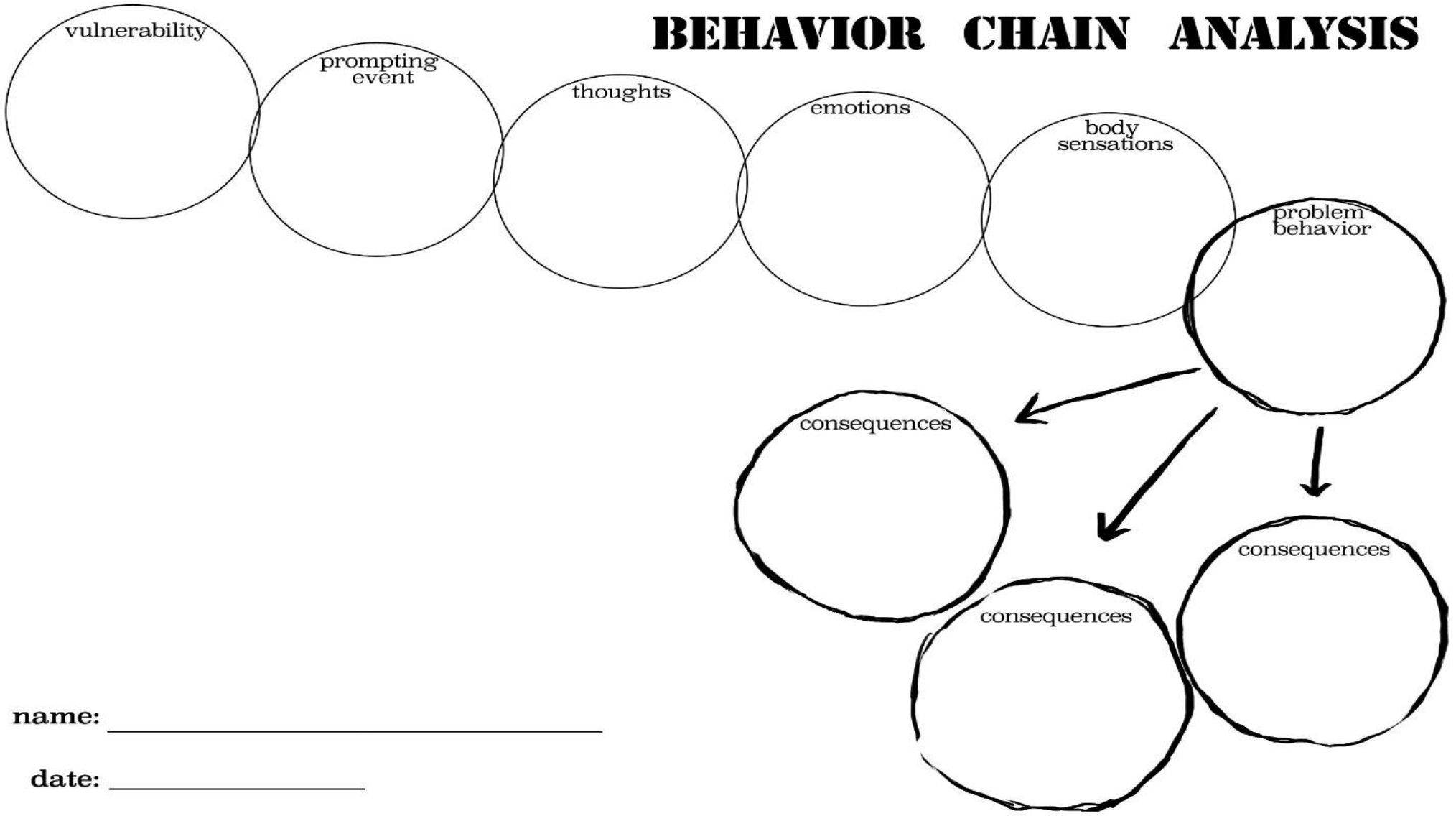
What are triggers?

ENVIRONMENTAL

EMOTIONAL

PHYSICAL

BEHAVIOR CHAIN ANALYSIS



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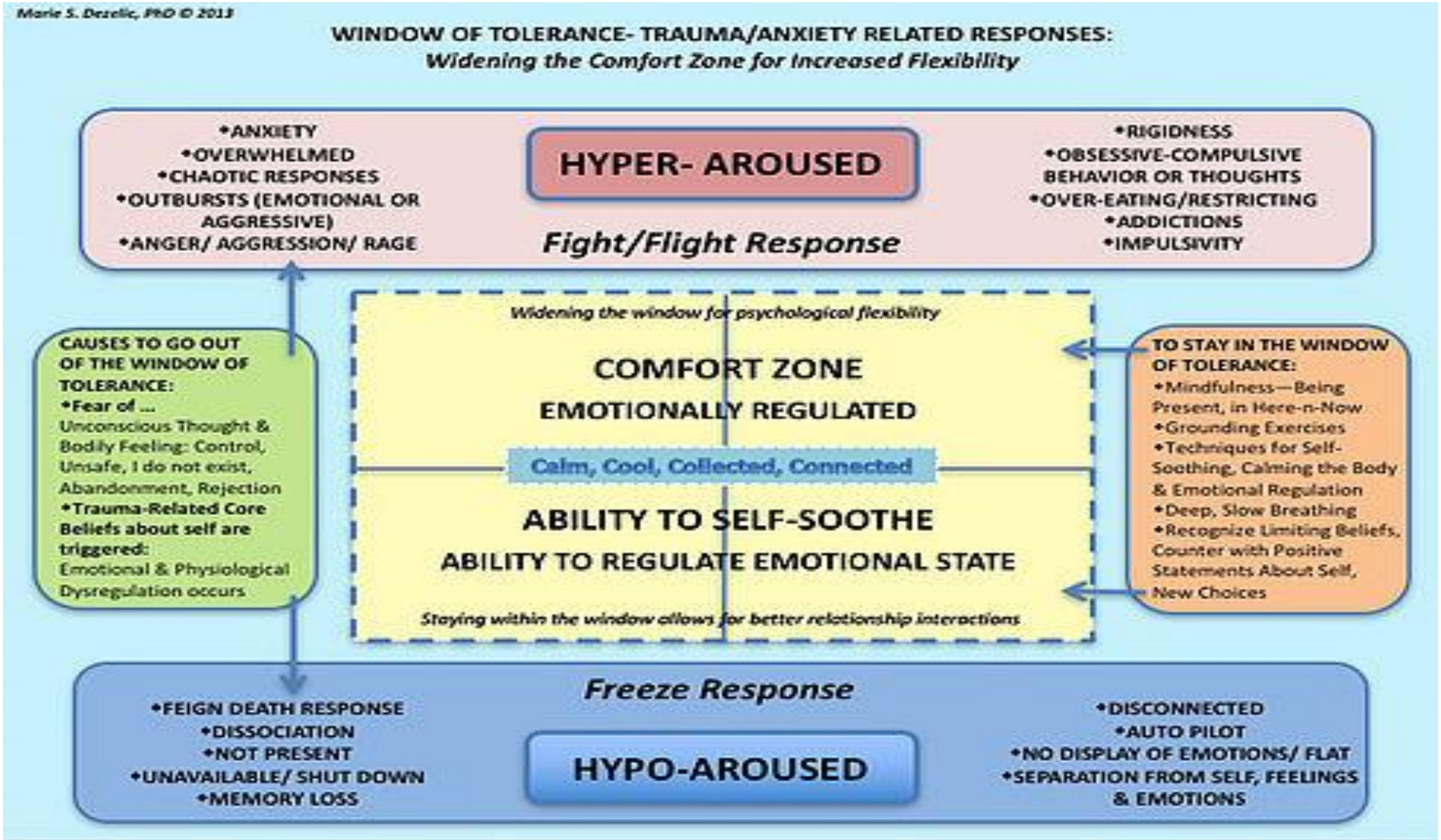
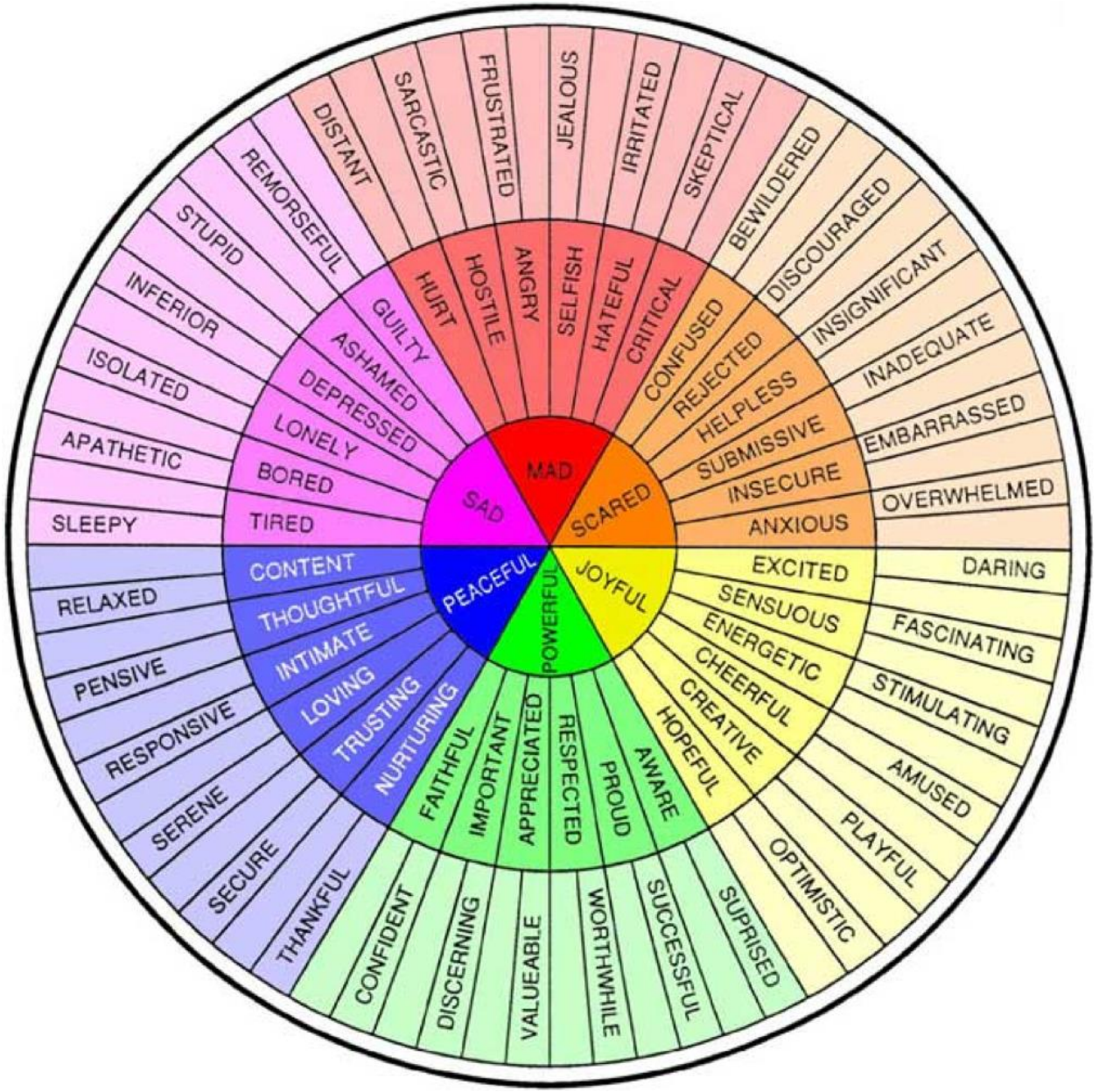
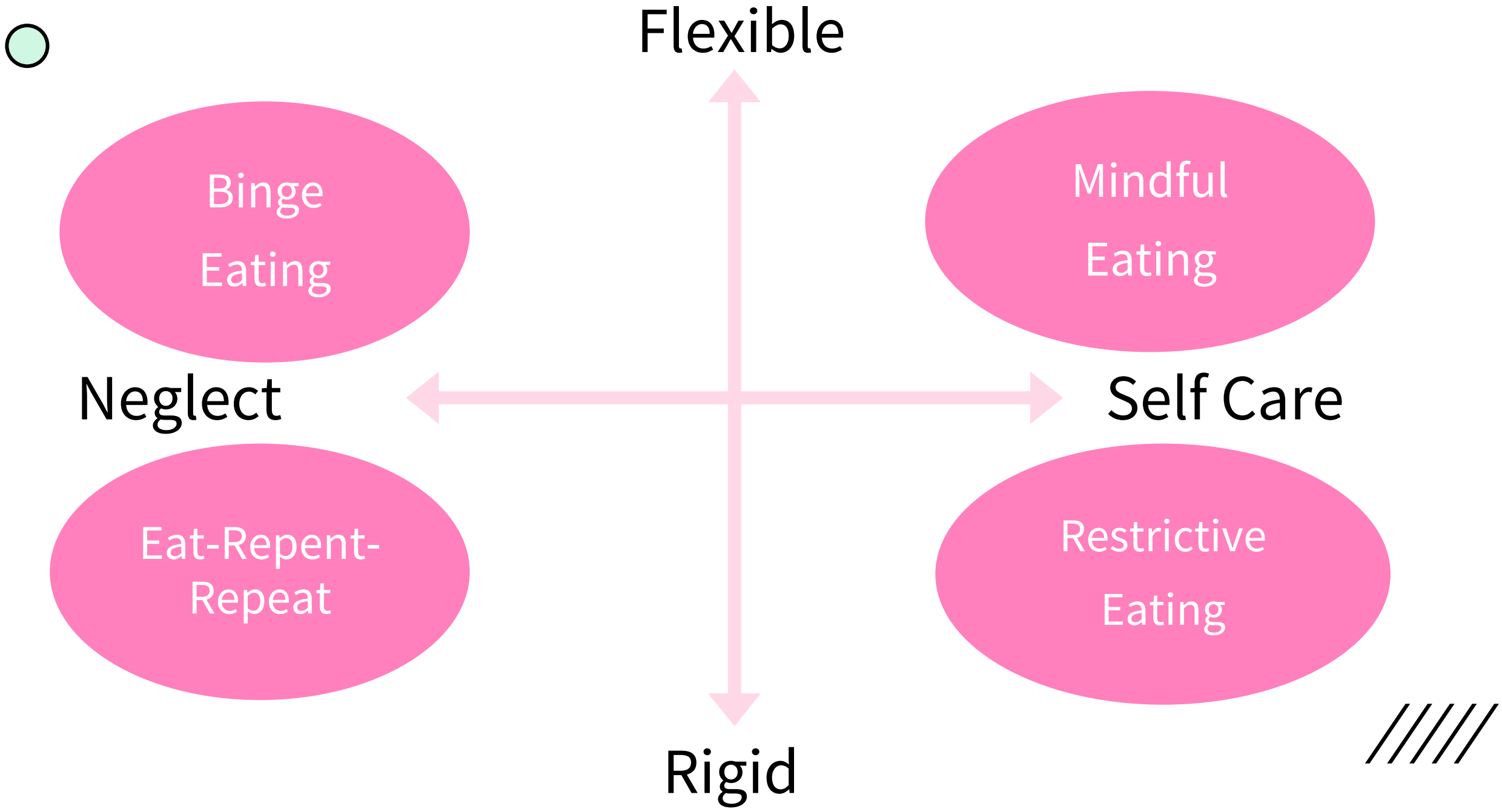

Marie S. Dezelic, PhD © 2013
WINDOW OF TOLERANCE- TRAUMA/ANXIETY RELATED RESPONSES:
Widening the Comfort Zone for Increased Flexibility
•ANXIETY
•OVERWHELMED
•CHAOTIC RESPONSES
•OUTBURSTS (EMOTIONAL OR AGGRESSIVE)
•ANGER/ AGGRESSION/ RAGE
HYPER- AROUSED
Fight/Flight Response
•RIGIDNESS
•OBSESSIVE-COMPULSIVE BEHAVIOR OR THOUGHTS
•OVER-EATING/RESTRICTING
•ADDICTIONS
•IMPULSIVITY
CAUSES TO GO OUT OF THE WINDOW OF TOLERANCE:
•Fear of ...
Unconscious Thought & Bodily Feeling: Control, Unsafe, I do not exist, Abandonment, Rejection
•Trauma-Related Core Beliefs about self are triggered:
Emotional & Physiological Dysregulation occurs
Widening the window for psychological flexibility
COMFORT ZONE
EMOTIONALLY REGULATED
Calm, Cool, Collected, Connected
ABILITY TO SELF-SOOTHE
ABILITY TO REGULATE EMOTIONAL STATE
Staying within the window allows for better relationship interactions
TO STAY IN THE WINDOW OF TOLERANCE:
•Mindfulness—Being Present, in Here-n-Now
•Grounding Exercises
•Techniques for Self-Soothing, Calming the Body & Emotional Regulation
•Deep, Slow Breathing
•Recognize Limiting Beliefs, Counter with Positive Statements About Self, New Choices
Freeze Response
•FEIGN DEATH RESPONSE
•DISSOCIATION
•NOT PRESENT
•UNAVAILABLE/ SHUT DOWN
•MEMORY LOSS
HYPO-AROUSED
•DISCONNECTED
•AUTO PILOT
•NO DISPLAY OF EMOTIONS/ FLAT
•SEPARATION FROM SELF, FEELINGS & EMOTIONS


MAD
SCARED
JOYFUL
POWERFUL
PEACEFUL
SAD
ANGRY
HOSTILE
HURT
SELFISH
HATEFUL
CRITICAL
CONFUSED
REJECTED
HELPLESS
SUBMISSIVE
INSECURE
ANXIOUS
JEALOUS
IRRITATED
SKEPTICAL
BEWILDERED
DISCOURAGED
INSIGNIFICANT
INADEQUATE
EMBARRASSED
OVERWHELMED
FRUSTRATED
SARCASTIC
DISTANT
REMORSEFUL
STUPID
INFERIOR
ISOLATED
APATHETIC
SLEEPY
GUILTY
ASHAMED
DEPRESSED
LONELY
BORED
TIRED
EXCITED
SENSUOUS
ENERGETIC
CHEERFUL
CREATIVE
HOPEFUL
DARING
FASCINATING
STIMULATING
AMUSED
PLAYFUL
OPTIMISTIC
AWARE
PROUD
RESPECTED
APPRECIATED
IMPORTANT
FAITHFUL
SUPRISED
SUCCESSFUL
WORTHWHILE
VALUEABLE
DISCERNING
CONFIDENT
CONTENT
THOUGHTFUL
INTIMATE
LOVING
TRUSTING
NURTURING
RELAXED
PENSIVE
RESPONSIVE
SERENE
SECURE
THANKFUL


Flexible
Binge Eating
Mindful Eating
Neglect
Self Care
Eat-Repent-Repeat
Restrictive Eating
Rigid

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