DOUBLE JEOPARDY: OVERCOMING SELF-HARM IN EATING DISORDERS AND ADDICTIONS

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ABSTRACT
A significant subset of the eating disorder population (disorders of self-harm) also suffers from co-morbid problems with addictions—substance abuse and/or dependency. This workshop will discuss the shared genetic predispositions that underly the dual symptomatology, the biological features in common & unique to each diagnosis, and the in-patient and out-patient treatment challenges & paradoxes.

OUTLINE
I. INTRO: emphasis on alcohol abuse; caveat about opioid prevalence
II. ETIOLOGICAL FACTORS & DUAL DIAGNOSIS: genetics & biological risk, underlying mood disorders, prevalence
III. DOUBLE JEOPARDY IN DIAGNOSIS
IV. DOUBLE JEOPARDY IN RESEARCH
V. DOUBLE JEOPARDY IN Treatment
VI. WHICH COMES FIRST, CHICKEN OR EGG, IN TREATMENT?
VII. TREATMENT ISSUES
A. History of divergent approaches to E.D vs SA—talk therapy, 12-step, CBT, combination
B. Effective timing of in-patient or residential approaches
C. Differences in meaning of relapse/cure or recovery/role of therapist
VIII. VIGNETTES
A. Late adolescent with low weight bulimia and alcohol abuse with residential treatment and AA
B. Overweight adult with binge eating disorder with out-patient and AA
C. Middle-aged woman with bulimia, alcohol abuse without AA
I. Introduction

- Until 2014, lack of evidenced-based research on co-morbid populations and treatment
- More questions than answers: are genetics shared? are eating disorders addictions? how does trauma/PTSD trigger? how are they similar/different?
- Focus today will NOT include: gambling/shopping/compulsive exercise/anabolic steroid use. Caveat about the opioid crisis

II. ETIOLOGICAL FACTORS & DUAL DIAGNOSIS

A. Both aggregate in families.
B. Increased risk with one diagnosis: 50% of ED pts. meet criteria for SUD; 1/3 of SUD report eating pathology; having SUD<=>risk of psychiatric disorder (see Table of Risk-next slide)
C. Dopamine implicated in both: similar neural systems for appetite control and drug use. 45% of obese subjects had DRD2 gene, as did alcoholics
D. Chromosome studies:
E. Similarities/differences in neurobiology from neuroimaging
F. Appetite peptides and suppressing hormones also seem to regulate addictive behaviors.
Co-Morbidity Risk:
Large, Population-Based Epidemiological Surveys
from Brownell & Gold, Food & Addiction (2012)

29.7% of respondents w/ LIFETIME SUD have LIFETIME MOOD DISORDER
N=1-1.5, respondents w/ LIFETIME MOOD DISORDER have LIFETIME SUD

40.7% of respondents w/ LIFETIME SUD have LIFETIME ANXIETY DIS
N=2.5, respondents w/ LIFETIME ANXIETY DIS have LIFETIME SUD

45.2% of respondents w/ LIFETIME PTSD have LIFETIME SUD
N=3.0, respondents w/ LIFETIME PTSD have LIFETIME SUD

27% of respondents w/ LIFETIME ANOREXIA have LIFETIME SUD
N=4.0, respondents w/ LIFETIME ANOREXIA have LIFETIME SUD

36.8% of respondents w/ LIFETIME BULIMIA have LIFETIME SUD
N=5.0, respondents w/ LIFETIME BULIMIA have LIFETIME SUD

36.8% of respondents w/ LIFETIME BINGE ED have LIFETIME SUD

Co-Morbid...
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 that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior 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 behavior (i.e., self-induced vomiting or the misuse 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 behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas.)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g., within any two-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behavior 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 three 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: The minimum level of severity is based on the frequency of inappropriate compensatory behaviors (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Mild: An average of 1 to 3 episodes per week. Moderate: An average of 4 to 7 episodes per week. Severe: An average of 8 to 13 episodes per week. Extreme: An average of 14 or more episodes per week.

DSM-5 Criteria for Binge Eating Disorder

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

• The binge-eating episodes are associated with three (or more) of the following:
  - eating much more rapidly than normal
  - eating until feeling uncomfortably full
  - eating large amounts of food when not feeling physically hungry
  - eating alone because of feeling embarrassed by how much one is eating
  - feeling disgusted with oneself, depressed, or very guilty afterwards
  - marked distress regarding binge eating is present.

• The binge eating occurs, on average, at least once a week for three months.

• The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, or avoidant/restrictive food intake disorder.
DSM-5 Criteria for Substance Use Disorder

A. Problematic pattern of substance use leading to clinically significant impairment or distress as manifested by at least two of the following occurring in a 12-month period:

1. Substances are often taken in larger amounts or over a longer period of time than was intended.
2. Persistent desire or unsuccessful efforts to cut down or control substance use.
3. Great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving or strong desire to use the substance.
5. Recurrent use resulting in failure to fulfill major role obligations.
6. Continued substance use despite having persistent or recurrent social or interpersonal problems.
7. Important social, occupational, or recreational activities are given up or reduced because of substance use.
8. Recurrent use in situations in which it is physically hazardous.
9. Substances use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substances.
10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of substance.
11. Withdrawal, as manifested by either of the following:
   a. Characteristic withdrawal syndrome for the substance.
   b. Use of the same or closely related substance is taken to relieve or avoid withdrawal symptoms.

Severity Specifiers:

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 or more symptoms

Course Specifiers:

- Early remission
- Sustained remission
- In a controlled environment
- On maintenance therapy

(Note: 1-10 can apply to food-as-substance; 11 applies in animal studies.)

IV. DOUBLE JEOPARDY IN RESEARCH

A. “Research on how best to treat co-occurring eating disorders and substance use disorders is almost entirely lacking.”

B. Problems conducting research on dual diagnosis/treatment:
   1. No uniform definition of “food addiction,” therefore likelihood of misclassification.
   2. Screening tools for dual are not validated; self-report not consistent.
   3. Eating Disorders AND Substance Use Disorders are comprised of heterogeneous subgroups.
   4. Validation of the Yale Food Addiction Scale (YFAS) ongoing, but based upon the DSM-IV.

C. Reliance on animal models—studies on rats bred with tendencies to prefer alcohol, drink saccharin, etc., and observing their responses to sweets/naltrexone may not generalize.

V. DOUBLE JEOPARDY IN TREATMENT

A. “To date, there are no evidence-based treatments to guide the practitioner faced with this co-morbid condition”

B. 3 models for dealing with both:
   1. Sequential
   2. Parallel
   3. Integrated

C. Few empirical studies—only ones are for #3.

D. Historically, in SUD programs, only 1/2 assessed for E.D. and typically did not treat.

E. Biggest problem is that treatment models for both are unimpressive for full recovery.
VI. WHICH COMES FIRST, CHICKEN OR EGG, IN TREATMENT?

A. Assess and screen for medical issues, dual diagnosis, need for detox.
B. Pharmacological treatment of psychiatric conditions (implications for relapsing substance users).
C. Medical complications may mandate (esp in ED).
D. Detox may mandate (esp in SUD), and approved meds.
E. Expertise in the facility—3 blind men and the elephant.
F. Grilo’s suggestion: “In the absence of EBT, use CBT, DBT, etc., as starting point...,” but WHAT ABOUT AA??
VII. TREATMENT ISSUES (continued)

C. Meaning of relapse/recovery/role of therapist

1. Relapse SUD: HALT, Lapse/Relapse/Collapse, Serenity Prayer are key
   Relapse E.D. Expected, opportunity for growth, problem solving, identifying
   emotional triggers.

2. Recovery SUD: Expected with complete sobriety, always recovering.
   Recovery E.D.: 1/3, 1/3, 1/3—approximate percentages who make full versus
   partial recovery versus remaining chronically eating-disordered.

   BOTH HAVE VARIABLE COURSES OF RECOVERY

Betty Ford Center definition: voluntarily maintained lifestyle composed and
characterized by sobriety, personal health, and citizenship.

3. Therapist Role in Both: motivate and address obstacles to recovery.

UNIQUE
MANUALIZED
RECOVERY PROGRAM
TARGETING
DUAL DIAGNOSIS OF
ED/SUD

Features of S.F. Greenfield’s Treating Women with
Substance Use Disorders, The Women’s Recovery
Group Manual

A. Four sessions entirely devoted to Managing Mood, Anxiety, & Eating Problems
   without Using Substance.

B. Offers some explanations for the relationship between SUD and anxiety,
   depression, eating disorders.

C. Specific coping strategies for addressing ALL ILLNESSES, e.g.:

   1. Understand/accept that the substance disorder and the other disorder or disorders are BOTH/ALL IMPORTANT and require
      attention/treatment.

   2. Don’t use substances to manage the other disorders AND don’t let the other disorders stop you from your recovery from substance problem.

   3. Cravings and negative thinking in both are explained. SELF-CARE TECHNIQUES TO COPE WITH BOTH ARE
      ENCOURAGED.
VIII. DISCUSSION
QUESTIONS
FOR VIGNETTES

A. What is the role of biological factors in diagnosis?
B. Would you consider any aspect of this an addiction?
C. What should the priority be in treatment?
D. Is there a disorder that seems primary?
E. What are the pros/cons of treating one or the other first?
F. What are the pros/cons of a more structured treatment environment?

VIII. VIGNETTE #1
Late adolescent with low weight bulimia and alcohol abuse with residential treatment and AA.

~Robin was a 19 year old second semester college freshman when she presented for treatment after a 6 week stay at an eating disorder inpatient facility. She embraced various aspects of the program (family meetings, nutrition counseling) and reported that she identified with other young women in the community, and felt less socially anxious in that environment. She acknowledged that, when away at school, she often binge-drink, but that her patterns were similar to her roommates. She was determined to return to school in the fall and resume her studies and social activities.

~Her return to school was marked by regression with the ED, exacerbation of her drinking, and lead to a DUI. She wanted to return to ED residential treatment, but there were concerns that the alcohol problem was not being addressed. It is noteworthy that both parents were adult children of alcoholic fathers, and there are aunts and cousins with drinking problems.

~Seeking treatment was a conundrum because the ED program wanted her to treat the SUD first, and a world class SUD program recommended she treat the ED first.

~Eventually, she found an IOP that offered focus on both at the same time, with a firm requirement to attend AA meetings.

VIII. VIGNETTE #2
Overweight adult with binge eating disorder with out-patient and AA.

~Sharon was 26 when she returned to psychotherapy years after an adolescent bout with anorexia and bulimia, for which she was treated and stabilized, albeit at a high weight for her height. She was managed on anti-depressant medication (there had been a suicide attempt before college). Her mother was a functional alcoholic (successful in her career) and through the earlier phase of treatment made it clear that she was not going to stop drinking.

~Sharon admitted that she frequently drove drunk and knew this was a serious problem. In addition, she admitted that she had become a binge eater, and at times acted out sexually with men she met online. She needed to retain her nanny job to cover insurance expenses and ready herself for moving out of her parents' home, which she felt exacerbated her problems. She had insight and motivation, but not a network of support.

~Therapy focused on letting go of attempts to persuade her to return to an in-patient program, and instead to work with her motivation to stop drinking on an out-patient basis. The first hurdle was overcome when she found a suitable AA meeting and a sponsor, who was less than 10 years older than she. Sharon took to AA like a duck to water, and often shared her story. Therapy attempted to combine a focus on the binge eating problem, but Sharon was deeply resistant to this.
VIII. VIGNETTE #3

A middle-aged woman with bulimia, alcohol abuse without AA

~Betsy had been in therapy in her mid-thirties after she developed bulimia at an atypical developmental stage. She appeared to use therapy well to reduce her binging and purging, although it was never completely eliminated. She reported having other therapists who believed her problems would be solved if she got into an intimate relationship, but in this phase of therapy, her living alone was accepted as her chosen lifestyle. Her father and brother both appeared to have serious anger management problems, with the brother also experiencing bouts of depression.

~She was quite resistant to any recommendations to have a physical with blood work, usually an early treatment requirement, and showed up one day with a notarized statement absolving the therapist of any liability because she was choosing not to follow this treatment recommendation.

~Fast forward about 15 years and Betsy returned with an astonishing confession: she had been a daily binge drinker and had stopped cold turkey about 4 years before returning to therapy when her bulimia resumed and she had a series of severe anxiety attacks. She was proud of having achieved an alcohol-free life style without additional therapeutic or 12-step support, but recognized that she still was “numbing out” with food, and that was still not managing her anxiety. She attended an ED/weight management group, got short-term medication for her anxiety, and began using therapy in a more honest, revealing way.

SELECTED BIBLIOGRAPHY