11/5/2018

**Taking off the Blindfold to Better Support Clients with Eating Disorders**

Ben Meyers, MA, LPCC
Therapist - Eating Disorder and Substance Use Disorder Program

**2018 MARRCH Annual Conference**

---

**Lessons I've Learned (so far!)**

**Our Agenda**

- Defining Eating Disorders
- Exploring interaction with substance use
- Explore trends and considerations within various cultural populations
- Exploring ways in which we can see if disordered eating is occurring with our clients

---

11x
Person with SUD is 11x more likely to have an eating disorder.

5x
Person with ED is 5x more likely to abuse drugs and alcohol than a person without an eating disorder.

---

**What Does an Eating Disorder Look Like?**

---

**What Does an Eating Disorder Look Like?**
Eating Disorder Statistics

In the United States, **20 million** women and **10 million** men suffer from a clinically significant eating disorder at some time in their lives.

And the Frightening Facts...

Eating Disorders (AN, BN, EDNOS) are among the deadliest mental health diagnosis and are surpassed only by Opioid use.

A recent figure shows almost **70%** of Americans are overweight or obese.

DSM-5

Feeding and Eating Disorders

*Anorexia Nervosa*

*Bulimia Nervosa*

*Binge-Eating Disorder*

Other Specified Feeding or Eating Disorder

Unspecified Feeding or Eating Disorder

Avoidant/Restrictive Food Intake Disorder

Rumination Disorder

*Pica*

**Common slang:**

“Drunkorexia”    “Diabulimia”    “Orthorexia”

Anorexia Nervosa - signs and symptoms

• Weight Loss
• Always dressed in layers
• Excessive/compulsive exercise
• Pacing, constant movement
• Makes excuses not to eat
• Restrictive rules about eating
• Cutting out food groups
• Mood and personality changes
"They're always there—the thoughts in my head, tormenting me, telling me I'm too fat, I'm too weak. The only thing that shuts them up is to not eat and exercise. Then I get peace for about 10 minutes before it all starts up again."

**What is Binge Eating?**

- A sense of lack of control over eating
- Eating extremely rapid
- Eating until feeling uncomfortably full
- Eating large amounts of food when not hungry
- Eating alone
- Feeling disgusted with oneself, depressed or very guilty afterward
- Marked distress regarding binge eating is present

**Bulimia Nervosa—signs and symptoms**

- Can be any weight
- Not eating or eating little around others, though appearing to be maintaining or gaining weight.
- Going to the bathroom or showering after meals
- Prioritizing exercise over people, exercising excessively
- Isolating from others
- Large amounts of food unexpectedly “disappearing.”

"I start eating and can’t stop. It makes me feel numb. Then I can’t stand the feeling of fullness, so I have to purge. It disgusts me but being fat/full disgusts me more."

"I actually love purging. I binge so I can purge. It’s a total high, I look forward to it. I feel like I’m addicted to it."

Patient with Anorexia Nervosa

Patient with Bulimia Nervosa
Binge Eating Disorder

- No weight criteria, but high overlap with obesity
- Binge eating at least 1/week for 3 months
- No compensatory behavior

I keep telling myself I’m not going to binge anymore, but I can’t seem to stop myself. I try to eat healthy but can’t stop obsessing about the food I want, until I finally give in. I feel so ashamed.

Patient with Binge Eating Disorder

Avoidant Restrictive Food Intake Disorder - ARFID

Signs and Symptoms of ARFID

- Significant weight loss
- Significant nutritional deficiency
- Dependence on supplements
- Negative impact on psychosocial functioning
- Can be age, no stipulation on weight
- Food phobias, experiences through conditioning, or selective eating
- Function of avoidance is different

He only eats four foods, all of which are white.

Mother of patient with ARFID

I maintain a vegan lifestyle which incorporates eating organic, gluten-free, casein-free foods without any artificial colors, sweeteners, additives, or corn syrup. I can no longer eat in restaurants or at the homes of my friends and family. I’m starting to feel less healthy instead of more healthy and I don’t know why.

Patient with “orthorexia” (ARFID)
Exploring the relationship between Eating Disorders and Substance Use

**Eating Disorder**
- 50% diagnosed with an eating disorder will struggle with substance abuse,
- Whereas only 9% of the general population is diagnosed with SUD.

**Substance Abuse**
- Conversely, 35% of those who abuse substances have been found to have an eating disorder compared to 3% of the general population diagnosed with ED.

**Prevalence of EDSUD**
At least 25% of our patients at Melrose Center struggle with substance abuse

**EDSUD Relationship**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Eating Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>↓ Eating ↑ Purge</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>↓ Eating</td>
</tr>
<tr>
<td>Cocaine</td>
<td>↓ Eating</td>
</tr>
<tr>
<td>Caffeine</td>
<td>↓ Eating</td>
</tr>
<tr>
<td>Marijuana</td>
<td>↓ Eating &quot;Munchies&quot;</td>
</tr>
<tr>
<td>Naloxone</td>
<td>↓ Eating Weight gain when stop smoking</td>
</tr>
<tr>
<td>Ephedrine</td>
<td>↓ Eating</td>
</tr>
<tr>
<td>Laxatives</td>
<td>↓ Eating ↑ Purge</td>
</tr>
<tr>
<td>Diuretics</td>
<td>↑ Purge</td>
</tr>
</tbody>
</table>

**Suicide and Dual Diagnoses**
- Deaths associated with eating disorders are often caused by medical complications. The high mortality rate of those with an Eating Disorder increases with co-occurrence of SUD.
- High risk of suicide in both ED & SUD
  - 1 in 5 deaths in anorexia are suicide
  - AUD 10 times more likely to die by suicide
  - IV drug users 14 times more likely to die by suicide

**Common Risk Factors for ED and SUD**
- Low self-esteem
- Impulsive personality
- Mood & anxiety disorders
- High rates of borderline personality disorder in both
- Onset during developmental transitions
- History of trauma
- Secrecy
- Shame
Anorexia & SUD

- Those with AN are 19 times more likely to die from SUD (primarily alcohol)
- Medical concerns
  - Increased toxicity
  - Liver damage x2
- "Drunkorexia"

Bulimia & SUD

- Alcohol use disorders more common in BN and AN-binge/purge subtype
- Using alcohol to “assist” the ED
- Shared personality traits
  - Impulsivity

Binge Eating Disorder & SUD

- Addiction transference
- Bariatric surgery & addiction
  - 4 themes post-op
    - Unresolved psychological issues
    - Addiction transfer
    - Increased effects of substances
    - Increased availability of pain meds

"I respond very differently to pills now. It used to take 1/2 an hour to feel the effects. Now I feel the effects within 10-15 minutes. The effects are more intense but they don’t last as long, so you have to take more to get that euphoria."

How Patients Experience the Connection

Attempts to cope with the eating disorder:
"I use pot so I can eat during family dinners"
"Pot helps me eat and not purge after meals"
"Alcohol allows me to have a break from following the rules of the ED"

Attempts to engage more in the eating disorder:
"I work out for hours and take pain meds to deal with the pain"
"Drinking makes me feel full and then it’s easier not to eat"
"Drinking the night before helps me purge the next day"

ED and SUD get worse together (dysregulation model):
"When I drink alcohol, my awareness of food goes down and I tend to overeat"
"If I drink, I won’t eat because it’s too many calories"
"I binge eat really bad when I smoke pot"

Adaptive Function

- ED/SUD have functions
  - Manages or solves problems (social, psychological, physical, interpersonal)
  - Temporarily fulfill unmet needs
- Unaware of the connection
- Understanding adaptive function helps guide them to healthier skills/problem solving

Adaptive Function of ED’s

- Manage maturity fears
- Manage sexual conflicts
- Provide predictability and control
- Self-Identity
- Get attention or help
Treatment Approaches

- Family Based Therapy (FBT)
- Cognitive Behavior Therapy (CBT)
- Cognitive Behavior Therapy Enhanced (CBT-E)
- Cognitive Behavior Therapy-Avoidant Restrictive (CBT-AR)
- Dialectical Behavior Therapy (DBT)
- Radically Open Dialectical Behavior Therapy (RO-DBT)
- Motivational Interviewing (MI)
- Acceptance and Commitment Therapy (ACT)
- Play Therapy
- Occupational therapy
- Physical therapy
- Spiritual therapy

Importance in Removing the Cultural Blindfold

Asian Americans

Trends: Less likely to be referred due to held stereotypes
- Degree of risk nearly equals that of Caucasian women
- “Not severe enough” mentality
- Messages received from the family

Considerations: Individual treatment, solution-focused brief therapy,
- Focusing on past, family can decrease engagement
- Explore: Messages communicated and impact on body image, perceptions of ED

Latino Americans

Trends: Increase rates of binge eating and bulimia
- Other studies have demonstrated higher rating of disordered eating vs non-Latina white women
- Infrequent treatment
- 43% Latina Americans experienced hurt weight related comments
  “Las penas con pan duelen menos” The sorrows with bread hurt less
- Centrality of food in Latino culture: family ties, cultural identity, and comfort provided by food

Considerations:
- Bilingual, bicultural facilitators and materials
- Interaction between family conflict and disordered eating
- Include family and support network
- Include cultural themes
- Meal plan with busy work schedule

African American

Trends:
- Binge eating disorder highest (studies found 1.4 to 4.5),
- Bulimia 1.5 AA adults, higher than national average of 1%
- Anorexia rarest
  - Acculturation and Escape theory
  - Assessing for how one copes with societal pressures, discrimination, threats

Considerations: Interact between body shame and impulsivity
- Distress tolerance and mindfulness based approaches
Native Americans

Trends:
- Higher prevalence of Native American endorsed ED symptoms compared to Caucasian women
- Meal skipping, body image issues, and binge eating episodes
- ED symptoms rare amongst Native men

Considerations
- 50% received hurtful weight comments compared to 28% of Caucasian women
- Exploring messages received from family and how that impacts body image

East African

Trends: Literature search revealed lack of published research.

Considerations: Monitor weight and psychological status

Transgender

Trends: LGBTQ at higher risk of developing ED
- Transgender, body dissatisfaction, and disordered eating
- Body image issues more severe when focus on body part not in congruence with one's identity

Treatment: Family rejection can increase complexity of ED care, include if possible
- Consideration for transition,
- Introduction with pronouns
- Exploration: How do you feel about your body including parts you have and/or parts you want or don't have?
- What would your ideal body look like?
- How has your body image been helped or harmed by your family
- Actively support, educate, advocate for clients' rights to determine what's best for body, including emotional support involved in gender-confirming surgery or other procedures

Non-heterosexual Men

Trends: 4% of men in general population identify as gay or bisexual, comprise of 42% of men in treatment.
- 7 times more likely to endorse binging, 12 times more likely to endorse purging
- Process of coming out, experiences of violence (gay bashing), discrimination, and being bullied
- Heightened emphasis on lean, muscular physique and face increased pressure
- Increased drive for thinness and dieting frequency

Consideration: CBT-E self-evaluation and impact on levels of self-worth

Non-heterosexual Women

• Trends: One study: No significant differences between heterosexual women and lesbian or bisexual females
• Another study: Disclosing sexual orientation can impact prevalence of eating disorder
• Considerations: Social support with similarities can interact with body image, enlarge social support system

Males

Trends: 10% fallacy
- 25% with anorexia nervosa and bulimia, 36% binge eating disorder
- Men do care about their bodies
- Masculinity and the impact on eating disorder behaviors

Considerations
- Confused societal body ideals for males
- Normalizing, de-stigmatizing
Other factors to consider and rule out first:

• Food deprivation/starvation
• Food Insecurity

66 years ago we learned about the relationship between deprivation and binge eating

The Minnesota Semi-Starvation Study of 1944 documented binge eating in normal weight men who lost 25% of their body weight (Keys, 1950)

Food Insecurity

Limited or uncertain availability of nutritionally adequate and safe foods at some point during a measured time period.

Food Insecurity and Eating Disorders

35% of “normal” dieters...progress to pathological dieting

20 to 25%...of those progress to an eating disorder

Religion

• Fasting in religion
• Ramadan in Islam, Christian season of Lent, Jewish holy day Yom Kippur
• Health and Fasting
• Interaction between ED thinking and religious practices
• Non-food fasting: media/technology, negative self-talk, mirror use
Most Eating Disorders start with a **DIEt**

![Image of a dieting person]

**Eating Behaviors Continuum**

- Dieting, Restricting
- Normal Eating
- Excessive or Binge Eating

**National Eating Disorders Association**

https://www.youtube.com/watch?v=OU768PVZagI

**Role Play**

- What questions were effective? Ineffective?
- What are some different ways in which those questions could have been asked?
- Do you have any questions you would like to ask in order to gain insight into the eating habits of this client?

**SCOFF Questionnaire**

1. Do you make yourself *Sick* because you feel uncomfortably full?
2. Do you worry you have lost *Control* over how much you eat?
3. Have you recently lost more than *One* stone (14 lbs) in a 3-month period?
4. Do you believe yourself to be *Fat* when others say you are too thin?
5. Would you say that *Food* dominates your life?

A score of 2 or more indicates possible risk for eating disorder and warrants further assessment.
What to watch for...

- Eating same food repeatedly
- Skipping meals, saying they’re not hungry
- High amounts of zero calorie beverages
- Very fast or slow eating, pushing food around
- Hiding food (napkins, pockets)
- Talks non-stop about food, weight, calories
- Body checking, body jiggling
- Requesting weight checks
- Hiding/hoarding food
- Always using restroom right after meals
- Exercising in room / distress if miss gym time

Starting the Conversation

- Approach in a concerned, non-judgmental manner
- Don’t be vague, ask specific questions
- Use “I” statements rather than “you” statements
- Avoid placing shame, blame or guilt on the person regarding their actions or attitudes
- Avoid giving simple solutions
- Consider getting some collateral information from parents or other support people who may be with them

Window of Recovery

Full and lasting recovery can be achieved if the eating disorder is treated within 5 years from onset.

References

References


