Eating Disorders and Substance Use Disorders – the interface

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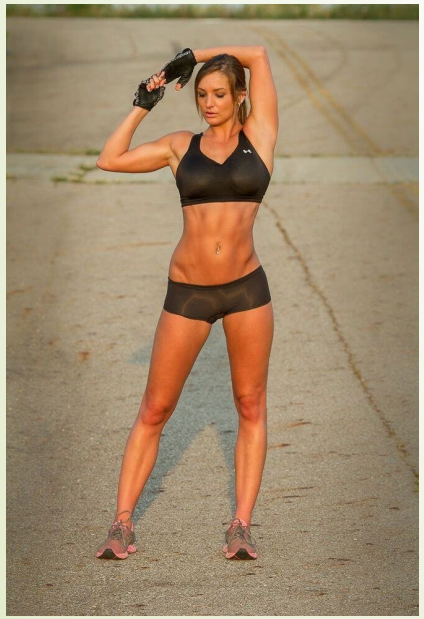
Which person has the eating disorder?



Screening questions

SCOFF

- A five item screening tool that uses a cutoff score of 2:
  - Do you make yourself **Sick** because you feel uncomfortably full?
  - Do you worry you have lost **Control** over how much you eat?
  - Have you recently lost more than **One** stone (14 lbs or 7.7 kg) in a three month period?
  - Do you believe yourself to be **Fat** when others say you are thin?
  - Would you say that **Food** dominates your life?

- When patients answer yes to 2 or more items, they have a 40-60% chance of having an ED
- Further follow-up would be required to diagnose an ED

(Morgan, Reid, & Lacey, 1999)

Common types of eating disorders (DSM-5)

Anorexia Nervosa

- Restricting energy intake
- Low weight
- Undue influence of shape & weight
- Specify: restricting or binge/purge type
- 0.46% 3-month prevalence

Bulimia Nervosa

- Binge eating
- Compensatory behaviours
- Undue influence of shape & weight
- 0.99% 3-month prevalence

Binge Eating Disorder

- Recurrent episodes of binge eating
- No recurrent compensatory behaviours
- 1.71% 3-month prevalence

OSFED

- Other Specified Feeding or Eating Disorder
- Atypical AN
- Purging Disorder
- Low frequency symptoms – BN, BED
- 3.2% 3-month prevalence

Qian et al. (2022)

Commonalities with SUDs and Ed's

- Both disorders highly stigmatized – such that behaviours are secretive, associated with guilt, shame and self-destructive
- Substance and/or food are used to "self-medicate" negative affective states
- While trying to reduce behaviours individuals with SUD's will have cravings/urges to eat and individuals with Ed's will use substances to relieve tension/urges or to escape emotions (cook 2014)
- Pauwels et al 2018 explored common personality traits – insufficient self-control and impulsivity
- Interpersonal and family relationships are strained, employment/academic pursuits are compromised and overall QOL is reduced
- Psychosocial and medical/mortality/morbidity are higher than other SMI

CoMorbidity with ED's and SUD's

- The shared genetic risk association between BN and AUD/SUDs is significant, at 35%–53% (Wade and Bulik 2018).
- The shared genetic risk is higher in binge-type eating disorders that involve compensatory behaviors. Baker et al. (2017) suggested that the role of genetics in the association between eating disorders and SUDs may be better explained by symptoms than by diagnoses. For example, early-onset alcohol use has been associated with subsequent bulimic behaviors, specifically binge eating and compensatory behaviors (Baker et al. 2017).
- Genetic variants in the dopamine and serotonin systems have also been implicated in the development of both eating disorders and SUDS (Franks 2014, Rozenblat et al. 2017)

CoMorbidity with ED's and SUD's

- WHO MH survey found lifetime rates of any SUD in individuals with BN and BED and AN-BP substype up to 27%.
- Meta-Analysis by Bahji et al. 2019 found SUD comorbidity among individuals with ED's 23.9% in a lifetime and 7.7%current prevalence.
- Several studies found cocaine, cannabis, tobacco and opioids to most common substances .
- In a group college women report using illicit stimulants for appetite suppression and weight reduction (Brueninget cal. 2018)
- A few studies have explored the relationship between OUD and disorder eating. About 1/3 entering a methadone maintenance treatment program reported loss of control related to eating and/or BED (Goldschmidt et al. 2018)
- Individuals with eating disorders have higher rates of trauma, and this trauma may be a common mediating link between eating disorders and SUDs (Mitchell et al. 2012).

Longitudinal studies

- Lu et al 2017 studied a community sample for prevalence of ISU, RBE and Comorbid RBE and ISU over 6 years. From year 2-4, individuals with baseline ISU more likely to develop RBE along or RBE with ISU whereas those with baseline RE either remained unchanged or remitted but unlikely to develop ISU.
- 9 year longitudinal study of individuals with AN or BN and risk for developing SUD. Number of psychiatric hospitalizations, Suicide attempt were predictive for AN and severity of symptoms for BN (Franko 2008)
    - So ? Binge eating may be an alternative compensatory coping mechanism in the absence of SUD

New Drinking Guidelines

Canada's Guidance on Alcohol and Health

To reduce the risk of harm from alcohol, it is recommended that people living in Canada consider
reducing their alcohol use.
The reasons to do so derive from the following facts:
a. There is a continuum of risk associated with weekly alcohol consumption where the risk of harm from alcohol is:

- Low for individuals who consume 2 standard drinks or less per week;
- Moderate for those who consume between 3 and 6 standard drinks per week; and
- Increasingly high for those who consume 7 standard drinks or more per week.

b. Consuming more than 2 standard drinks per drinking occasion is associated with an increased risk of harms to self and others, including injuries and violence.
c. When pregnant or trying to get pregnant, there is no known safe amount of alcohol use.
d. When breastfeeding, not drinking alcohol is safest.

Sex and Gender

Above the upper limit of the moderate risk zone for alcohol consumption, the health risks increase more steeply for females than males.
Far more injuries, violence and deaths result from men's alcohol use, especially in the ca

Regular eating explained

- The only way out of an eating problem is eating on time.
  - 3 meals and 2 snacks
  - Eating enough at every meal and snack

  - WHY?
    - This is the way our body is designed.
    - Glucose to cells – organs, brain
    - Protein stabilizes glucose
    - Grains provide energy
    - Full/Hunger explained

What to do if you observe your participant having ED symptoms

Undereating/restricting/sudden wt loss

- Introduce your observations
- Ask if they have noticed? Is this intentional?
- Absence of calories related to ETOH abstinence can be substantial

IF they say yes – Then what?

Provide Teaching about Symptom swapping

How else can you manage emotions instead of controlling your shape/wt?

Teach regular eating – eating on time, eating enough

What to do if you observe your participant having ED symptoms

Excessive Exercise:

- Introduce your observations
- Ask if they have noticed? Is this intentional?

IF they say yes – Then what?

Provide Teaching about Symptom swapping

How else can you manage emotions instead of controlling your shape/wt?

Activity doesn't need to be zero but it needs to be managed

What to do if you observe your participant having ED symptoms

Binge Eating:

- Introduce your observations
- Ask if they have noticed? Is this intentional?

IF they say yes – Then what?

Provide Teaching about Symptom swapping

How else can you manage emotions instead of controlling your shape/wt?

Most individuals binge eat because they restrict food all day.

Introduce the importance of regular eating – eating on time and eating enough. Especially- snack in the afternoon and evening

QUESTIONS? COMMENTS? DISCUSSION?