

Treating Eating Disorders as Substance Use Disorders

Presenter: Marty Lerner

Should we treat eating disorders similar to how we treat Substance Use Disorder in regards to medication assisted treatment?

A: There is no simple answer with respect to that question. In other words, we need to consider the nature of the substance used with substance use disorders and the type of ED with an eating disorder. There is no equivalent to suboxone or methadone, for example, for an eating disorder. In that respect, the answer would be no. The exception might be some medications that, at least intermediate term, we've employed with minimal benefit – these include some appetite suppressants such as a newer medication "Contrave" for binge eating disorder (combines Naltrexone with Bupropion [Wellbutrin]). Prozac and a few other SSRI's have been utilized to treat depression, thought to contribute to bulimia and BED. Where both ED's and SUDs join is in the area of treating co-morbid mood disorders such as recurrent depression with appropriate antidepressant meds and/or mood stabilizers such as Abilify and Lamictil. Longer term, I believe medications such as Suboxone and Contrave should not be relied upon as they have limited value in long term recovery.

Regarding neuroplasticity, if the brain is able to heal itself, why "once an addict, always an addict?"

A: When you speak of the brain "healing itself" it really comes down to reversing tolerance with the body no longer needing to "down regulate" the dopamine and/or other relevant receptors [e.g. opiate receptors]. Hence there is a restoration of normal levels of these neurotransmitters available over time. Despite this, there exists the "sleeping Gorilla" of what we term "sensitivity" – this translates to permanent structural [neural] changes via the process of neural plasticity. Although these "connections" between the reward structure of the brain [nucleus accumbens] and prefrontal cortex are dormant during abstinence [aka sobriety and abstinence], they are almost immediately called into action and reactivated as soon as one "picks up or resumes" ingestion of either the drug or addictive behavior "of choice" or, get this, a related behavior or substance. Welcome now to the phenomenon of "cross addiction"- Translation, many a drug addict has switched from drugs to alcohol and become dependent and many a binge eater has become and alcoholic, and so on. In fact, we're seeing a surge among gastric by-pass patients developing late onset alcohol use disorders – not rocket science to figure out why and connect the dots.

How do you tell the difference between healthy fasting and starvation?

A: I would argue fasting is not exactly healthy. Although the intention may be to "detoxify" the body or "cleanse" – eating in such a fashion is experienced, and reacted to, by the body as starvation – even though your telling yourself it's a "fast" for health or diet reasons. When someone has a history of an eating disorder I think they would be "playing with fire" to depend on their "judgment" to tell them what is healthy fasting and what is starvation – as thinking [judgment] tends to be distorted. It's sort of like asking me to tell the difference between still having pain from a dental procedure that justifies another Percocet and convincing my self I'm not doing it for the effect [buzz]. Some folks can do a "juice fast" for a few days with minimal ill effects. Others can get caught up in the mood and mind altering effects.

Have you ever spoken with anyone who is struggling with an eating disorder (more specifically, those mentioned in the presentation) and attempted to explain their behaviors and symptoms in terms alike to those used in substance abuse treatment facilities? I ask because I recently began my career as a substance abuse counselor, and I am also recovering from a severe case of bulimia. When I began to learn more about addiction, cravings, and the neural pathways involved in addiction, everything about my eating disorder suddenly made sense, it seemed. I can relate to people with substance abuse problems more than I can relate with people with other kinds of eating disorders.

A: To answer in a word – yes. Keep in mind there are several similarities with the addict population as well as subtle differences [e.g. cocaine and methamphetamine addicts and alcoholics, opiate addicts and nicotine addicts, on so on]. Likewise there are similarities between an anorexic patient and a binge eater, a bulimic and compulsive overeater. That said, where you would likely [and they would likely] find common ground is 1. The extent their behavior has played havoc with their lives [unmanageability] and 2. Identifying with all the criteria we currently believe define use / abuse / addiction. [DSM V criteria]. You likely identify “more” with a substance dependency because of the confusion over defining abstinence with respect to an eating disorder and the more clearly defined boundaries with chemical / alcohol use.

Do artificial sweeteners have the same effect as high fructose corn syrup or sugar?

A: No, HFCS is 10X more potent [concentrated] and is the “Fentanyl” of processed foods. People vary with their response to different artificial Sweeteners or sugar substitutes – some respond to the taste [sweetness] by being triggered even though there are no or little calories, others are prone to slight blood sugar spikes followed by mild low blood sugar, and yet others have no ill effects on their hunger, appetite, or blood sugar. We see a similar effect with caffeine. The research still is inconclusive. Fact is, some people they’ve studies eat a triple cheeseburger, fries, and always order a diet soda with it – and the data reflects people gain weight on diet soda – correlation not causation. The issue is more likely about “conditioned” responses to the taste of sweetness and it becomes a problem if you “transfer” your dependency on sweet and low to ice cream. So, for a few folks-it’s a gateway substance. For me, it’s a great tool to avoid sugar and sweets and for diabetics, a lifesaver. Aren’t you glad you asked... lol 😊

Do you see more instances of psychosis in EDs than SUDs?

A: Psychosis tends to be more within the SUD population and usually while under the influence of certain substances [Flaka, LSD, etc], and not so much with an eating disorder.

Are there evidenced based questionnaires that you would recommend giving to patients to help identify eating disorders?

A: Yes – The Eating Disorders Inventory, Beck Depression Scale, and Yale Food Addiction Scale are evidence - based instruments one can utilize in an evaluation. These all have a history of Reliability and Validity studies for the past several years. Personally, I rely on the pre-admission questionnaire we use at Milestones. Of course, any instrument assumes the patient or responder is prepared to answer honestly.

Thank you again for all your questions. They were all good ones and show a lot of thought and understanding of the subject. Fell free to contact me at www.MilestonesProgram.Org any time if you have any other questions or simply wish to consult on any of your cases,

Marty Lerner