VERITAS COLLABORATIVE

A SPECIALTY HOSPITAL SYSTEM FOR THE TREATMENT OF EATING DISORDERS
Eating Disorders and Substance Use Disorders:
Assessment, Conceptualization, and Treatment

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She has no financial relationships to disclose.
Presentation Overview

- Epidemiology
- Assessment
- Treatment Modalities
- Case Conceptualization
- Interventions
  - Psychotherapeutic
  - Dietetic
  - Medical
At least **30 million** people in the United States meet clinical criteria for an eating disorder diagnosis at some point in their lifetime.

Prevalence rates by diagnosis:
- Anorexia Nervosa: 0.6% average lifetime prevalence in the United States
- Bulimia Nervosa: 1% average lifetime prevalence in the United States
- Binge Eating Disorder: 2.8% average lifetime prevalence in the United States
- ARFID: prevalence rates still being studied, may affect up to 5% of children

Prevalence rates by population:
- Most common among cis-females (85-90%), however becoming increasingly prevalent among cis-males as well; transgender individuals are particularly vulnerable
- Bulimia Nervosa and Binge Eating Disorder are more prevalent among Latino and African-American populations than non-Latino Caucasian populations
- Inpatient admissions for eating disorders treatment for individuals over the age of 40 is increasing
Epidemiology – Substance Use Disorders (SUDs)

- Prevalence by diagnosis:
  - Alcohol Use Disorder (AUDs): 29.1% lifetime prevalence
  - Nicotine Use Disorder (NUDs): 27.9% lifetime prevalence
  - Drug Use Disorders (DUDs): 9.9% lifetime prevalence

- More prevalent among:
  - Men
  - Caucasian and Native American populations
  - Members of the LGBT community
  - Younger individuals
  - Previously or never married people
  - Individuals with lower education and income

- Helpful resource: Substance Abuse Treatment: Addressing the Specific Needs of Women (TIP 51)
Epidemiology – Comorbid EDs and SUDs

- Eating Disorders and Substance Use Disorders Overall
  - 50% of patients with an ED will abuse a substance
  - 35% of individuals who abuse substances have an ED

- Eating Disorders and Substance Use Disorders By Eating Disorders Subtype
  - BN typically has the highest association with substance use, followed by BED
  - Substance use in AN may be more common than originally thought
    - Likely accounted for by patients diagnosed with AN-B/P
    - Patients diagnosed with AN-R may actually have lower rates of substance use than the general population

- Eating Disorders and Substance Use Disorders by Substance Use Disorder Subtype
  - Alcohol Use Disorders are most common among individuals diagnosed with BN, BED, or AN-B/P
  - Use of caffeine and tobacco across eating disorder subtypes reported across studies has been inconsistent, although may be slightly higher in individuals diagnosed with AN; amphetamine use is higher in patients with AN
  - Use of illicit substances is higher in individuals with EDs, with the exception of individuals who meet criteria for AN-R
Epidemiology – Key Take-Home Points

• EDs and SUDs co-occur on a regular basis
  • Purging behavior and correlation with substance use
• Stereotypes about populations of individuals struggling with EDs and SUDs
• Correlations between class of substance used and eating disorder diagnosis
Assessment of EDs and SUDs

- The Importance of Multidisciplinary Assessment
- Screening and Quantitative Assessment
  - Eating Disorders: EDE-Q, DSED, BUILT-R, EAT, EDI-2, EDQ, QEWP
  - Substance Use Disorders: SCOFF, CAGE, TWEAK, MAST, ADS, DAST, DSQ
  - Assessment of Withdrawal: CIWA-Ar, COWS
  - Labs: Urinalysis, Blood Chemistry, EKG, Stool Samples, Imaging
- Qualitative Assessment
  - Assessment as a method to begin to explore function of ED and SUD
  - Provider qualities when conducting qualitative assessment
  - Obtain collateral information when feasible
• Practice Guideline for the Treatment of Patients With Eating Disorders (Third Edition):
  • Assessment of the following domains:
    • Medical status
    • Suicidality
    • Weight as percentage of healthy body weight
    • Motivation to recover, including cooperativeness, insight, and ability to control obsessive thoughts
    • Co-occurring disorders (substance use, depression, anxiety)
    • Structure needed for eating/gaining weight
    • Ability to control compulsive exercise
    • Purging behavior (laxatives and diuretics)
    • Environmental stress
    • Geographic availability of treatment program
Determining Appropriate Levels of Care – APA Guidelines – Current Levels of Care

Medical Acute Crisis
Inpatient (IP)
Acute Residential (RES)
Partial Hospitalization (PHP)
Intensive Outpatient (IOP)
Outpatient (OP)

Revision- Guidelines Watch August 2012
Determining Appropriate Levels of Care – ASAM Criteria – The Six Dimensions of Multidimensional Assessment

### AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

1. **Acute Intoxication and/or Withdrawal Potential**
   - Exploring an individual's past and current experiences of substance use and withdrawal

2. **Biomedical Conditions and Complications**
   - Exploring an individual's health history and current physical condition

3. **Emotional, Behavioral, or Cognitive Conditions and Complications**
   - Exploring an individual's thoughts, emotions, and mental health issues

4. **Readiness to Change**
   - Exploring an individual's readiness and interest in changing

5. **Relapse, Continued Use, or Continued Problem Potential**
   - Exploring an individual's unique relationship with relapse or continued use or problems

6. **Recovery/Living Environment**
   - Exploring an individual's recovery or living situation, and the surrounding people, places, and things
Determining Appropriate Levels of Care – ASAM Criteria – Continuum of Care

REFLECTING A CONTINUUM OF CARE

Outpatient Services

Intensive Outpatient/Partial Hospitalization Services

Residential/Inpatient Services

Medically Managed Intensive Inpatient Services

Early Intervention

0.5

1

2

2.1

2.5

2.9

2.5

3.1

3.3

3.7

Note:
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.
Determining Appropriate Levels of Care - Considerations With ED and SUD Comorbidity

• Eating Disorders and Substance Use Disorders should be:
  • Addressed simultaneously
  • Utilizing a multidisciplinary approach
  • At the appropriate Level of Care for an appropriate duration of time
Let’s Practice!

• Think of a patient you currently treat or have treated who struggles with an eating disorder, and use the APA Guidelines to make a determination about the appropriate Level of Care
  • If you have not treated a patient with an eating disorder previously, a vignette has been provided
Common Therapeutic Modalities Used in the Treatment of Comorbid EDs and SUDs

- Dialectical Behavior Therapy (DBT)
- Motivational Interviewing (MI) / Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Mindfulness-Action Based Cognitive Behavioral Therapy (MACBT)
- Adjunct Treatments:
  - Mutual Support Programs (AA/NA/CA and SMART Recovery) for Substance Use Disorders
  - Family-Based Therapy for Eating Disorders
The importance of understanding the function of behaviors and the possibility of behaviors with different topographies serving comparable functions

- **Weight Loss:**
  - ED Behaviors: Restricting, compulsive exercise
  - Substances: Caffeine, tobacco, insulin, thyroid medications, stimulants, laxatives, diuretics

- **Decreasing Negative Affect:**
  - ED Behaviors: Restricting, bingeing, purging, compulsive exercise
  - Substances: Alcohol, psychoactive substances

- **Increasing Positive Affect:**
  - ED Behaviors: Restricting, bingeing, purging
  - Substances: Alcohol, psychoactive substances

- Conceptualization of disorders as disorders of undercontrol vs. disorders of overcontrol
Let’s Practice!

• Using the previous slide as a guide, sketch out a brief case conceptualization of a patient with whom you currently work or with whom you have worked who struggles with an eating disorder and/or substance use disorder
  • If you have not treated a patient with an eating disorder or substance use disorder previously, use the vignette provided for practice
Psychotherapeutic Interventions for Comorbid EDs and SUDs

- Building a collaborative therapeutic relationship
- Psychoeducation
- Enhancing motivation for treatment and recovery
- ABC Model / ARC Model / Chain Analysis / Behavior Analysis
- Building of skills and coping mechanisms
- Cognitive challenging of attitudes and beliefs
- Relapse prevention
Building a Collaborative Therapeutic Relationship

• Psychotherapy as a “social healing practice”
  • Key elements of the therapeutic relationship that impact outcomes in psychotherapy: Goal consensus/collaboration, empathy, alliance, positive regard/affirmation, congruence/genuineness, cultural adaptation

• EDs and the therapeutic relationship
  • Recommendations regarding therapeutic stance from RO DBT: Relaxed and playful professional style, responsive and flexible, treating patient as a person of equal status, willingness to demonstrate vulnerability, approach of open curiosity and willingness, actively addresses and repairs alliance ruptures

• SUDs and the therapeutic relationship
  • “Butterfly” patients
Psychoeducation

- Psychoeducation about physical and psychosocial effects of eating disorders and substance use disorders, and the factors that contribute to the development of these disorders
- Addressing misconceptions that perpetuate guilt and shame (e.g. substance use is a moral failing), lead to maintenance of the disorder (e.g. purging is an effective form of weight control), and/or prevent individuals from seeking treatment (e.g. medication assisted treatment is just swapping one addition with another)
- Orientation to the treatment approach being used
Enhancing Motivation for Treatment and Recovery – Values-Based Work

• Showing intense interest in our patient as a person, and helping them to define and build their own “life worth living”

• From an eating disorder standpoint, helps to address the overvaluation of shape and weight (when pertinent) through increasing the number and significance of other domains for self-evaluation

• From a substance use disorder standpoint, can address key triggers for substance use (e.g. boredom, loneliness)

• Can also help to set the stage for developing discrepancy (part of Motivational Interviewing)

• Exploring values across life domains:
  • Writing exercises
  • Values card sort
  • Assessments
Enhancing Motivation for Treatment and Recovery –
Motivational Interviewing

• Principles:
  • Express empathy through reflective listening
  • Develop discrepancy between the client’s goals or values and their current behavior
  • Avoid argument and direct confrontation
  • Adjust to client resistance rather than opposing it directly
  • Support self-efficacy and optimism

• Examples of matching your intervention to the patient’s stage of change:
  • Procontemplation: Exploring events that led your patient to seek treatment
  • Contemplation: Emphasize client control, acknowledge ambivalence, use pros and cons
  • Preparation: Offering a menu of change options
  • Action: Developing a coping plan

• To learn more:
Enhancing Motivation for Treatment and Recovery – Commitment Strategies

- Evaluating the Pros and Cons
- Playing the Devil’s Advocate
- Foot-in-the-Door/Door-in-the-Face Techniques
- Connecting Present Commitments to Prior Commitments
- Highlighting the Freedom to Choose and the Absence of Alternatives
- Using Principles of Shaping
- Cheerleading
- Agreeing on Homework
• ABC Model = Antecedents, Behavior, Consequences
• ARC Model = Antecedents, Response (including thoughts, feelings, and behaviors), Consequences
• Chain Analysis = vulnerability factors in play prior to the target behavior and emotions, behaviors, bodily sensations, thoughts, and environmental events that occur before and after the target behavior
• Behavior Analysis = compilation of insights gained about patterns based on multiple chain analyses
Building of Skills and Coping Mechanisms

- Dialectical Behavior Therapy skills designed to treat both EDs and SUDs:
  - Urge Surfing
  - Alternate Rebellion
  - Burning Bridges
  - Dialectical Abstinence
- Skills from other therapeutic modalities (e.g. CBT, ACT)
Cognitive Challenging of Attitudes and Beliefs

• Examples of cognitions:
  • ED cognitions: “I’m not hungry so I don’t need to eat my morning snack,” “I need to restrict a little bit so that if I eat more on a day I won’t go over my maintain weight,” “I’m not sick enough to deserve treatment”
  • SUD cognitions: “Smoking weed isn’t a problem, it’s opiates that ruined everything for me,” “It’s been a crappy day, I deserve just one drink,” “I need to keep wine glasses in the house for when we have company”
  • Cognitions that increase unpleasant emotions: “Things will never get better,” “I’m worthless”

• Examples of cognitive approaches:
  • Learning to observe and describe thoughts as thoughts rather than facts
  • Exploring the thought (e.g. Does this thought get me in trouble and if so, how? Does the data I have available support this thought and if not, why?)
  • Identifying the cognitive error (e.g. black-and-white thinking, emotional reasoning)
  • Generating statements that are aligned with facts, goals, and values
Relapse Prevention

• **Common Topics**
  - Cultivating and Sustaining Motivation (e.g. Pros and Cons, Connecting With Values)
  - Maintaining Positive Changes
  - Building and Maintaining Structure
  - Addressing Current and Potential Challenges, Including Triggers and High Risk Situations
  - Identifying Warning Signs
  - Challenging Disordered Thinking
  - Identifying and/or Creating a Support Network
  - Addressing Lapses and Relapses

• **Relapse Prevention Plans**
  - Living document
  - Shared with multidisciplinary team and identified supports
Let’s Practice!

• Think of a patient with whom you currently work or with whom you have worked who struggles with an eating disorder and/or substance use disorder. If you have not treated a patient with an eating disorder or substance use disorder previously, use the vignette provided for practice.
  • How could the aforementioned interventions fit in to a treatment plan?
  • How would you sequence these interventions?
  • What feels like it is missing from your treatment plan?
Dietetic Interventions for Comorbid EDs and SUDs

- Dietetic education
- Establishing “regular eating”
- Addressing and challenging dietary rules
- Developing skills
- Specific considerations when working with comorbid SUDs
  - Changes in craving
  - Interplay between substance use and eating disorder behaviors
  - Specific body image fears
Medical Interventions for Comorbid EDs and SUDs

• Caveats and considerations
  • Familiarize yourself with the medical complications associated with specific eating disorders and specific classes of substances

• Recommended medical interventions:
  • Labs: Urinalysis, Blood Chemistry, EKG, Stool Samples, Imaging
    • Used to inform medical interventions that may be needed

• Potential contraindications:
  • Depend on substances being used and ongoing risk assessment and cost/benefit analysis
  • Contraindication for bupropion due to increased seizure risk
  • A word on cannabis

• Examples of situations of heightened risk:
  • Patient who engages in purging behavior and who has an alcohol use disorder and/or benzodiazepine use disorder
  • Patient who is at risk for cardiovascular complications due to their eating disorder (e.g. arrhythmia due to electrolyte imbalance) and who has an opioid use disorder
Summing It All Up

- Eating Disorders and Substance Use Disorders commonly co-occur and these patients are at increased medical and psychiatric risk – thorough assessment is key.
- Multidisciplinary treatment at the right level of care for the appropriate duration of time that targets both disorders concurrently is critical.
- Literature on best practices in the treatment of comorbid Eating Disorders and Substance Use Disorders is limited, although there are promising directions.
Translating Training into Practice

- What is one topic that was discussed today that you will plan to learn more about?
- What is one assessment or treatment strategy that was discussed today that you will make intentional efforts to incorporate into your practice?
  - How will you go about doing this?
  - What barriers do you anticipate encountering? How will you address these barriers?
  - When will you evaluate how things are going with the assessment or treatment strategy you have chosen to use?
Questions?


