Understanding Eating Disorders in Recovery from Substance Use Disorders

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General Course Objectives: The goal of this continuing education course is to offer mental health providers the knowledge, tools, and structure to develop insight into the psychological features of eating disorders (ED) that may present for individuals in recovery from substance use disorders (SUD). Importantly, participants will also gain an understanding of the process and application of psychological theory, evidence-based practice, skills, and techniques, relevant to developing client-centered solutions for the treatment of challenging, co-occurring psychiatric disorders.

Part One. Introduction

2. Eating and Substance Use Disorders

Eating disorders affect people from all demographics and are not caused by any single factor. They arise from a combination of long-standing biological, behavioral, emotional, psychological, interpersonal, and social factors [1]. With respect to prevalence, there are only a handful of recent studies that explore the co-occurrence of eating and substance use disorders and even fewer (if any) studies on the treatment and management of co-occurring EDs and SUDs. The economic costs and health factors associated with each of these disorders is substantial in the United States, with costs estimated at 400 Billion for eating disorders [1b] and over 740 billion for substance use disorders [1c].

For decades, there’s been significant debate with respect to the relationship between these two disorders. The addictions model purports that both EDs and SUDs are based on chemical dependency with similar genetic, familial, personality and socio-cultural influences [2]. To date, no substantial research directly supports this hypothesis. While studies indicate a genetic heritability for these disorders separately, there is no research in support of a shared SUD-ED genetic or familial link[3]. The term “food addiction” is becoming commonplace in the media, but it’s important to clarify the types of foods (e.g., processed food substances or those high in saturated fats, sugars and certain chemicals, that have addictive qualities and may lead to overconsumption and perceptions of dependence.

Eating disorders (e.g., anorexia nervosa, bulimia nervosa) are associated with high premature mortality and are generally considered to be among the most lethal of all psychiatric disorders [4]. Similarly, mortality from substance use disorders is well documented. [5].
It has been established that having an ED increases a person’s risk for using substances, or medications to achieve a desired body-image. Conversely, in recovery from SUD, an eating disorder may develop as a maladaptive strategy to ease psychological (dis)stress.

It’s a vicious cycle. Some stimulant medications such as those used for ADHD and other mental health disorders, support appetite suppression and weight loss. For others suffering with bulimia nervosa (BN) or binge eating disorders (BED), substance use may relieve the emotional (dis)tress or stigma associated with body-image and metabolic disorders such as obesity. From a shared perspective, these disorders increase the likelihood for developing co-occurring disorders, have poor rates of remission [6] and can result in permanent incapacitation or death.

3. Danish Cohort Study

A major retrospective cohort study of Danish nationals included 20,759 patients with eating disorders and 83,036 matched control subjects. For those participants with comorbid substance and eating disorders there is significantly increased risk of all-cause mortality, when compared with control subjects without SUDs [6].

<table>
<thead>
<tr>
<th>Category</th>
<th>Increased Risk for Mortality Compared with National Control Group (ND)</th>
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<tbody>
<tr>
<td><strong>Anorexia Nervosa (AN)</strong></td>
<td></td>
</tr>
<tr>
<td>AN (No SUD)</td>
<td>3.1 (x)</td>
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<tr>
<td>AN and Alcohol or Marijuana Use Disorders</td>
<td>11.28</td>
</tr>
<tr>
<td>AN &amp; Hard Drug Combination</td>
<td>22.34</td>
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<tr>
<td><strong>Bulimia Nervosa (BN)</strong></td>
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<td>BN (NO SUD)</td>
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<td>BN and Alcohol or Marijuana Use Disorders</td>
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<td>ED &amp; Hard Drug Combination</td>
<td>15.53</td>
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</tbody>
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4. Similarities Shared by Eating and Substance Use Disorders.

Developmental Influences

In recovery from SUD, mental health conditions and disorders such as depression, anxiety, a history of trauma, suicidality, unstable relationships, and family of origin issues, often surface in
the course of treatment. These conditions, as well as a legacy of negative influences (parents, peers, partners etc.,) and experiences typically exist prior to the development of substance use disorders. Not surprisingly, these same conditions are closely correlated with the development of body-image issues, and the onset of eating disorders [7].

Environmental Influences

There is no data (yet) that correlates social media with an increased risk for developing these disorders. That said, from an influential perspective, most of us, our patients included, are tethered to electronic devices at all hours. Social media and immersive marketing efforts have one message:

**If you don’t look like this, have this, do this, or feel like this; you’re not okay!**

Targeted and geo-fenced messaging specifically focuses on socio-economic factors, age, race, culture, and other variables directly relevant to selling the “message of missing out” to increase revenue without regard for community mental health and physical health consequences [8].

5. Emotional Similarities

There are similar expressions or “red flag” statements that speak directly to core emotions and beliefs that may present in either or both of these disorders.

- “I’m not okay the way I am.”
- “I’ll never be enough.”
- “I hate myself.”
- “I look like crap.”
- “I don’t matter; what I want doesn’t matter either.”
- “I feel like I don’t fit in anywhere.”
- “No one gives a @B(#P! about me!”

These feelings and beliefs may emerge anywhere across childhood, puberty, or adolescence, and persist well into adulthood. Importantly, these feelings reveal underlying MH disorders that likely preceded the onset and development of substance or eating disorders. We’ll talk more about that in Part 3.

Entering treatment, some patients may have a fear of feeling vulnerable, or being seen as “damaged” in some way. Sensitive to perceived criticism or judgement, they may not disclose or express core beliefs (or anything else for that matter) that they perceive will present themselves in a “poor light” or with “diminished capacity”*. Likely, we’ll have to dig deep into our patient’s history, narrative, and expressed preferences, to ferret out self-defeating beliefs that may correlate with an increased risk of developing comorbid disorders and lead to relapse.

When one’s perception of self is grounded in negative emotions and self-loathing, then defensive cognitive strategies may develop to support, or cope with an unhealthy self-view, narrative, and biases. These elements can fuse and become the cognitive framework or schema for “selective” or filtered awareness, evaluation, communication, and ultimately, decision-making. Some cognitive patterns shared across mental health disorders include:

- All – or - nothing thinking: A rigidity and tendency to interpret experiences in “black and white” categories, ignoring shades of gray (or any other colors).
- Over-focusing on the negatives: Picking out a single negative detail and ignoring the positives. (*groups).
- Disqualifying the positives: Rejecting positive information or affirmation, because it doesn’t fit the existing narrative.
- Catastrophizing or Awfulizing: Amplifying the “badness” of an interaction or event, which escalates emotional responses.
- Conditionality: “I’ll be okay when____.” “It” will be better when____. “If I do this – I’ll feel better.” (mindfulness)

7. Psychological Similarities

Patterns of secrecy, deception, and avoidance are prevalent in both eating and substance use disorders. While we discuss these attributes in greater detail with regard to brain chemistry, just the thought of “engagement” (whether it be using, hoarding, or purging) will stimulate dopamine activity in the brain. Patients in recovery from SUDs and ED, have shared that it’s the familiar “rush” associated with secret keeping and having “one thing they could secretly control” that prompted the onset of unhealthy eating behaviors and a focus on body-image. *AN is discussed separately.

Inhibitory control is problematic in the development of ED and SUD. Individuals with BN and BED frequently demonstrate reduced inhibition that extends beyond food (e.g., substance use, shoplifting, and self-injury) [9]. Insufficient activation in the control-related regions of the brain may manifest as difficulty in stopping eating during binge episodes, as well as difficulty in resisting urges to purge [9].

Punishment sensitivity occurs for individuals with clinical and subclinical ED and SUDs [10, 11]. In broad terms for our discussion, punishment can be thought of as a state of withdrawal or weight gain that motivates behavior. The state of withdrawal in turn can interfere with motivation or the ability to learn from experience [11].

Physical illness is associated with mental health disorders as well as ED and SUD disorders. Illness not only affects the body and daily functioning, but can significantly affect cognitive and emotional functioning and increase the risk for developing depression and anxiety disorders [12]. There are greater functional impairments and mortality rates for those with comorbid mental and physical health illnesses [12].
Treatment dropout is common both among people in treatment for eating disorders and for substance use disorders [13]. In a small study of 122 women in treatment, 17% (21) left treatment against medical advice. Analysis showed that eating disorder symptoms were significantly associated with decisions to leave treatment, after controlling for age, years of education, depression symptoms, alcohol problems, and drug problems [13].

There are a few studies that discuss personality disorders (PD) in the context of ED and SUDs. While some shared traits emerge, such as impulsivity or sensation-seeking, there is insufficient evidence to suggest that PD’s present an increased risk for the development of ED or SUD disorders.

Substance use and eating disorders may develop concurrently which adds significant complexity for clinicians who specialize in the treatment of one but not necessarily both, disorders. There are very few inpatient facilities that treat these disorders, concurrently. Facilities for addiction recovery typically won’t accept patients with active eating disorders, and facilities that treat eating disorders, won’t accept patients with active SUD disorders. If the patient wants or needs inpatient treatment, this forces them to conceal or lie about conditions or behaviors that could preclude admission.

In the next section we’ll quickly review eating disorders and behavioral observations that may suggest the presence of an eating disorder and associated health concerns.

**Part Two. DSM-V Criteria for Eating Disorders, Observable Behaviors, and Associated Health Concerns.**

As we review these disorders it’s important to recognize that suicide is the second leading cause of death among individuals with AN, and rates of suicidal behavior are elevated in individuals with BN and BED. Physical appearance is not a reliable indication as to whether a patient may be suffering from any of these ED subtypes.

8. **DSM – V Criteria - Anorexia Nervosa**

To be diagnosed with anorexia nervosa, the following criteria must be met:

- 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.
- Intense fear of gaining weight or becoming fat, even though underweight.
- 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 denial of the seriousness of the current low body weight. [14].

Without getting into too much detail, there are two AN subtypes: a restricting type (AN-r) and a binge-eating/purging type (AN-bp). Individuals with AN-r purely restrict their food intake and increase activity, while those with AN-bp usually restrict their food intake and regularly engage
in binge eating and/or purging behaviors. The two subtypes are characterized by different behaviors and personality characteristics. Individuals who restrict show high persistence and low novelty-seeking behaviors, whereas those with binge-eating disorders, including AN-bp, have high impulsivity, sensation-seeking, and novelty-seeking traits [16].

Even if all the DSM-5 criteria for anorexia are not met, a serious eating disorder can still be present. Atypical anorexia includes those individuals who meet the criteria for anorexia but who are not (yet) underweight despite significant weight loss. Research studies have not found a difference in the medical and psychological impacts of anorexia and atypical anorexia [17].

9. Behaviors and Health Concerns

Patients with EDs, particularly AN, may underreport symptoms. Observable Behaviors may include: refusing or delaying eating, restricting food intake, avoiding certain types of food, suddenly adopting a specific diet or eating style, annoyance when the “diet” foods are unavailable. Wearing bulky concealing clothes, binge eating, purging, compulsive exercise regimens, the use of laxatives, and frequent use of appetite suppressants such as nicotine and caffeine diet pills, nutritional or herbal supplements, muscle building supplements, to name a few. When eating, they may dawdle, excessively tear or cut up foods, chew each bite a certain number of times, and avoid particular combinations of foods. They may also try to avoid social situations because of heightened sensory experiences of others’ food, feelings of disgust at watching others eat, or self-consciousness about others commenting on their food choices.

Health Consequences may include: malnutrition, anemia, osteoporosis, heart conditions, dizziness, low blood sugar, liver and kidney problems, hypoglycemia, fatigue, low testosterone (males), loss of period (female), dry skin and brittle hair, hyponatremia, and more [18]. ** Diff dx.

There are a few features that distinguishes AN from other disorders related to impulse control; and delay of gratification. In AN-r there is no substance of abuse [19]. A possible theory that arises is whether individuals with anorexia nervosa are “addicted” to the sensation of controlling hunger, and that this hunger serves as a mediator for continued weight loss [19]. Recent fMRI studies of individuals with AN reveal increased activity within dorsolateral cognitive circuitry associated with decision-making and inhibitory control [19]. This enhanced cognitive control likely contributes to an ability to restrict intake even when emaciated [20].

That said, Casper (2006) makes interesting observations. “The relentlessness with which individuals with anorexia nervosa pursue starvation despite profound negative physical, emotional, and social consequences is similar to the maladaptive cycle seen in individuals with addiction.” [21] Another parallel, is that “individuals with anorexia nervosa behave similarly to individuals with substance abuse by narrowing their behavioral repertoire so that weight loss, restricting food intake, and excessive exercise interfere with other activities” [21].
10. DSM – V Criteria - Bulimia Nervosa

The DSM-V diagnostic criteria for bulimia nervosa include:
Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- Eating, in a discrete period of time (e.g. within any 2-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.
- 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).
- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for three months [14].

11. Behaviors and Health Concerns - BN

**Observable Behaviors** may include: People suffering with BN commonly binge eat in an uncontrolled manner, then purge to try to get rid of the calories. In community dining situations, an individual with an ED, may leave abruptly during a meal, only to return a few minutes later. Ahead of planning a binge-purge event, they may attempt to hide, or hoard food. In conversation, there may be a marked preoccupation with body image that reflects on how they look, or want to look.

“I'm leaving here with a six-pack; not talking beer y' know.”

These individuals may share openly that “I don’t want to gain any weight in recovery” but their “public” eating behaviors don’t align with this goal. In shared living environments, roommates may become aware of binge-purge and restricting behaviors well ahead of clinical or residential staff.

**Health Consequences** may include: tooth decay, dehydration, heart conditions, kidney failure, abdominal discomfort, digestive issues, gastric reflux and more [18].

12. DSM – V Criteria - Binge Eating Disorder

The DSM-5, diagnostic criteria for binge eating disorder include:

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 two-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 [14].

BED is the most common eating disorder in the United States. Contrary to BN, BED is not associated with purging or other unhealthy methods to “get rid” of the calories consumed during the binge [21].

13. Behaviors and Health Concerns - BED

Observable Behaviors may include: excessive consumption of food, hiding or hoarding food, lying about how much or how often one is eating. Might find stashes of empty wrappers.

Health Consequences may include: Heart disease, high blood pressure, reduced hepatic functioning (high cholesterol), Type II Diabetes, obesity and weight gain, impaired cognitive functioning and an increased risk for developing early-onset Alzheimer’s disease and dementia disorders [18].

14. Summary: A short list of diagnostic and behavioral similarities:

• Continued and repeated behavior, despite negative consequences to one’s health.
• *An inability to stop the behavior.
• Escalation in both frequency of behavior, as well as associated health consequences.
• A desire to return to old behaviors after recovery or remission.
• Continuing behavior even when it causes problems in relationships.
• Giving up important social, occupational, or recreational activities.
• Shame, remorse, and feelings of hopelessness, stigma, and social isolation.
• Friends and family members expressing concern related to behavior.
NOTE 1. ARFID was first included in DSM-5 in 2013, and consists of an eating or feeding disturbance associated with avoidance or restriction of food intake. Criteria include “Significant weight loss (or failure to achieve expected weight gain or faltering growth in children), significant nutritional deficiency, dependence on enteral feeding or oral nutritional supplements, [or] marked interference with psychosocial functioning.” To fulfill the diagnostic criteria for ARFID, the eating and feeding disturbances cannot be the result of a psychiatric condition (e.g., AN, BN), must exceed the impact on eating/feeding contributed by another medical condition (e.g., GI disease), and cannot be a reflection of culturally related eating practices or food scarcity [14].

NOTE 2: Body Dysmorphic Disorder may present as a shared factor contributing to underlying MH conditions like depression and anxiety as well as the development of eating patterns in support of the “desired” body-image. There are efforts underway to research the similarities, differences, and co-occurrence of BDD with ED and SUD disorders.

Diff Dx. *According to the current psychiatric classification scheme, DSM-5, there is a phenomenological overlap between Substance-related and Addictive Disorders and Feeding and Eating Disorders [14], in that ‘control’ plays a prominent role in the criteria for disorders within these two categories [15]. Hebebrand et al., (2014) point out however that there are behavioral differences with respect to “control”. Impaired control before and after use in the context of SUDs is not the same as a “sense of lack of control over eating during the (binge eating) episode” a key feature of both Bulimia Nervosa (BN) and BED [15].

15. The Brain – Body Connection

Teaching patients about their brain and the neurochemistry underlying many mental health disorders, lets clinicians begin to shift conversations away from pathology toward a shared understanding. This type of education can help patients begin the transition from personalization (I am a disorder) to normalization (I have a disorder). Away from internalization (character) to acceptance (task/choice).

Studies of BN and BED, indicate deficient activation in brain regions related to inhibitory control, similar to patterns of activation reported in drug and alcohol users [20, 23]. For those with BN or BED, activation in response to food cues, mirrors the increased activation in these regions for substance users exposed to drug-related cues [22]. These similarities implicate similar neurotransmitters, particularly those key to cognitive control, reward, and salience [20, 23].

We discuss the role of neurotransmitters functions and the disturbances in neurotransmitter function in dopamine, serotonin, gamma aminobutyric acid, and endogenous opiate systems common to EDs and SUDs. We also present basic information on neural circuitry in the brain and problems with interconnected reward and inhibitory circuits [23].
There are overlapping circuits shared by SUD, BN, and BED, but not AN. This is an important distinction. With AN, brain circuitry supports greater inhibitory control and the ability to resist body signals and impulsive behaviors.

16. Similarities:

SUD: A drug-seeking circuit, a drug reinforcement circuit and a drug or cue-induced reinstatement neurocircuit [24].

For BN and BED: A circuit that supports impulsive behavior, a behavioral reinforcement circuit (reward and stress reduction) and a behavioral reinstatement neurocircuit (relapse).

1. At the heart of the first circuit is the insula, anterior cingulate and ventral tegmental area. The insula processes basic sensory information [25], receives strong dopaminergic innervation, contains a high density of D1 dopamine receptors, as well as a high concentration of endogenous opioids and high density of µ-opioid receptors [25]. Dopaminergic neuron terminals of the insula originating in the ventral tegmental area (VTA) influence dopamine neuronal reactivity and dopamine release in the nucleus accumbens NAcc (critical for addictive behaviors) [25].

2. The second pathway, the “reward” pathway includes the NAcc, putamen, caudate, orbitofrontal cortex and amygdala. The NAcc is a component of the mesolimbic pathway which is stimulated during rewarding experiences. Connections between the NAcc, amygdala (emotions), and hippocampus (memory) are responsible for rewarding and monitoring the value of eating and contribute to the approach or avoidance of food [25].

3. The third network, the dorsal caudate and dorsal anterior cingulate, prefrontal cortex, and parietal cortex are responsible for “control” and consideration of both short and long term outcomes. This system weighs the reward value and the consequences of consuming (or using) to maintain homeostasis [25, 26].

17. Stress

Environmental factors such as chronic stress, trauma, or drug exposure can induce changes in gene expression, which can alter functioning in neural circuits and ultimately impact behavior [24]. Beginning even in utero, early life stress and chronic stress can cause long-term alterations in the HPA axis, which affects limbic brain circuits that are involved in motivation, learning, and adaptation. These features often impaired in individuals with substance use disorders [23]. Stress, (a known risk factor for a range of MH disorders) likely provides a common neurobiological link between the disease processes of comorbid disorders [23]. Stress and stress-related disorders have a high risk for addiction to substances as well as significant risk for cycles of relapsing behavior.
18. Brain Damage May be Reversible

Studies suggest that reversal of some brain damage associated with AN or BN is possible. It’s been demonstrated that individuals with anorexia demonstrate notable reductions in three critical measures of the brain: cortical thickness, subcortical volumes, and cortical surface area, highlighting the effects of undernutrition. However, recent studies suggest that structural brain abnormalities are reversible in individuals with eating disorders after long-term recovery [28] and that structural brain insults inflicted by starvation in anorexia nervosa may be reversed at a rate much faster than previously thought if interventions are successful before the disorder becomes chronic [28].

19. Relapse

As with recovery from SUDs, recovery from EDs can be a long process with periods of relapse and recovery, and relapse to one disorder may affect a client’s recovery from the other [29]. Relapse prevention counseling is critical to recovery from both disorders [29]. For example, peer influences are important aspects for people with both EDs and SUDs. EDs often occur in clusters among particular groups (e.g., sports teams, sororities, and cliques), so changes in friends and recreational activities to avoid triggers are important in ED recovery as well as in SUD recovery [30].

20. Potential Indicators for Relapse

- Increase in Stress
- Changes in Thinking
- Changes in Feelings
- Changes in Behavior
- Change in Appetite
- Changes in Energy
- Changes in Sleep
- Changes in Activities
- Changes in Pervasive Mood
- Changes to Environment


Following inpatient treatment, many individuals in recovery from SUD, are required to participate in strictly supervised activities to comply with legal, licensing, and other return-to-work or school mandates. These activities can include regular attendance at intensive outpatient meetings, weekly meetings with mental health practitioners, random testing, daily 12-step meetings, as well as documented meetings with 12-step sponsors, peer monitors and representatives from company and licensing boards.

During intense initial recovery efforts, patients share that they feel like they’ve completely surrendered autonomy over their life and daily activities. In some cases this means they’re required to give up familiar places, or people that enabled active using and dependence. For most, they trade comfortable and familiar haunts for hard plastic chairs and the company of strangers in cold church basements. We know that some patients have simply had enough, and
welcome these changes. That said, for others there may be resistance, resentment, and disdain for the reality of recovery.

The perception of loss of autonomy or “control” over daily activities is key to understanding and challenging the emotional and behavioral indicators that can lead to the onset of eating (and other) disorders in recovery. Sometimes the only thing a patient feels they can control is their body and physical appearance. It’s not all about anorexia and bulimia. Binge eating disorder is more frequently diagnosed than other types of eating disorders.

For clients who relied on stimulants to maintain their weight or appearance prior to treatment there have be other challenges that contribute to relapse. Weight gain is a known side-effect of some medications effective in the treatment of underlying MH such as major depressive disorders, anxiety disorders and bipolar disorders. At times, this concern (or actual weight gain) may affect patient compliance with taking prescribed mood-stabilizing medication(s).


22. Implementing Treatment Protocols.

For most mental health disorders, ethical care is informed by theoretical approaches, evidence based practices, as well as recommended assessment and treatment protocols. As a community, we already have the resources, tools, and skills necessary for successful and concurrent treatment of these disorders.

When we review the underlying mental health conditions (depression, anxiety, trauma, etc.), brain functioning, DSM –V diagnostic criteria, health and social factors, striking similarities emerge that inform the development of co-occurring treatment protocols. For example, a lifetime history of depression or anxiety have been identified as common underlying factors for EDs and SUDs. Patients often endorse criteria from several disorders such as mixed anxiety and depression. This suggests that to treat co-occurring disorders we explore evidence-based practices that support recovery from shared underlying mental health conditions.

23. Common Underlying Conditions

24. Integrated Treatment is Effective Treatment.

In our work with clients we use evidence based practices to address underlying disorders to support emotional, cognitive, and behavioral change. Patient workbooks, sessions and supporting resources, as well as our online learning programs sequentially address all these categories. In part, this is because behavioral or emotional problems may not be severe enough for a diagnosis, but subclinical mental health issues may still be present [30].
• Brain-body education
• Addiction
• Depression
• Anxiety
• Trauma
• Personality
• Relationships
• Environmental Factors


• Motivational Interviewing
• Cognitive Behavioral Therapy
• Family of Origin Awareness
• Attachment Theory
• Addiction Theory
• Environment & Epigenetics
• REBT
• Transactional Analysis
• Mindfulness
• Psychological Education

26. Address Social Determinants of Health

• Primary Relationships
• Family dynamics & attachment style(s)
• Social environment
• Workplace
• Community
• Social Media
• Communication Skills

27. Key Concepts for Initial Recovery

• Delay of Gratification.
• Self-Regulation.
• “Enough.”
• Changing perceptions of emotional reward.
• Resisting mood altering behaviors.
• Challenging self-defeating thought processes
28. **Cognitive Restructuring (CR) – Intro 4R approach.**

When our BreakThrough! team develops structured resources to meet client needs, we implement a 4-part framework. This 4R framework is designed to develop awareness, explore skills or techniques to develop resistance, and progressively engage in the challenge of cognitive restructuring. The goal is to help clients develop a positive, empowering sense of self that celebrates strengths, acknowledges preferences, with the awareness to recognize challenges, and skills to support success.

- Recognition
- Resistance
- Resilience
- Recovery.

29. **CR – From Recognition to Recovery.**

- Recognition: (new information) provides insight into behavior and traits. Teaches clients how to make healthy (long-term) choices to help them reach goals
- Resistance: takes advantage of brain plasticity. Affirmative self-talk and new skills help re-wire and re-orient impulsive or emotionally – driven behaviors
- Resilience: is a result of consistent and purposeful resistance. Describes new brain regulation that supports and advocates life-sustaining, healthy choices
- Recovery: encompasses both an improved capacity for optimal self-regulation as well as a new operating range.

30. **CR – Alignment 4 R Approach and Practices.**

- Recognition: Psychoeducation, Family of Origin, Attachment Styles, Identification of Problematic Behaviors (DR) Inner Critic, Brain Chemistry
- Resistance: CBT – REBT- Active Cognitive Restructuring (DBT, MBSR, ACT etc.)
- Resilience: REBT – Mindfulness – Relapse Prevention
- Recovery: Inner Coach Social Support

31. **CR – Use of “We” and Humor.**

32. **CR – Brain and Eating Behaviors (BN – BED example).**

33. **CR – Betty, Brian and the Hippo. (Illustration with text)**

34. **CR – “Betty” Personalizes the Inner Critic for Our Clients. (Illustration)**

35. **CR – Cognitive Dysfunction. (Illustration)**

36. **CR – Daily Reflection.**

37. **CR – Cycle of Emotions, Thoughts, and Behaviors.**

38. **CR – Consistency in Information.**
40. CR – Exercise Example Challenging Thoughts.
41. CR – Disputing the Inner Critic (REBT).
42. CR – Anxiety and Perception
43. CR – Resistance and Reflexive Thinking (MTCBT).
44. CR – Setting Goals
45. CR – Celebrate Strengths
46. CR – Mindfulness
47. Time for Discussion
48 - 50. References

References


32. Mothersill, K. (2016). Enhancing positivity in cognitive behavioural therapy. Canadian Psychology/Psychologie Canadienne, 57(1), 1