Substance Abuse and Mental Health Services Administration
SAMHSA ADVISORY
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Behavioral Health Is Essential To Health • Prevention Works • Treatment Is Effective • People Recover

CLIENTS WITH SUBSTANCE USE AND EATING DISORDERS

Eating disorders (EDs), which cause serious health problems and can be fatal, frequently co-occur with substance use disorders (SUDs). There are numerous psychosocial consequences of EDs (e.g., problems with family, friends, school, or work; lowered perceived happiness).[1] When SUDs and EDs co-occur, the consequences, assessment, treatment, and recovery are more complicated for both disorders than for either disorder alone.[2]

Although researchers have called for integrated treatment of SUDs and EDs,[3, 4] few programs provide such treatment, and no research exists on the best ways to provide simultaneous treatment for both disorders. An analysis of National Treatment Center Study data found that, of 351 publicly funded SUD treatment programs surveyed, only 16 percent offered treatment for co-occurring EDs.[5] Furthermore:

- Only half the programs screened for EDs.
- Only 14 percent of those that did screen used a standardized instrument.
- Only 3 percent had formal referral arrangements with ED treatment providers.

SUD treatment counselors are in a good position to help their clients with undiagnosed EDs by being aware of the disorders, screening clients for EDs in the SUD treatment setting, and/or supporting their recovery from SUDs and EDs. Counselors need to understand EDs and their treatments so they can:

- Identify clients with possible EDs.
- Make appropriate referrals for evidence-based ED treatments.
- Help clients with both EDs and SUDs attain and maintain recovery by understanding the effects of EDs on SUDs and vice versa.

The goals of this *Advisory* are to raise counselors' awareness of EDs and their relationship to SUDs and provide an overview of screening and evidence-based treatments for EDs. The *Advisory* does not provide comprehensive, how-to information for treating clients with EDs. Resources for more information are listed throughout the document and in the Resources section.

What are eating disorders?

EDs are characterized by disturbed eating patterns and dysfunctional attitudes toward food, eating, and body shape. The primary features of EDs are similar to those of SUDs: compulsive use or behavior, loss of control, and continuing behavior despite negative consequences. Genetics and other biological factors, as well as environmental factors, appear to be involved in the etiology of EDs, although exact mechanisms remain unknown.[6, 7] The median age range for the onset of EDs is between ages 8 and 21,[8] although EDs can begin earlier or later in life.

The *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision (DSM-IV-TR),[9] describes three diagnostic categories for EDs: anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified. Healthcare providers often consider compulsive overeating an ED as well; however, this disorder is included in DSM-IV-TR only as a possible symptom of other behavioral health disorders.

Anorexia Nervosa

Primary characteristics of AN are an extreme desire to be thin and failure to maintain minimal body weight (defined as 85 percent of that expected based on age and height, using standard weight tables). A stricter indicator of AN is a body mass index (BMI) of 17.5 or less, according to DSM-IV-TR and based on the World Health Organization's (WHO's) International

Exhibit 1. Body Mass Index[10, 11]

BMI is a number derived from a calculation based on a person's weight and height. For most people, BMI correlates with their amount of body fat. Measuring BMI is an inexpensive and easy alternative to a direct measurement of body fat percentage and is a useful method of screening for weight categories that may lead to health problems. BMI categories are:

Underweight: BMI score of less than 18.5

Severe thinness	*BMI score of less than 16*
Moderate thinness	*BMI score between 16.00 and 16.99*
Mild thinness	*BMI score between 17.00 and 18.49*

Normal range: BMI score between 18.5 and 24.9

Overweight: BMI score between 25.0 and 29.9

Obese: BMI score of 30.0 or more

BMI in children and adolescents is calculated somewhat differently from BMI in adults. More information and BMI calculators for adults and children/adolescents are on the Centers for Disease Control and Prevention (CDC) Web site: http://www.cdc.gov/healthyweight/assessing/bmi

Classification of Diseases-10 diagnostic criteria (Exhibit 1). However, these are guidelines only. Low body weight alone is not enough for a diagnosis of AN; a person may be severely underweight because of severe malnutrition from addiction or from illness.

Although anorexia literally means lack of appetite, people with AN do experience hunger and appetite, but they severely restrict food intake regardless of hunger. DSM-IV-TR criteria for AN are listed in Exhibit 2.

ED workgroups for the fifth edition of the *Diagnostic and Statistical Manual* (DSM-5) currently in development have recommended changes in the diagnostic criteria for AN. A significant proposed change is to eliminate criterion D, amenorrhea. The reason for the proposed change is that some individuals exhibit all other symptoms and signs of AN but report at least some menstrual activity. Also, amenorrhea is limiting as a criterion because it cannot be applied to premenarcheal females, females taking oral contraceptives, postmenopausal females, or males.[12]

There are two subtypes of AN: *restrictive* and *binge eating/purging*. People with the restrictive subtype maintain a low body weight by restricting food intake and, often, exercising to excess. People with the binge eating/purging subtype also maintain a low body weight by restricting eating but have episodes of binge eating (an inability to control eating to the point of discomfort or pain) followed by purging (self-induced vomiting and/or using laxatives and diuretics). Both subtypes can have many serious medical consequences, including delayed puberty and/or slowed growth, bone mass reduction, nutritional deficiencies, serious cardiac problems, and severe anemia.

The mortality rate for AN is high; more than 10 percent of those diagnosed with the disorder die from it. Death typically is caused by starvation, suicide, or electrolyte imbalance.[9]

Exhibit 2. DSM-IV-TR Diagnostic Criteria for Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. 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.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods only occur following hormone, e.g., estrogen, administration.)

Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, (Copyright 2000). American Psychiatric Association.

Bulimia Nervosa

Binge eating and purging after a binge eating episode are the primary characteristics of BN. Periods of fasting, misuse of laxatives and diuretics, use of enemas, and excessive exercise are common. People with BN typically are of normal or higher than normal weight. DSM-IV-TR criteria are listed in Exhibit 3.

BN also has two subtypes: purging and nonpurging. People with the nonpurging subtype use other compensatory behaviors (e.g., fasting, excessive exercise).

Medical consequences of either subtype include potentially dangerous fluid and electrolyte imbalances, nutritional deficiencies, and menstrual irregularity and other reproductive system problems.[9] Rare but potentially fatal complications include esophageal tears and gastric rupture from purging, as well as cardiac arrhythmias. Erosion of tooth enamel (from stomach acid) is common with the purging subtype. People with purging BN are more likely than those with the nonpurging type to experience severe medical problems.

Eating Disorder Not Otherwise Specified: Binge Eating Disorder

DSM-IV-TR includes binge eating disorders (BEDs) in EDs not otherwise specified. The proposed revisions for DSM-5 include BED as a separate diagnostic category (Exhibit 4, see next page).

Unlike individuals with BN, those with BED do not purge and they tend to be obese. Medical consequences are typically those of obesity such as type 2 diabetes, high blood pressure and high cholesterol, stroke, cancers (e.g., endometrial, breast, colon), osteoarthritis, liver and gallbladder disease, and gynecological problems (e.g., abnormal menses, infertility).[14]

Compulsive Overeating

Although compulsive overeating is a primary characteristic of both BED and BN, compulsive overeating *without* purging or binge eating or with infrequent binge eating is common. Compulsive overeating is characterized by eating large amounts of food to cope with emotions and often eating without regard to hunger or feelings of fullness.[15] Compulsive overeating is a serious problem that can lead to obesity and associated medical consequences.

How common are eating disorders?

EDs occur more frequently in women, but men also are vulnerable and experience the same types of physical and behavioral signs and symptoms as women. However, men are less likely to be diagnosed with an ED, which is often considered a female disorder.[7] Hudson and colleagues[8] analyzed a subset from the National Comorbidity Survey Replication study that consisted

Exhibit 3. DSM-IV-TR Diagnostic Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. 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
   2. 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)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Reprinted with permission from the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, (Copyright 2000). American Psychiatric Association.

Exhibit 4. Proposed DSM-5 Diagnostic Criteria for Binge Eating Disorder[13]

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (for example, within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
   2. 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)

B. The binge eating episodes are associated with three (or more) of the following:
   1. Eating much more rapidly than normal
   2. Eating until feeling uncomfortably full
   3. Eating large amounts of food when not feeling physically hungry
   4. Eating alone because of being embarrassed by how much one is eating
   5. Feeling disgusted with oneself, depressed, or very guilty afterwards

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for three months.

E. 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.

of adults ages 18 and older with an ED. Exhibit 5 summarizes lifetime prevalence estimates of EDs (based on DSM-IV-TR diagnostic criteria) found in the Hudson study.[8]

Overweight and obesity are common in the United States. A 2010 analysis of National Health and Nutrition Examination Survey data of adults ages 20 and older found:[16]

- 68 percent of the general population is overweight or obese (72 percent of men, 64 percent of women).
- 34 percent of the general population is obese (32 percent of men, 35.5 percent of women).

Exhibit 5. Lifetime Prevalence Estimates of EDs (n=2,980)[8]

Disorder	Women (%)	Men (%)
Anorexia nervosa	0.9	0.3
Bulimia nervosa	1.5	0.5
Binge eating disorder	3.5	2.0

What is the relationship between EDs and SUDs?

A 2010 review found that both clinical and community studies have reported high co-occurrence of EDs among women with SUDs.[3] For example:

- Gadalla and Piran[17] found that women with either an SUD or an ED were more than four times as likely to develop the *other* disorder as were women who had neither disorder.
- Gilchrist and colleagues[18] examined the co-occurrence of EDs and SUDs and reported that 14 percent of women with an SUD had AN and 14 percent had BN.

Exhibit 6. Lifetime Comorbidity Estimates of EDs and SUDs (n=2,980)[8]

Disorder	Alcohol Abuse or Dependence (%)	Illicit Drug Abuse or Dependence (%)	Any Substance Use Disorder (%)
Anorexia nervosa	24.5	17.7	27.0
Bulimia nervosa	33.7	26.0	36.8
Binge eating disorder	21.4	19.4	23.3

Similarly, Hudson and colleagues[8] found that men and women with EDs had high rates of co-occurring SUDs (Exhibit 6).

Piran and Robinson[19] looked at the relationship between EDs and SUDs and found that:

- As EDs became more severe, the number of different substances used increased.
- Severe BED was consistently associated with alcohol use.
- Attempts to lose weight by purging (with or without binge eating) were associated with stimulant/amphetamine and sleeping pill (e.g., triazolam, flurazepam) abuse.

People often use food and substances to help them cope.[2] A person in recovery from an ED often uses substances to cope with the stresses of recovery. Similarly, a person in recovery from an SUD may use disordered eating to cope with or to compensate for the lack of chemical reinforcement.

For a person with AN, treatment typically begins with *refeeding*, a process of incrementally increasing calorie intake to achieve a weight gain of 0.5 to 1 pound per week. Refeeding and the subsequent weight gain are particularly stressful, and a client in this process should be monitored closely for relapse to ED and substance use.[2] During this process, the SUD treatment counselor must closely coordinate with the ED specialists (e.g., therapist, dietitian), psychiatrist, physician, and other professionals treating the person for AN.

As with recovery from SUDs, recovery from EDs can be a long process with periods of relapse and recovery,[2] and relapse to one disorder may affect a client's recovery from the other. Relapse prevention counseling is critical to recovery from both disorders. 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, cliques),[2] so changes in friends and recreational activities to avoid triggers are important in ED recovery as well as in SUD recovery.

Exhibit 7. Lifetime Comorbidity Estimates of EDs and Other Behavioral Health Disorders (n=2,980)[8]

Disorder	Co-Occurring Anxiety Disorders (%)	Co-Occurring Mood Disorders (%)	Co-Occurring Impulse Control Disorders* (%)
Anorexia nervosa	48	42	31
Bulimia nervosa	81	71	64
Binge eating	65	46	43

*Includes intermittent explosive disorder, attention deficit hyperactivity disorder, oppositional-defiant disorder, and conduct disorder.

What is the relationship between EDs and other behavioral health disorders?

Co-occurring behavioral health disorders (particularly anxiety and mood disorders) are common in people with EDs.[6] Exhibit 7 (see page 5) lists incidence rates of common co-occurring disorders found in the study by Hudson and colleagues.[8]

DSM-IV-TR links EDs to a range of specific behavioral health disorders, such as:[9]

- AN is an associated disorder for major depressive disorder and narcissistic personality disorder.
- Both AN and BN are associated disorders for bipolar II disorder.
- EDs in general (but BN in particular) are disorders associated with borderline personality disorder.

When and how should SUD treatment counselors screen for EDs and refer for ED treatment?

Screening Clients for EDs

Little is known about ideal screening for EDs in SUD treatment programs. Merlo and colleagues[2] recommend that SUD treatment programs screen for EDs, along with other behavioral health disorders, at intake and intermittently during treatment of all clients in SUD treatment. An analysis of National Treatment Center Study data notes that programs that screen for EDs do so during intake and assessment. About half these programs screen *all* admissions for EDs, and half screen only when an ED is suspected.[5]

Screening for EDs only when one is suspected can be complex, because signs and symptoms of EDs can overlap

Exhibit 8. Possible Indications of Eating Disorders[2, 9]

Disorder	Indication
Anorexia nervosa	Eating tiny portions, refusing to eat, and denying hunger Dressing in loose, baggy clothing (to hide weight loss) Exercising excessively and compulsively Feeling cold frequently Experiencing hair loss, sunken eyes, or pale skin Complaining of being fat, even when underweight Developing *lanugo*, fine body hair that develops along the midsection, legs, and arms
Bulimia nervosa	Eating little in public but overeating in private Disappearing after eating; spending a lot of time in the bathroom Sounding hoarse Experiencing bruised or callused knuckles, bloodshot eyes, or light bruising under eyes Hiding food wrappers and other evidence of binge eating Experiencing severe dental problems (loss of enamel)
Binge eating disorder	Hiding food to eat later Eating little in public but overeating in private Hiding food wrappers and other evidence of binge eating
Compulsive overeating	History of repeating cycles of losing and regaining body weight (yo-yo dieting) Believing that all problems could be solved by losing weight Eating little in public but overeating in private Hiding food wrappers and other evidence of binge eating

with those of SUDs or with those of other behavioral health problems. For example, weight loss, lethargy, changes in eating habits, and depressed mood can indicate an SUD or an affective disorder. In addition, signs may not be readily observable to counselors, because people with EDs often go to great lengths to disguise and hide their disorder.[2] However, counselors should be aware of common red flags for EDs that tend not to overlap with those of other behavioral health disorders. Exhibit 8 (see page 6) lists some indications (in addition to DSM criteria) that an ED may be present.

Screening *all* clients for EDs will likely result in identification of more clients in need of further assessment and treatment. SUD treatment counselors can easily (and unobtrusively) incorporate some ED screening into the SUD assessment in a number of ways:

- As part of the drug use assessment, ask clients about their use of over-the-counter and prescription laxatives, diuretics, and diet pills.
- As part of taking a medical history, ask clients about past hospitalizations and behavioral health treatment history, including for EDs.
- As part of assessing daily activities, ask clients how often and for how long they exercise.
- Ask clients, "Other than those we've discussed so far, are there any health issues that concern you?"

Counselors also can use a standardized screening instrument. Exhibit 9 lists the five questions in the SCOFF questionnaire.[20] This screening tool was originally developed and validated in the United Kingdom and has been validated for use in the United States.[21] Other validated brief screening instruments include:

- The Eating Attitudes Test (a 26-item version of the original 40-question Eating Attitudes Test[22, 23]
- The Bulimia Test—Revised (BULIT—R)[24]

Clients in SUD treatment may be confused or defensive about being asked questions regarding their eating and body image. Counselors can prepare clients by:

- Explaining that EDs commonly co-occur with SUDs.
- Explaining that it is important to have a clear picture of the client's overall health status.
- Asking the client for permission to pursue ED screening (e.g., "May I ask you some questions about your eating habits?").

Exhibit 9. The SCOFF Questionnaire[20, 21]

1. Do you make yourself **S**ick [induce vomiting] because you feel uncomfortably full?
2. Do you worry you have lost **C**ontrol over how much you eat?
3. Have you recently lost more than **O**ne stone* in a 3-month period?
4. Do you believe yourself to be **F**at when others say you are too thin?
5. Would you say that **F**ood dominates your life?

Two or more "yes" responses indicate that an ED is likely.

*14 pounds

Screening does not end at intake. Counselors should remain alert for signs of EDs, including changes in weight that may appear later in treatment or recovery.

Referring Clients for Further Assessment and Treatment

Ideally, a person with both an ED and an SUD would receive integrated treatment from one program.[3] However, because such programs are rare, SUD treatment counselors generally need to refer clients with EDs to specialized ED treatment programs and vice versa.

After medical stabilization (if necessary), treatment of the SUD should generally come first when integrated treatment for both disorders is unavailable,[2, 4] because a client with an active SUD will be less likely to engage in and benefit from ED treatment. In addition, many specialized ED programs are not prepared to treat a client who also has an SUD.

Treatment decisions (such as whether the SUD and ED will be treated sequentially or concurrently or on an inpatient or outpatient basis) should be made together by the client and family, the SUD treatment counselor, the physician, and the ED specialist as part of a multidisciplinary team approach. This team approach

to treating SUDs and EDs is critical. Counselors should consider developing formal referral relationships with local evidence-based ED treatment resources to enhance the referral process and ongoing treatment of both disorders.

ED treatment resources include specialized programs and practitioners, dentists, and nutritionists/dietitians. Possible sources of ED treatment referral information include:

- American Dietetic Association. A list of registered dietitians is at http://www.eatright.org
- Families Empowered and Supporting Treatment of Eating Disorders (F.E.A.S.T.). A list of treatment resources by State and country is at http://www.feast-ed.org/clinics.aspx; a list of active clinical trials is at http://www.feast-ed.org/SearchResults.aspx?Search=clinical+trials
- National Association of Anorexia Nervosa and Associated Disorders. A list of resources by State is at http://www.anad.org/get-help/treatment-centers/
- Community behavioral health centers and other behavioral health specialists.
- Hospital psychiatry departments and outpatient clinics.
- University- or medical school-affiliated programs specializing in EDs.
- Employee assistance programs.
- Local medical and/or psychiatric societies.

What is the treatment for EDs?

Evidence-based specialized treatment for EDs generally includes some combination of:

- Medical stabilization.
- Nutritional rehabilitation.
- Pharmacotherapy.
- Psychosocial treatment.

Medical Stabilization

Immediate inpatient medical care and stabilization are necessary for individuals with AN who are severely malnourished or for those with AN or BN with dehydration or electrolyte imbalances. Inpatient medical care for other physical consequences of EDs also may be necessary. For people with less severe malnutrition and medical consequences, medical care may be provided on an outpatient basis.[2]

Nutritional Rehabilitation

Nutritional rehabilitation is a critical aspect of treatment for those with EDs.[25] For individuals with AN, nutritional rehabilitation begins with a process of refeeding. Refeeding is usually initiated in an inpatient setting for severe malnutrition. The process must be done slowly and must be closely supervised to avoid *refeeding syndrome*, a cluster of possibly severe consequences (including cardiovascular problems) associated with a too-rapid increase in nutrient intake.[25] In less severe cases, refeeding may be done on an outpatient basis.

Nutritional rehabilitation for EDs also includes other services, typically provided by a registered dietitian. A dietitian may evaluate a client's nutritional status, provide information about risk regarding the ED, educate about nutrition, and monitor weight gain or loss.

Pharmacotherapy

Pharmacotherapy is often used for BN and BED. No medications have been found to be effective for AN. The selective serotonin reuptake inhibitor (SSRI) fluoxetine has been approved by the U.S. Food and Drug Administration for the treatment of BN and is commonly used to treat BED. Topiramate may also be effective for both disorders.[26] Preliminary research has found that:[26]

- Trazodone and desipramine may be effective treatments for BN.
- SSRIs (other than fluoxetine), imipramine, and sibutramine may be effective treatments for BED.

Psychosocial Treatments

More research on treatment for specific EDs is needed. However, some psychosocial treatments have been found to be more effective than others for particular EDs and/or age groups. Two extensive reviews of the literature

Exhibit 10. Overview of Evidence-Based Psychosocial Treatments for EDs[26, 27]

Population	Anorexia Nervosa	Bulimia Nervosa	Binge Eating Disorder
Preadolescents/adolescents (ages 10–17)	Maudsley Approach Manual-guided self-help	Maudsley Approach	Inconclusive evidence
Older adolescents/young adults (ages 18–20)	Maudsley Approach (if client is still living at home) CBT Manual-guided self-help	CBT Manual-guided self-help	Inconclusive evidence
Adults (ages 21 and older)	Nonspecific individual psychotherapy CBT (*after* near-normal weight is gained)	CBT IPT	CBT IPT

found that the most promising of these treatments include Maudsley Approach family therapy, cognitive–behavioral therapy (CBT), Interpersonal Psychotherapy (IPT), and self-help approaches.[26, 27] Exhibit 10 provides an overview of the psychosocial treatments that have been found to be most effective for particular EDs and age groups.

Maudsley Approach Family Therapy

Maudsley Approach family therapy is based on family systems theory and is a mainstay of AN treatment for adolescents. It also has been adapted for use with adolescents with BN.[27] The therapy has three phases:

- Phase 1: With coaching by a clinician with specialized training in ED treatment, parents of an adolescent with AN take control of the adolescent's eating (i.e., what, when, how much he or she eats). When the adolescent has BN, parents disrupt his or her ED behaviors (e.g., binge eating, purging).
- Phase 2: After significant weight gain is achieved (or ED behaviors have significantly decreased), control over eating behavior is carefully returned to the adolescent. At the same time, the family explores issues related to the ED.
- Phase 3: The ED clinician and family work to restore normal and age-appropriate developmental processes and relationships within the family.

Cognitive–Behavioral Therapy

CBT approaches, used widely in SUD treatment, have been tailored for treating EDs. For EDs, cognitive approaches address distorted thought processes related to body shape and image that drive ED behaviors. Behavioral approaches are directed at altering the food restriction of AN, compulsive overeating, or binge/purge behavior. These approaches appear to be most effective when combined.[26] CBT appears to be most effective for clients with BN or BED. It also appears to reduce relapse in adult clients with AN, but only after the client has reached near-normal weight.[26]

Interpersonal Psychotherapy

IPT focuses on interpersonal problems rather than intrapsychic processes. IPT has been found effective in treating BN or BED and is sometimes combined with CBT. When IPT is used to treat EDs, the premise is that negative interactions may lead to negative emotions that then lead to ED behaviors. During IPT sessions, clients with BN or BED focus on how to cope with the tension and frustration that can result from negative interpersonal interactions and learn to improve their relationship skills.

Self-Help Approaches

Self-help approaches show promise for treating EDs.[26, 27, 28] These approaches use highly structured audiovisual materials or manuals based on CBT principles. Manuals can be used by clients independently, in peer-led groups, or with a nonspecialized clinician (guided self-help).

Are there mutual-help groups for EDs?

Yes. Two mutual-help groups focus on people with EDs; both offer face-to-face, online, and telephone meetings:

- Overeaters Anonymous (OA) is a well-established mutual-help group based on the 12-Step model. OA was developed for people with compulsive overeating but has since broadened its scope to welcome those with other EDs. For example, it offers an informational packet titled *Focus on Anorexia and Bulimia*. More information and a meeting locator are available at http://www.oa.org/new-to-oa/about-oa.php
- Eating Disorders Anonymous (EDA) is appropriate for people with any ED. More information and an EDA meeting locator are at http://www.eatingdisordersanonymous.org

Although research on mutual-help groups for clients with EDs is virtually nonexistent, these groups may be useful for clients in long-term recovery from EDs.

Resources

Web Resources

Academy for Eating Disorders
http://www.aedweb.org

Alliance for Eating Disorders Awareness
http://www.allianceforeatingdisorders.com

American Dietetic Association
http://www.eatright.org

American Psychiatric Association
Treatment of Patients With Eating Disorders, Third Edition
http://www.psychiatryonline.com/pracGuide/pracGuideTopic_12.aspx

Eating Disorder Referral and Information Center
http://www.edreferral.com/index.html

Eating Disorders Anonymous
http://www.eatingdisordersanonymous.org

F.E.A.S.T.
http://www.feast-ed.org

International Association of Eating Disorder Professionals
http://www.iaedp.com

National Association of Anorexia Nervosa and Associated Disorders
http://www.anad.org

National Eating Disorders Association
http://www.nationaleatingdisorders.org

National Institute of Diabetes and Digestive and Kidney Diseases, Weight-control Information Network
http://win.niddk.nih.gov

National Institute of Mental Health
http://www.nimh.nih.gov/health/topics/eating-disorders/index.shtml

National Library of Health, Medline Plus
http://www.nlm.nih.gov/medlineplus/eatingdisorders.html

The National Women's Health Information Center
http://www.womenshealth.gov/bodyimage/eatingdisorders/

Overeaters Anonymous
http://www.oa.org/new-to-oa/about-oa.php

Relevant Publications from SAMHSA

Treatment Improvement Protocol (TIP) 35: *Enhancing Motivation for Change in Substance Abuse Treatment* (SMA) 08-4212

TIP 39: *Substance Abuse Treatment and Family Therapy* (SMA) 08-4219

TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (SMA) 08-3992

Women's Mental Health: What It Means to You (OWH09-CONSUMER) and the companion publication for professionals, *Action Steps for Improving Women's Mental Health* (OWH09-PROFESSIONAL)

These publications can be ordered from the Substance Abuse and Mental Health Services Administration (SAMHSA) by calling 1-877-SAMHSA-7 (1-877-726-4727). Publications also can be ordered or downloaded via the SAMHSA Store at http://store.samhsa.gov/home

Notes

[1] Piran, N., Robinson, S. R., & Cormier, H. C. (2007). Disordered eating behaviors and substance use in women: A comparison of perceived adverse consequences. *Eating Disorders, 15,* 391–403.

[2] Merlo, L. J., Stone, A. M., & Gold, M. S. (2009). Co-occurring addiction and eating disorders. In R. K. Ries, D. A. Fiellin, S. C. Miller, & R. Saitz (Eds.), *Principles of addiction medicine* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

[3] Harrop, E. N., & Marlatt, G. A. (2010). The comorbidity of substance use disorders and eating disorders in women: Prevalence, etiology, and treatment. *Addictive Behaviors, 35,* 392–398.

[4] Woodside, B. D., & Staab, R. (2006). Management of psychiatric comorbidity in anorexia nervosa and bulimia nervosa. *CNS Drugs, 20*(8), 655−663.

[5] Gordon, S. M., Johnson, J. A., Greenfield, S. F., Cohen, L., Killeen, T., & Roman, P. M. (2008). Assessment and treatment of co-occurring eating disorders in publicly funded addiction treatment programs. *Psychiatryonline.org, 59*(9). Retrieved September 14, 2010, from http://psychservices.psychiatryonline.org/cgi/content/full/59/9/1056

[6] Klump, K. L., Bulik, C. M., Kaye, W. H., Treasure, J., & Tyson, E. (2009). Academy for Eating Disorders position paper: Eating disorders are serious mental illnesses. *International Journal of Eating Disorders, 42*(2), 97–103.

[7] National Institute of Mental Health. (2007 revision). *Eating disorders.* NIH Publication No. 07-4901. Bethesda, MD: U.S. Department of Health and Human Services.

[8] Hudson, J. I., Hiripi, E., Harrison, G. P., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 61*(3), 348–358.

[9] American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

[10] Centers for Disease Control and Prevention. (n.d. b). *Healthy weight: It's not a diet, it's a lifestyle.* Retrieved September 14, 2010, from http://www.cdc.gov/healthyweight/assessing/bmi

[11] World Health Organization. (2006). *Global database on body mass index.* Retrieved September 14, 2010, from http://apps.who.int/bmi/index.jsp?introPage=intro_3.html

[12] American Psychiatric Association. (2010a). Anorexia nervosa: Rationale. *DSM-5 Development.* Retrieved September 14, 2010, from http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=24#

[13] American Psychiatric Association. (2010b, February 10). DSM-5 *proposed revisions will include binge eating disorder and revisions to other eating disorders criteria.* Retrieved September 14, 2010, from http://www.dsm5.org

[14] Centers for Disease Control and Prevention. (n.d. a). *The health effects of overweight and obesity.* Retrieved September 14, 2010, from http://www.cdc.gov/healthyweight/effects/index.html

[15] American Dietetic Association. (n.d.). *Eating disorders.* Retrieved September 14, 2010, from http://www.eatright.org/Public/content.aspx?id=6819&terms=compulsive+overeating

[16] Flegal, K. M., Carroll, M. D., Ogden, C. L., & Curtin, L. R. (2010). Prevalence and trends in obesity among U.S. adults, 1999–2008. *JAMA, 303*(3), 235–241.

[17] Gadalla, T., & Piran, N. (2007). Co-occurrence of eating disorders and alcohol use disorders in women: A meta analysis. *Archives of Women's Mental Health, 10,* 133–140.

[18] Gilchrist, G., Gruer, L., & Atkinson, J. (2007). Predictors of neurotic symptom severity among female drug users in Glasgow, Scotland. *Drugs: Education, Prevention, and Policy, 14*(4), 347–365.

[19] Piran, N., & Robinson, S. R. (2006). The association between disordered eating and substance use and abuse in women: A community-based investigation. *Women and Health, 44*(1), 1–20.

[20] Morgan, J. F., Reid, F., & Lacey, J. H. (1999). The SCOFF questionnaire: Assessment of a new screening tool for eating disorders. *British Medical Journal, 319,* 1467–1468. Used with permission from the primary author, John F. Morgan, M.D., M.R.C.Psych.

[21] Parker, S. C., Lyons, J., & Bonner, J. (2005). Eating disorders in graduate students: Exploring the SCOFF questionnaire as a simple screening tool. *Journal of American College Health, 54*(2), 103–107.

[22] Garner, D. M., & Garfinkel, P. E. (1979). The Eating Attitudes Test: An index of the symptoms of anorexia nervosa. *Psychological Medicine, 9*(2), 273–279.

[23] Garner, D. M., Olmstead, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The Eating Attitudes Test: Psychometric features and clinical correlates. *Psychological Medicine, 12,* 871–878.

[24] Thelen, M. H., Farmer, J., Wonderlich, S., & Smith, M. (1991). A revision of the bulimia test: The BULIT—R. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3*(1), 119–124.

[25] American Dietetic Association. (2006). Position of the American Dietetic Association: Nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders. *Journal of the American Dietetic Association, 106,* 2073–2082.

[26] Berkman, N. D., Bulik, C. M., Brownley, K. A., Lohr, K. N., Sedway, J. A., Rooks, A., et al. (2006). Management of eating disorders. *Evidence Report/Technology Assessment, 135,* 1–166.

[27] Keel, P. K., & Haedt, A. (2008). Evidence-based psychosocial treatments for eating problems and eating disorders. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 39–61.

[28] Peterson, C. B., Mitchell, J. E., Crow, S. J., Crosby, R. D., & Wonderlich, S. A. (2009). The efficacy of self-help group treatment and therapist-led group treatment for binge eating disorder. *American Journal of Psychiatry, 166,* 1347–1354.

SAMHSA Advisory

This *Advisory* was written and produced under contract number 270-09-0307 by the Knowledge Application Program (KAP), a Joint Venture of JBS International, Inc., and The CDM Group, Inc., for the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS).

Disclaimer: The views, opinions, and content expressed herein do not necessarily reflect the views or policies of CSAT, SAMHSA, or HHS. No official support of or endorsement by CSAT, SAMHSA, or HHS for these opinions or for particular instruments, software, or resources is intended or should be inferred.

Public Domain Notice: All materials appearing in this document except those taken directly from copyrighted sources are in the public domain and may be reproduced or copied without permission from SAMHSA/CSAT or the authors. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

Electronic Access and Copies of Publication: This publication may be ordered from SAMHSA's Publications Ordering Web page at http://www.store.samhsa.gov/home. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727).

Recommended Citation: Substance Abuse and Mental Health Services Administration. (2011). Clients With Substance Use And Eating Disorders. *Advisory*, Volume 10, Issue 1.

SAMHSA Advisory
Clients With Substance Use And Eating Disorders

HHS Publication No. (SMA) 10-4617
First Printed 2011