Eating Disorders and Substance Abuse

JOAN ELLEN ZWEBEN, PH.D.*

Clinicians involved in substance abuse treatment have been aware for some time that women with alcohol or other drug abuse problems also frequently suffer from eating disorders. Some of the similarities, such as feelings of shame, need to hide the behavior, and the compulsive quality have led to speculations of an underlying common dynamic, and possibly to common organic predisposing factors. The treatment challenge is complex: One does not have the luxury of postponing the exploration of anxiety-producing issues until abstinence (sobriety) is well secured. Eating disorders are health threatening and some-times life threatening, and are frequently closely connected with the alcohol or other drug abuse pattern.

This article focuses on bulimia and anorexia nervosa, omitting obesity because it is not characteristically associated with a distinct psychological or behavioral pattern (Norman 1984). It aims to clarify some of these issues and to provide recommendations to the treating clinician: guidelines on when to tackle the problem within the context of the substance abuse treatment and when to refer the clients elsewhere. It will also describe the major treatment approaches in the eating disorders field and offer criteria for selecting a program or therapist with whom to collaborate.

EATING DISORDERS: SOCIOCULTURAL PERSPECTIVES

Bodily functions have perhaps always been an arena in which human feelings and conflicts are expressed (Erickson 1950; Fenichel 1945). Although eating behaviors have received increasing attention over the past 15 years, there is ample reason to think that eating disorders have moved in and out of prominence throughout history (Boskind-White & White 1986; Strober 1986; Schwartz, Thompson & Johnson 1985; Bruch 1973). Weight concerns are pervasive among American women today, and obesity is stigmatized, particularly in higher socioeconomic groups (Streigel-Moore, Silberstein & Rodin 1986). Over the past several decades, one can trace a clear shift in societal preference toward thinner and thinner women. This is reflected in the changing measurements for what is termed "symbolically ideal groups of women," such as Miss America contestants and Playboy Bunnies (Garner et al. 1980). Root, Fallon and Friedrich (1986) pointed out that in 1978 the weight of the winner of the Miss America pageant was 78 percent of the average weight for women according to the actuarial charts, making her almost qualify for a *Diagnostic and Statistical Manual (DSM-IH)* (American Psychiatric Association 1980) diagnosis of anorectic (75% of body weight).

Contradiction is apparent within the culture: The "Vogue-Playboy dichotomy" represents one ideal for the epitome in fashion and another standard for sexual attractiveness (Bennett & Gurin 1982). What does it mean that contemporary society, which is bombarded with diverse images of abundance, fosters a thinner and thinner ideal for women? It is hardly surprising that disturbed eating behaviors become increasingly apparent, and specialized treatment programs are rapidly proliferating.

*Executive Director, Pacific Institute for Clinical Training, Education and Consultation, 714 Spruce Street, Berkeley, California 94707.

EATING DISORDERS AND SUBSTANCE ABUSE

The literature on eating disorders has frequently noted an apparently high incidence of alcohol abuse--and to a lesser extent other drug problems--either coexisting with or preceding the treatment attempt for an eating disorder. Studies and clinical discussions exploring the close connection between eating disorders and substance abuse in more detail are just now starting to appear.

Mitchell and colleagues (1985) reported that over one third of their bulimic patients described a history of problems with alcohol or other drugs, and most indicated substantial social impairment as well. Hatsukami and colleagues (1982) compared bulimics with women who had alcohol or other drug problems and reported similar Minnesota Multiphasic Personality Inventory (MMPI) profiles, and distribution of MMPI code types. Weiss and Ebert (1983) reported that bulimic patients demonstrated higher levels of psychopathology and impulsive behavior, and a history of more suicide attempts, psychiatric hospitalization, episodes of stealing, and problems with drug use. Johnson and Berndt (1983) studied the life adjustment of bulimic patients and found it to be significantly poorer in all areas than that of a normal community sample, and that it was most similar to that of a comparison group of alcoholic women.

Brisman and Siegel (1984) viewed the crossover of addictions as a manifestation of symptom substitution, with the central issue being a failure of the maintenance of self-regulatory functioning. They examined bulimia and substance abuse within the framework of ego growth, with a particular focus on developmental deficits and compensatory actions. Additionally, they noted parallel treatment strategies: identification of triggers; development of alternative coping strategies; use of peer support groups; and exploration of underlying issues.

Rand, Lawlor and Kuldau (1986) questioned 10 women who had both an eating disorder and a history of alcohol abuse about their food and alcohol consumption, and about their perceptions of related events. These women reported that the emotions associated with eating binges were quite similar to those associated with heavy alcohol use: anger, anxiety, boredom and depression. Half considered their problems with food and alcohol to be essentially the same. However, when the exact relationship between the eating behavior and alcohol use was explored, variability was found. Some women drank and binged at the same time, others alternated heavy drinking with eating binges, others reported that the compulsion to binge-purge became more intense when they stopped drinking or using other drugs. It appears that the eating behaviors are enmeshed with the substance abuse, but the nature of the relationship varies.

Systematic inquiries about the drug use of clients with eating disorders are still rare, but they are starting to appear. Jonas and Gold (1986a) administered structured diagnostic interviews to 259 consecutive callers to 800-Cocaine (the national cocaine hotline) who met *DSM-III* criteria for cocaine abuse. Using the *DSM-III* criteria for eating disorders, they identified individuals who had at some time met the criteria for anorexia nervosa and bulim-ia. They examined the frequency and duration of binging and purging behavior, and obtained information on drug habits and the influence of drug use on eating patterns. In their sample, 22 percent met the *DSM-III* criteria for bulimia, seven percent met the criteria for both anorexia nervosa and bulimia, and two percent met the criteria for anorexia nervosa alone.

Among cocaine users without an eating disorder diagnosis, 82 percent binged twice a month or less. Among those who at some time in their lives met the criteria for bulimia, 60 percent had a history of binging at least once a week. Jonas and Gold (1986a) concluded that patients with eating disorders should be questioned about and possibly tested for drug use, and that cocaine patients be screened for eating disorders. Abnormalities in eating patterns should not be attributed to drug involvement alone. The nature of the link is unknown. Jonas and Gold stated that "perhaps eating disorders and substance abuse have a third disorder in common, such as affective disorder. Alternatively, the propensity to addictive and compulsive behaviors may be expressed as the abuse of food or drugs."

EATING DISORDERS AND AFFECTIVE ILLNESS

Several authors have explored the possibility that substance abuse, eating disorders and depression are a sufficiently common symptom cluster to suggest a common base. Affective illness has been described by numerous authors in a subset of substance abuse clients (Mirin 1984; Schuckit 1983).

Lee and Rush (1985) indicated that 52 percent of their bulimic subjects (by *DSM-III* diagnosis) reported a personal history of affective disorder, and in 59 percent of their first-degree relatives. Those subjects with first-degree relatives with drug dependence, alcoholism or depression had an earlier onset of bulimia than those without such relatives. These authors speculated that bulimia may be symptomatically or pathologically related to depression.

Hatsukami et al. (1984) used *DSM-III* criteria to identify bulimic women with affective disorder and alco-

hol or other drug abuse. In this sample (N = 108), 43.5 percent had a history of affective disorder and 18.5 percent had a history of alcohol or other drug abuse. Approximately 56 percent of the bulimia patients scored within the moderate to severe range of depression on the Beck Depression Inventory.

Although most authors lean toward the view that the link is more than coincidental, Viesselman and Roig (1985) presented data suggesting that eating disorders are unique disorders and not variants of affective disorder or alcoholism. They divided their sample into categories of bulimia (binge eating, dieting), bulimarexia (bulimic symptoms, including self-induced vomiting or use of cathartics and/or diuretics), and anorexia nervosa. The incidence of major depression was very high in the sample (80%). However, the patients differed in terms of the family histories of eating disorders, but not in terms of alcoholism or depression. This study poses problems of interpretation in that it used slightly different criteria and procedures for diagnosis than is characteristic of the other studies. In terms of treatment, their main conclusion does not differ essentially from those of others: Eating disorders are entities in their own right and require a specialized treatment approach.

DIAGNOSIS

There are several ways in which eating disorders may manifest themselves in the substance abusing population. They may coexist, with women presenting at alcohol and other drug abuse treatment facilities who also have current eating disturbances. They may be part of a pattern of symptom substitution; eating disorder specialists note that previous alcohol or other drug abuse is frequently reported by their clients seeking treatment, but there appears to be no current abuse. Inasmuch as most mental health therapists are not trained in how to determine if there is a substance abuse problem, it is likely that many current problems are missed. And finally, substance abuse problems are frequently reported in the family members of clients with eating disorders.

There are a number of ways in which disturbed eating behaviors are intertwined with substance abuse problems. From the late 1940's to the late 1970's, many women were put on amphetamine combinations to suppress their appetites, and many date their involvement with stimulants (and other drugs) to that time. Anorexics report being drawn to cocaine because it makes them not want to eat, and gives an enhanced sense of power. Since cocaine is an appetite suppressant and chronic users are often quite thin, the possibility of a coexisting eating disorder is frequently overlooked. Some bulimics report being attracted to heroin because it makes them vomit. For them, the vomiting behavior may then become a conditioned association to heroin use, and must be addressed early in substance abuse treatment. Other women use alcohol to medicate the panic states that accompany the binging and vomiting. Still others substitute alcohol to gain the release experienced with the bulimia; for them, being intoxicated replaces the relief of abandoning controls that they once gained from binge eating.

Eating disorders are regarded by clients as being at least as shameful as alcoholism or other drug abuse problems. These problems frequently remain hidden even from therapists, especially when the client is not asked directly. One client appeared for an assessment of whether of not she was an alcoholic, and described using alcohol to cope with the anxiety that accompanied vomiting. She had labeled herself bulimic for some time, but had avoided any group activities focused on eating disorders. After attending an Overeaters Anonymous (OA) meeting in which several bulimic women spoke, she concluded that she was primarily bulimic, but was hoping for a diagnosis of alcoholism because it was somehow more acceptable.

Just as mental health therapists need to routinely ask about alcohol and other drug use patterns, substance abuse treatment professionals need to ask women about their attitudes and behaviors about food and weight maintenance. Males also manifest eating disorders, though less frequently (Copeland 1985; Norman 1984). Some indications for further exploration include feeling guilty for eating; seeing oneself as fat, though others see the client as normal or underweight; use of laxatives or diuretics for weight control; and use of vomiting for weight control. Guidelines for more detailed inquiry will be offered later.

Bulimia

Bulimia is characterized by episodes of binge-eating, alternating with periods of little or no food intake. Binge episodes are pursued in isolation and are usually followed by depressive feelings and low self-esteem. Self-induced vomiting or laxative abuse is frequently employed to prevent weight gain or facilitate weight loss. Most of these individuals are preoccupied with their weight (Mitchell, Pyle & Eckert 1985).

DSM-III criteria for bulimia focus on the following eating pattern (American Psychiatric Association 1980: 70-71):

> A. Recurrent episodes of binge-eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours at a time).
>
> B. At least three of the following: consumption of high-caloric, easily ingested food during a binge; termination of such eating episodes by ab-

dominal pain, sleep, social interruption, or self-induced vomiting or use of cathartics and/or diuretics; frequent weight fluctuations greater than 10 pounds due to alternating binges and fasts.

C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.

D. Depressed mood and self-deprecating thoughts following eating binges.

E. Bulimic episodes are not due to anorexia nervosa or any known physical disorder.

Mitchell, Pyle and Eckert (1985) also pointed out several problems with these criteria. The lack of frequency parameters create problems for research, as bulimic-type behaviors are common in populations of college-age women and are often transitory in this group. The question of why this behavior pattern escalates out of control in some and not in others remains unanswered.

It should be noted that it is the presence of binge behavior itself that is definitive; vomiting or laxative abuse may or may not be present. The term "bulimarexia," which was introduced in 1976, refers to binge behavior in conjunction with purging via vomiting, laxatives, diuretics or constant dieting (Boskind-White & White 1986). In the view of these authors, it represents a tenacious habit, not a disease process, and as such can be unlearned.

Parallels between bulimics and patients with alcohol and other drug problems have been noted. Commonalities include loss of control over the use of the substance, secretiveness of the behavior, and the social isolation that accompanies the behavior (Hatsukami et al. 1982). Some individuals may spend $50 or more per day on foods for binging, and may either shoplift the food or steal to be able to buy it (Herzog & Copeland 1985).

Another striking parallel is the way in which initial effects change over time, so much so that the chronic effects may be opposite from the experience originally sought. For example, alcohol is initially attractive to many for its sedating and relaxing effects. However, chronic users eventually manifest greater and greater anxiety. Johnson and Pure (1986: 445) described the progression of the binge-purge pattern in similar terms: "Though most bulimic patients begin to binge eat without purging, within approximately one year they feel sufficiently out of control to start purging. Once they begin purging, it appears that a transformation takes place whereby the binging, which began as a tension reducer, becomes a tension producer. Eventually the binging no longer reduces dysphoric feelings, but instead exacerbates them, and it is the act of purging that restores a sense of control." Although the relative contribution of pharmacological or physiological and psychological factors may vary in these examples, the process in which the solution becomes the problem is common to both of them.

Anorexia Nervosa

Anorexia nervosa is often considered to be the most serious of the eating disorders, with mortality rates reported between six to nine percent (Hsu 1980). Such individuals go to great extremes in order to lose weight. This may include drastically reducing caloric intake, incessant exercise, hyperactivity, binge-purge cycles, and use of laxatives, diet pills or diuretics. An obsessive preoccupation with food is characteristic, and eating behaviors themselves may be very bizarre (Norman 1984). Some authors use the subtype bulimic anorectic to describe those individuals with a persistent binge-purge pattern, and restrictive anorectics (or restrictors) to designate the pure dieters (Herzog & Copeland 1985).

DSM-III criteria for anorexia nervosa include the following (American Psychiatric Association 1980: 69):

A. Intense fear of becoming obese, which does not diminish as weight loss progresses.

B. Disturbance of body image, e.g., claiming to "feel fat" even when emaciated.

C. Weight loss of at least 25% of the original body weight, or if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%.

D. Refusal to maintain body weight over a minimal normal weight for age and height.

E. No known illness that would account for the weight loss.

In her classic work on eating disorders, Bruch (1973) distinguished between primary anorexia nervosa and disorders that appear similar but are nonetheless distinct. She summarized the characteristic features as a pursuit of thinness in the struggle for independent identity, delusional denial of thinness, preoccupation with food, hyperactivity, and striving for perfection. She distinguished these patients from those who suffer from psychogenic malnutrition, which has a variety of causes, and the atypical group. The latter complain about their weight loss, do not want to stay thin or value it only secondarily as a means of coercing others. They may desire to stay sick in order to stay in the dependent role, in contrast to the struggle for an independent identity that characterizes the primary group.

In summary, basic questions for preliminary screening for eating disorders include the following: (1) How much do you worry about becoming overweight (listen for intense fears) and how important is it for you to be thin?;

(2) Do you binge eat (consuming large quantities of food in a few hours) and do you try to make sure that others do not know about it?; (3)How much does you weight fluctuate? (Look for five-pound fluctuations within hours or days.); (4) Do you fear or feel you cannot stop eating voluntarily and do you often feel your eating behavior is out of control?; (5) Do you diet frequently?; (6) Do you vomit, or use laxatives or diuretics in an effort to control your weight?; (7) Do you think a lot about shopping and preparing food?; and (8) How much do you exercise?

Root, Fallon and Friedrich (1986) offered a more comprehensive screening tool called the Bulimia and Related Eating Disorders Screen (BREDS).[1] For example, Card 3 explores eating attitudes and behaviors in precise detail (see Figure 1).

Johnson and Pure (1986) offered another assessment tool that is equally comprehensive. These materials permit the identification of disturbed eating patterns that do not meet *DSM-III* criteria to be worthy of clinical attention. It is quite common in substance abuse treatment settings for transitory disturbances of eating behaviors to occur, and many of these merit careful exploration.

Distinctions Between Anorexia Nervosa and Bulimia

Although women with eating disorders have many common issues, there are some important differences based on the symptom picture. Root, Fallon and Friedrich (1986) offered a succinct comparison: Bulimic women are usually of normal or near-normal weight; anorectic women refuse to maintain recommended minimal weight. The former can distinguish *between feeling* fat and *looking* fat; the latter have a much more distorted body image. In keeping with this, bulimic women are much more likely to acknowledge abnormal eating patterns and seek treatment on their own. Denial is much stronger in anorectic women, and treatment is much more likely to be initiated by family and friends.

Root, Fallon and Friedrich also pointed out that the bulimic woman is more impulsive. Alcohol and other drug abuse is more common in this group of patients and in their families. Victimization experiences, such as rape, molestation and physical abuse, are more frequently reported. These authors cited a recent study in which over 66 percent of 172 bulimic women had had a victimization experience and urged sensitivity to that issue both in the initial assessment and in subsequent work. Anorectic women outwardly exhibit more self-control, and a history of substance abuse or victimization is less commonly observed in their families.

Finally, both groups have difficulties with intimacy, but the bulimic woman is much more likely to be in a relationship or married. The anorectic woman, by contrast, has a very low tolerance for intimacy. These differences may be related to the differences in age of onset--early adolescence for anorexia nervosa, and late teens or early adulthood for bulimia (Root, Fallon & Friedrich 1986). In any case, they help clarify why anorectics are more frequently seen as disturbed.

Diagnostic Dilemmas

The same diagnostic cautions are evident for eating disorders as for substance abuse: Once a person is caught in a disordered behavior pattern, psychopathology may appear magnified. Alcoholics, for example, are frequently diagnosed in a mental health setting as borderline, because the behavioral manifestations are so similar. However, when it is possible to do a careful history of symptoms preceding alcohol use, or once the patient is abstinent for more than a year, the diagnostic picture may change markedly (Vaillant 1981). For example, the impulsivity, anger and lack of intimate relationships characteristic of the borderline personality disorder may change considerably with recovery from the bulimia (Root, Fallon & Friedrich 1986). This is not to say that some patients do not have coexisting disorders, both of which will require concentrated attention. However, Root, Fallon and Friedrich (p. 9) recommended waiting "until the eating behavior has stabilized in order to avoid making a diagnosis on the basis of behavior and psychological styles that are physiologically and psychologically transient."

Garner and Isaacs (1986) pointed out that most clinicians tend to discount the degree to which chronic hunger, vomiting or general physiological disruption affects the psychological state. The consequences of starvation include the preoccupation with food, depression, anxiety, irritability, lability of mood, difficulties in concentration, sleep disturbance, loss of sexual interest, social withdrawal, and hyperactivity (Garner & Isaacs 1986; Dwyer 1985). It may take many months to restore the biochemical balance and clarify the diagnostic picture. Like substance abuse, psychopathology is often overestimated when assessed at the point of intake.

DYNAMIC CONSIDERATIONS

Looking retrospectively at individual and family dynamics, dysfunctional characteristics can be seen, but nothing that clearly distinguishes eating disorders from other kinds of symptomatology. It is thus useful to view an eating disorder as a heterogeneous entity representing a final common pathway of a number of etiological factors: ego, psychological, familial, organic and cultural (Schwartz, Thompson & Johnson 1985). In each individual case, one or another factor or factors will appear

more predominant. In certain patients, the influence of family dynamics may be so powerful and so specific that the woman would likely have developed an eating disorder in any time and place. In others, contemporary cultural factors clearly play a key role, as in the case of the woman who "learns" to vomit from her sorority sisters and discontinues the practice after graduation. With this in mind, some of the salient dynamic factors that are often involved will be examined.

Individual

Norman (1984: 44) stated that although the features of anorexia nervosa can occur in individuals with a wide range of premorbid personality characteristics, there is a consistent profile of emotional and psychological manifestations once the disorder develops: "Clinicians generally agree that the unrelenting pursuit of thinness manifests an underlying psychologic struggle to maintain a sense of personal autonomy and self-control. They insist they are happy, fully aware of their condition, and completely capable of taking care of themselves. But underneath they are stricken with a paralyzing sense of helplessness and ineffectiveness, with control over eating and body size the only mechanisms through which a sense of autonomy and mastery can be sustained."

The anorectic sees herself as overweight, or just right at a very low weight, and thinks that others see her similarly. The bulimic woman usually has a more accurate perception of her own weight, and is more able to distinguish between *seeing* herself as fat and *feeling* fat. Management of the presenting symptom varies, but both anorexia nervosa and bulimia have many developmental and psychological issues in common: low self-esteem, a sense of powerlessness, perfectionism, depression, anxiety, problems in relationships, and isolation (Garner & Isaacs 1986; Root, Fallon & Friedrich 1986). Many of these women have strong doubts as to the legitimacy of their own feelings, especially anger, and a lack of confidence in the validity of their own perceptions. It would be interesting to systematically assess whether women for whom these issues are especially salient are adult children of alcoholics. If so, the task of dismantling denial is more complex, but more treatment options are available.

Familial

A family systems perspective takes the approach that a symptom in an individual is a joint family production, designed to maintain homeostasis in the family. Families have rules, which are patterned ways of relating that are reflected in their communication patterns. When these rules do not fit the growth needs of the members, symptoms result. When the identified patient is an adolescent, most treatment programs more readily accept the need to include the family of origin in the actual treatment process. With adults, this may not be practical. However, it is nonetheless important that the therapist integrate a systems perspective into the individual therapy, otherwise major issues cannot be adequately dealt with.

Root, Fallon & Friedrich (1986:81) have taken the position that the "development of anorexia nervosa is related to the difficulty that the family has in negotiating the passage of the child into adolescence, while bulimia represents a more advanced maturational state in which the adolescent and family have difficulty negotiating movement from adolescence into young adulthood and independence." A major area of difficulty, then, is individuation and separation, including the ability to differ with and be assertive toward one's parents. Boundary issues -- how enmeshed family members are in one another's lives and how well they tolerate some personal distance -- are another important theme. Family organization may be overly rigid or overly chaotic; extremes typify dysfunctional families. The manner in which the expression and resolution of feelings occurs is another key area for scrutiny, because sound conflict resolution skills are generally lacking (Root, Fallon & Friedrich 1986). When the eating-disordered woman presents for treatment as an adult, there are replays of these difficulties in current intimate relationships, both at home and at work.

Cultural

Cultural and subcultural pressures, general and specific, exert an important influence and must be addressed in treatment. For example, members of professions or sports that dictate a certain body weight manifest a significantly greater incidence of eating disorders than those in professions that do not. This includes dancers, models, actresses, gymnasts and figure skaters.

The pursuit of fitness -- the endorsement of the "aerobics instructor look" -- is another source of pressure. Maintaining the perfect figure may be another required achievement of the accomplished woman in the workplace (Striegel-Moore, Silberstein & Rodin 1986).

In addition, pressures are considerable in college populations. One client of the present author reported that when a local sorority house had to replace its plumbing, the likely cause was corrosion by the acid from years and years of vomiting. Some fraternities have weight standards for the women its members may date. Given the mounting cultural pressures, it is not surprising that eating disorders appear to be highly contagious. Certainly women's assumptions about the value of thinness (versus health) are an important consideration in treatment.

TREATMENT

Finding the necessary treatment and integrating it in an appropriate way is the task currently facing substance abuse treatment professionals. Once the problem of underdiagnosis is addressed, clinicians still may encounter resistance to initiating concurrent treatment, as many practitioners remain convinced that all psychological exploration should be deferred until the client is securely abstinent/sober. Although understandable in the light of the history of the substance abuse field, this attitude can be quite dangerous, as these disorders can be both health threatening and life threatening. As is the case with major psychiatric disorders, it may often be necessary to treat both concurrently to be effective in either.

The overall treatment strategies for both eating disorders and substance abuse have many commonalities: education on health consequences of the disorder and the nature of the recovery process as an essential part of treatment; a combination of behavioral and dynamic approaches; a recognition of the importance of engaging the family in treatment and modifying dysfunctional patterns; and an endorsement of self-help groups as a useful activity (Herzog & Copeland 1985; Brisman & Siegel 1984).

Common features of most of the treatment approaches include the following:

1. Patient education about the disorder and its consequences. It is particularly important to review the consequences of starvation, which include an intense preoccupation with food, depression, anxiety, irritability, lability of mood, sleep disturbance, loss of sexual interest, and social withdrawal. Before the physiological bases of these experiences are addressed, psychological issues cannot be meaningfully explored (Garner & Isaacs 1986).
2. Normalization of eating and weight. Just as breaking the addiction cycle is one of the important early steps in substance abuse treatment, altering the disturbed eating behavior is a key to progress with eating disorders. In both cases, this is necessary to clarify the nature of the other issues. Both dieting and vomiting trigger binge eating, so modifying these behaviors is essential. Otherwise the role of psychological states or interpersonal conflict can be overemphasized (Garner & Isaacs 1986).
3. Self-monitoring techniques to heighten awareness of the eating behavior as well as the feelings and circumstances that influence it (Mitchell, Pyle & Eckert 1985).
4. Development of alternative coping skills, including assertiveness training, behavioral problem solving, and relaxation training (Mitchell, Pyle & Eckert 1985).
5. Modification of feelings and ideas about self-worth, body image and the role of food (Garner & Isaacs 1986; Mitchell, Pyle & Eckert 1985).
6. Addressing the underlying psychological and family system issues: self-esteem, perfectionism, confidence in the validity of thoughts and feelings, legitimacy of emotions, as well as separation and autonomy.

Hospitalization can provide an interruption of the binge-purge cycle, with the caveat that taking control of eating behavior from the patient can only be a temporary solution (Mitchell, Pyle & Eckert 1985). As in substance abuse, hospitalization provides an intensive experience that optimally serves as a powerful launching platform in a long-term recovery process. Indications for hospitalization include the following: marked medical instability and a need to assess or treat various physical complications; need for nourishment; severe laxative abuse -- because of difficulty of withdrawing, a need for supervision; to control binging and vomiting -- breaking the cycle; need to initiate medication trials where monitoring or compliance on an outpatient basis is problematic; severe depression and suicidality; and a need to disengage the patient from an interpersonal system that is maintaining the disorder (Garner & Isaacs 1986; Mitchell, Pyle & Eckert 1985).

Medication Tools

Pharmacological treatments for bulimia appear to be quite helpful for many individuals. Interest has centered around antidepressants, but the mechanism by which the antidepressants work remains unclear. Some clinicians report a correlation between the antidepressant effects and improvement in eating behavior among the depressed patients (Mitchell, Pyle & Eckert 1985).

In a recent review of the research on drug therapy for bulimia, Pope and Hudson (1986) examined more than 30 reports and concluded that antidepressants, and possibly other thymoleptic agents, are clearly superior to placebo for the treatment of bulimia. They concluded that the studies do not identify specific subgroups of bulimic patients who are, or are not, candidates for these agents. The presence of major depression -- past, present or within the family -- did not distinguish patients who responded well to antidepressants from those who did not. Although the ways in which thymoleptic agents reduce bulimic symptoms is unknown, Pope and Hudson tentatively concluded

that these agents benefit major affective disorder and bulimia via similar mechanisms.

Other authors (e.g., Viesselman & Roig 1985; Glassman & Walsh 1983: 203) concur that there is often a relationship between eating disorders and depression, but its nature is quite complex, and "everything that improves with an antidepressant is not depression." Some authors have focused on the experience of panic described by many as part of the cycle, and have speculated that the tricyclic antidepressants modify this in a way that is similar to the way that they aid in panic disorders (Viesselman & Roig 1985). Use of antianxiety agents -- such as benzodiazepines, which are among the most effective for anxiety -- has been problematic in the treatment of substance abusers because these agents have a high potential for abuse and often become a substitute addiction. Antidepressant medication operates via different mechanisms, does not have the abuse potential of the benzodiazepines, and hence does not present the same problems.

The endogenous opioid system has also received attention for its role in disturbed eating patterns (Copeland 1985). β-Endorphin appears to stimulate the appetite, and the opioid antagonist naloxone is reported to reduce it (Herzog & Copeland 1985). Jonas and Gold (1986b) selected 10 patients whose bulimia had not responded to antidepressants and treated them with naltrexone, a long-acting opioid antagonist. They hypothesized that in some individuals, compulsive binging and purging may be a type of addictive behavior arising from a regulatory malfunction of the endogenous opioid system. In this view, enhanced central opioid activity may be related to increased appetite, and thus related to binge eating. Four of their patients had complete resolution of their bulimic symptoms, not only their binging and purging, but of their preoccupation with food and weight at the end of the six-week trial. Others had a marked reduction of symptoms. Interestingly, four of these patients had substance abuse as an "other diagnosis," but the report did not discuss this in any greater detail so it is not possible to explore the connection further.

It is useful to place these pharmacological interventions in the same category as disulfiram (Antabuse®) and naltrexone -- used in the treatment of alcoholism and opiate addiction, respectively: They are tools, not complete solutions. Interruption of the disturbed eating behaviors is certainly a worthy accomplishment. However, in most cases much is left to do in order to secure lasting gains: examination of key triggers and stressors; identification of dangerous situations, such as holidays that emphasize food; realigning the family dynamics when the symptom has been a central organizing focus; resolution of some of the underlying developmental issues that may contribute to continuing vulnerability. Again, individualized treatment plans are likely to maximize successful long-term outcome.

Many practitioners view pharmacological interventions as somehow interfering with insight-oriented therapy. Indeed, clinical experience indicates that there are plentiful examples of medication inappropriately distorting affective states so that therapy becomes difficult. However, there are often times when the addition of the appropriate psychotropic medication permits the client to confront issues that were previously overwhelming. Other clients report the relaxation of denial because extreme defenses are no longer necessary. It is important to remain pragmatic about medications, and to make sure that one's personal preferences in this regard do not impair one's ability to observe carefully.

Selecting a Treatment Program

Selecting a good treatment program or outpatient therapist is always a challenge in an area where knowledge and understanding are growing rapidly. Certainly, both substance abuse and the treatment of eating disorders share this characteristic. Some substance abuse treatment personnel attempt to generalize the treatment approach they are comfortable with in substance abuse to eating disorders, and look for a program that approaches it similarly. Because mental health therapists have a long history of underdiagnosing substance abuse problems, medicating inappropriately and assuming the abusing behavior would disappear if the underlying dynamics were addressed, it is not surprising that many substance abusers mistrust them and have little faith in dynamic approaches to problems. They frequently turn to programs with a heavy behavioral emphasis and a strong reliance on OA.

Most eating disorder specialists concur that the population is actually quite heterogeneous and that a broad spectrum of therapeutic approaches is useful, indeed essential. Most would emphasize the importance of psychodynamic approaches earlier in treatment. Substance abuse problems often appear to have more functional autonomy than eating disorders. Their beginnings are often more innocuous (e.g., experimental or social/recreational drug use) and they acquire a life of their own, independent of what precipitated them initially. Disturbed eating patterns appear more closely connected with the emotional factors that originally gave rise to them: a sense of powerlessness, self-worth closely linked with being thin, an urgent press for autonomy. The rewards of stopping the behavior are not nearly so rapidly and clearly measurable as they are with drug abuse. Hence, earlier attention to the psychodynamic factors appears more useful as well as throughout treatment to maintain gains.

Individual, group and family work are recommended. Anorectics are seen by many as more disturbed, requiring clinicians who are highly skilled in dealing with a borderline population. Sophisticated diagnosticians need to be more of an integral part of the treatment program. Medication may be more likely to be useful.

All these factors need to be considered when seeking a specialized eating disorders program. How well trained are the clinicians? How differentiated is their thinking? Do they believe there is only one correct treatment method, or are they able to analyze the needs of the client and design an approach accordingly? How diagnostically sophisticated are they? What are their attitudes toward medication? Are these attitudes rigid in one direction, or can the decision be made on the basis of the client's needs, following a careful workup? What are the possibilities and systems for collaboration between the substance abuse clinician and the eating disorders specialist? Hopefully, as knowledge and understanding grow, options will continue to develop.

The Eating-disordered Client in Substance Abuse Programs

Some inpatient or residential programs unwittingly permit a situation that intensifies the anxiety of the eating disordered patient. Many have the attitude that asking someone to give up their psychoactive drugs is demanding enough, and they should not be challenged about the way they use tobacco (nicotine), caffeine or food. In some programs, this includes keeping snacks accessible all hours of the day and night. Thus, the patient with a disturbed relationship to food may binge (or starve), unnoticed or unattended. Far from providing a comfort, this situation increases the shame and anxiety. Some staff members feel that their job is to stay focused on the alcohol and other drug use as well as the patient's desire to conceal the problem while others view eating disorders as unrelated to substance abuse, which makes it unlikely that the issue will be raised openly in a therapeutic setting.

Problems in conducting treatment arise when practitioners are not sufficiently sensitive to the importance of the control dynamic in these women. Specifically, women with eating disorders tend to feel helpless and react intensely to the experience of having control wrested from them, especially in the absence of an adequately developed therapeutic alliance. Alcohol and other drug abuse treatment programs, particularly inpatient or long-term residential facilities, often approach the control issue in ways that are highly problematic for these women. The majority press for acknowledgment of loss of control over the substance of abuse, often using strong confrontation to penetrate the patient's denial. Although this breakdown of denial is ultimately beneficial, the all too common "bull in the china shop" approach to this task entails the hazard of intensifying the already severe sense of helplessness and ineffectiveness experienced by these women.

Unfortunately, staff in some drug abuse treatment programs may be both diagnostically unsophisticated and limited in their repertoire of intervention skills. They may handle the resistance of the eating-disordered patient by escalating confrontation in an effort to foster the surrender experience viewed as the beginning of the recovery process (Alibrandi 1978). This is often done without carefully establishing the therapeutic alliance required for progress on both the substance abuse problems and the eating disorder, and without adequate appreciation for the desperate sense of helplessness underlying the resistance to giving up control. Frequently these women join the ranks of premature dropouts or adopt behavior of surface compliance while they bide their time. These problems are not unique to the substance abuse treatment setting. Clinicians report that patients in eating disorders treatment settings, which take control of the patients' eating regimens, may lose what they have gained once they are out of the structured treatment environment (Norman 1984).

In treating both eating disorders and substance abuse problems, it is especially important that the clinician is sensitive to the transference complications when working with behavioral intervention. A therapeutic alliance in which the client and therapist collaborate to use behavior-shaping tools, and resistance is treated as a clinical issue rather than a stimulus for a power struggle, is especially important. When staff members quickly turn to confrontation, rather than inquiry and exploration of the sources of resistance, the stage is set for women to either comply or defy without making progress on the issues. The task at hand is to find the optimal blend of behavior-shaping and insight-oriented approaches.

CONCLUSION

It is both exciting to tackle a new area and dismaying to know that knowledge and understanding are growing so fast that opinions fondly held today will prove embarrassing in just a few years. Historically, the gulf between substance abuse treatment and mental health treatment has been excessively wide. Eating disorders pose a more general problem of the need to integrate the two: how to determine the severity; how do they interact; and what is the most effective method of intervention. Certainly the growing recognition of the need to address eating disorders within drug abuse treatment programs will prove to be a challenge to clinical skills and creativity.

NOTES

1. From *Bulimia: A Systems Approach to Treatment,* edited by M.P. Root, P. Fallon and W. Friedrich (New York: W.W. Norton, 1986). The BREDS is available from Maria Root, Ph. D., 1728 Madison Street East, Seat-tlc, Washington 98122. Copyright 1983 by M.P. Root and P. Fa!Ion. Reprinted with permission.

ACKNOWLEDGMENTS

The author wishes to thank the following people who shared their ideas and clinical impressions: Peter Banys, M.D.; Rosemary Bower, Ph.D.; Fran Krieger, Ph.D.; Haven Logan, Ph.D.; Marta Obuchowsky; Maria Root, Ph.D.; Avis Rumney, M.A., M.F.C.C.; David E. Smith, M. D.; and Jody Yeary, M.S., M.F.C.C.

REFERENCES

Alibrandi, L. 1978. The folk psychotherapy of Alcoholics Anonymous. In: Zimberg, S.; Wallace, J. & Blume, S. (Eds.). *Practical Approaches to Alcoholism Psychotherapy.* New York: Plenum. American Psychiatric Association Taskforce on Nomenclature and Statistics. 1980. *Diagnostic and Statistical Manual of Mental Disorders (DSM-HI).* 3rd ed. Washington, D.C.: American Psychiatric Association.

Bennett, W. & Gurin, J. 1982. The century of the svelte. *Harvard Magazine* March-April: 56A-56H.

Boskind-White, M. & White, W.C. 1986. Bulimarexia: A historical-sociocultural perspective. In: BrowneIl, K.D. & Foreyt, J.P. (Eds.). *Handbook of Eating Disorders: Physiology, Psychology, and Treatment of Obesity, Anorexia and Bulimia.* New York: Basic Books.

Brisman, J. & Siegel, M. 1984. Bullmia and alcoholism: Two sides of the same coin'? *Journal of Substance Abuse Treatment* Vol. l: 113-118.

Bruch, H. 1973. *Eating Disorders.* New York: Basic Books.

Copeland, P.M. 1985. Neuroendocrine aspects of eating disorders. In:
Emmett, S.W. (Ed.). *Theory. and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocuitural, and Psychological Perspectives.* New York: Brunner/Mazel.

Dwyer, J. 1985. Nutritional aspects of anorexia nervosa and bullmia, in: Emmett, S.W. (Ed.). *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocuitural, and Psychological Perspectives.* New York: Brunner/Mazel. Erikson, E. 1950. *Childhood and Society.* New York: W.W. Norton. Fenichel, O. 1945. *The Psychoanalytic Theory of Neurosis.* New York: W.W. Norton.

Garner, D.M.; Garfinkel, P.E.; Schwartz, D. & Thompson, M. 1980. Cultural expectations of thinness in women. *Psychological Reports* Vol. 47: 483-491.

Garner, D.M. & Isaacs, P. 1986. The fundamentals of psychotherapy for anorexia nervosa and bulimia nervosa, in: Keller, P.A. &Ritt, L.G. (Eds.). *Innovations in Clinical Practice: A Source Book.* Sarasota, Florida: Professional Resource Exchange.

Glassman, A.H. & Walsh, B.T. 1983. Link between bulimia and depression unclear (letter to the editor). *Journal of Clinical Psychopharmacology* Vol. 3(3): 203.

Hatsukami, D.; Eckert, E.; Mitchell, J.E. & Pyle, R. 1984. Affective disorder and substance abuse in women with bulimia. *Psychological Medicine* Vol. 14(3): 701-704.

Hatsukami, D.; Owen, P.: Pyle, R. & Mitchell, J. 1982. Similarities and differences on the MMPi between women with bulimia and women with alcohol or drug abuse problems. *Addictive Behaviors* Vol. 7(4): 435-439.

Herzog, D. & Copeland, P. 1985. Medical progress--eating disorders. *New England Journal of Medicine* Vol. 313(5): 295-303.

Hsu, L. 1980. Outcome of anorexia nervosa: A review of the literature (1954-1978). *Archives of General Psychiatry* Vol. 37: 1041-1046.

Johnson, C. & Berndt, D. 1983. Preliminary investigation of bulimia and life adjustment. *American Journal of Psychiatry* Vol. 140(6): 774-777.

Johnson, C. & Pure, D. 1986. Assessment of bulimia: A multidimensional model, in: BrowneIl, K.D. & Foreyt, J.P. (Ers.). *Handbook of Eating Disorders: Physiology, Psychology, and Treatment of Obesity, Anorexia and Balimia.* New York: Basic Books.

Jonas, J. & Gold, M. 1986a. Cocaine abuse and eating disorders. *Lancet* Vol. I: 390.

Jonas, J. & Gold, M. 1986b. Naltrexone in the treatment of bulimia. Paper presented as New Research (NR 25), at the American Psychological Association Conference, Washington, D.C.

Lacey, J. 1983. Bulimia nervosa, binge eating, and psychogenic vomiting: A controlled treatment study and long term outcome. *British Medical Journal* Vol. 286(6378): 1609-1613.

Lee, N. & Rush, A. 1985. Bullmia and depression. *Journal ofAffective Disorders* Vol. 9(3): 231-238.

Mirin, S. (Ed.). 1984. *Substance Abuse and Psychopathology.* Washington, D.C.: American Psychiatric Press.

Mitchell, J.: Hatsukami, D.; Eckert, E. & Pyle, R. 1985. Characteristics of 275 patients with bulimia. *American Journal of Psychiatry* Vol. 142 (4): 482-485.

Mitchell, J.; Pyle, R. & Eckert, E. 1985. Bulimia. In: Hales, R.E. & Frances, A.J. (Eds.). *American Psychiatric Association Annual Review,* Vol. 4. Washington, D.C.: American Psychiatric Press.

Norman, K. 1984. Eating disorders. In: Goldman, H.H. (Ed.). *Review of General Psw'hiatry.* Los Altos, California: Lange Publications.

Pope, H. & Hudson, J. 1986. Antidepressant drug therapy for bulimia: Current status. *Journal of Clinical Psychiatry* Vol. 47(7): 339-345.

Rand, C.S.W.; Lawlor, B. & Kuidau, J. 1986. Patterns of food and alcohol consumption in a group of bulimic women. *Bulletin of the Society of Psychologists in Addictive Behaviors* Vol. 5(2-3): 95-1 04.

Root, M.P.; Fallon, P. & Friedrich, W. (Eds.). 1986. *Bulimia: A Systems Approach to Treatment.* New York: W.W. Norton.

Schuckit, M. 1983. Alcoholism and other psychiatric disorders. *Hospital and Community Psychiatry* Vol. 34(l l): !022-1026.

Schwartz, D.; Thompson, M. & Johnson, C. 1985. Anorexia nervosa and bulimia: The sociocultural context. In: Emmett, S.W. (Ed.). *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives.* New York: Brunner/Mazel.

StriegeI-Moore, R.; Siiberstein, L. & Rodin, J. 1986. Toward an understanding of risk factors for bulimia. *American Psychologist* Vol. 41 (3): 246-263.

Strober. M. 1986. Anorexia nervosa: History and psychological concepts. In: BrowneIl, K.D. & Foreyt, J.P. (Eds.). *Handbook of Eating Disorders: Physiology, Psychology, and Treatment of Obesitv, Anorexia and Bulimia.* New York: Basic Books.

Swift, W.; Andrews, D. & Barklage, N. 1986. The relationship between affectire disorder and eating disorder: A review of the literature. *American Journal of Psychiatry* Vol. 143(3): 290-299.

Vaillant, G. 198 I. Dangers of psychotherapy in the treatment of alcoholism. In: Bean, M. & Zinberg, N. (Eds.). *Dynamic Approaches to the Understanding and Treatment of Ah'oholism.* New York: The Free Press.

Viesselman, J. & Roig, M. 1985. Depression and suicidality in eating disorders. *Journal of Clinical Psychiatry* Vol. 46(4): i 18-124.

Weiss, S. & Ebert, M. 1983. Psychological and behavioral characteristics of normal-weight bulimics and normal-weight controls. *Psychosomatic Medicine* Vol. 45: 293-303.