Drunkorexia: When Eating Disorders and Substance Abuse Collide

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Farley Center at Williamsburg Place
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Williamsburg, VA
After this presentation, participants will be able to:

1. List the DSM-5 criteria for Eating Disorders and describe the three main categories.
2. Describe how alcohol/ drug abuse and eating disorders occur together.
3. Review the treatments for patients with Eating Disorders.
4. Screen all clients for an Eating Disorder or Substance Use Disorder.
Two Women Drinking Beer
(1878-79)
Edouard Manet
Prevalence of Alcohol Use Disorders in Men and Women U.S.

- **Epidemiologic Catchment Area Study (ECA) (1980’s)** Male to female ratio of alcohol abuse and dependence was 5:1 (Helzer, 1991, Regier, et al 1990)

- **National Comorbidity Survey (NCS) (early 1990’s)** Male to female ratio of alcohol abuse and dependence was 2.45:1

- **National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (2001, 2002)** Male to female ratio of alcohol abuse was 2.3:1 and alcohol dependence 2.6:1 (Hasin DS, Stinson FS, Ogburn E, et al 2007)

Update on Women’s Issues—Presented at ASAM April 2014, Friedman, C et al.
According to the US Center for Disease Control:

- 1 in 8 U.S. women (nearly 14 million) binge drink about 3 times a month
- Women drink an average of 6 drinks per binge
- 1 in 5 high school girls binge drink
  - Binge Drinking: A serious, under recognized problem among women and girls CDC, Vital Signs, January 2013
- 33.2 % of 18-25 year old women binge drink
  - NSDUH 2011

Update on Women’s Issues—Presented at ASAM April 2014, Friedman, C et al.
Why discuss ED with Substance Abuse??

• Eating Disorders have the highest mortality rate of any mental illness 6-7%.

• Mortality rate associated with Eating Disorders is 12 times higher than the death rate of ALL causes of death for females ages 15-24 and the third most chronic illness among adolescents.

• [www.state.sc.us/dmh/anorexia/statistics.htm](http://www.state.sc.us/dmh/anorexia/statistics.htm)

• *Five to ten percent of anorexics die within ten years of onset, 18-20 percent die within twenty years of onset, and only 50 percent report ever being cured.*

*APA Practice Guidelines 2006*
A maladaptive pattern of substance use leading to significant impairment or distress, as manifested by 2 (or more) of the following within a 12-month period:

1. Alcohol is often taken in larger amounts or over longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol or recovery from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

8. Recurrent alcohol use in situations in which it is physically hazardous.

9. Alcohol use is continue despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

10. Tolerance: a need for increased amounts of alcohol to achieve intoxication or desired effect/ a diminished effect with continued use.

11. Withdrawal-has a specific withdrawal syndrome / benzodiazepines are taken to relieve or avoid withdrawal syndrome.
<table>
<thead>
<tr>
<th>Substance</th>
<th>Prevalence</th>
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</thead>
<tbody>
<tr>
<td>Nicotine</td>
<td>22.5%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>7.5%</td>
</tr>
<tr>
<td>Drugs</td>
<td>2.8%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>1.6%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.6%</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.1%</td>
</tr>
<tr>
<td>Psychotherapeutics</td>
<td>0.9%</td>
</tr>
<tr>
<td>—non medical use of pain relievers, tranquilizers, stimulants and sedatives</td>
<td></td>
</tr>
</tbody>
</table>
NIMH stated that 20% of women have an ED or Disordered Eating. US Population is ~312 million—55% is 171.6 Million—20% is ~34 Million
Prevalence of eating disorders and substance use disorders in females:

- Up to 50% of individuals with an ED abuse alcohol or illicit drugs compared with 9% in the general population.
- Up to 35% of alcohol or illicit drug abuses have eating disorders compared to 3 percent of the population.

Food for Thought: Substance Abuse and Eating Disorders, The National Center on Addiction and Substance Abuse at Columbia University, December 2003.
As with Classical Addictions, Eating Disorders...

- Begin with experimentation—
- Diets, starvation, and self-induced vomiting... only a small % lose control
- Lead to a chronic compromised nutritional and medical state
- Have a chronic relapsing course
- Have tragic outcomes

National Center on Addiction and Substance Abuse (CASA) at Columbia University (2003) Food for Thought: Substance Abuse and Eating Disorders
I won't eat
DSM-5: Eating Disorders

The Diagnostic and Statistical Manual (DSM-5) currently recognizes three main categories of eating disorders:

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder (BED)

Other Specified Feeding or Eating Disorder
Anorexia Nervosa DSM-5

- A. Restriction of energy intake relative to requirements leading to a significantly low body weight

- B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

- 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 persistent lack of recognition of the seriousness of the current low body weight.

- Binge–Eating/Purging or Restricting

  Partial Remission /Full Remission

  - Mild BMI ≥ 17 kg/m²
  - Moderate BMI 16-16.99 kg/m²
  - Severe BMI 15-15.99 kg/m²
  - Extreme BMI <15 kg/m²
Facts about Anorexia and Substance Abuse

• Surprisingly—most clients with anorexia nervosa use the least amount of drugs compared to BED and BN.

  • Nicotine
  • Caffeine
  • Cocaine/ Stimulants

  • Little alcohol, marijuana
  • Little opiates, meth
DSM-5 Bulimia Nervosa

1. Binge eating
   A. Eating an amount of food definitely larger than what most people eat
   B. Sense of lack of control
2. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications, fasting; or excessive exercise.
3. Above occur 1x / week for 3 months
4. Body image issues
5. Does not occur during Anorexia Nervosa

Partial Remission / Full Remission

- Mild—an average of 1-3 episodes of inappropriate compensatory behaviors per week
- Moderate—an average of 4-7 episodes/ week
- Severe—an average of 8-13 episodes/ week
- Extreme—an average of 14/week
Facts about Bulimia Nervosa and Substance Abuse

• Bulimia is most commonly associated with substance abuse.

• Those who abuse laxatives tend to have more psychopathology.

• Much attempt at emotion regulation.

• Women who BN and Alcohol Dependence have higher rates of suicide attempts, anxiety, personality disorders, conduct disorders and other drug dependencies.
Binge Eating Disorder

- Recurrent episodes of binge eating
  - 1. Eating an amount of food that is definitely larger than what most people would eat.
  - 2. A sense of lack of control

- Binge
  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 feeling embarrassed by how much one is eating
  5. feeling disgusted with oneself, depressed, or very guilty afterwards

- Distress, On average once a week for 3 months
  - Mild 1-3 binge-eating episodes per week
  - Moderate 4-7, Severe 8-13 and Extreme 14+
Other Specified Feeding or Eating Disorders
EDNOS is GONE!!

• **Atypical Anorexia Nervosa**
  • All of the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual’s weight is within or above the normal range.

• **Subthreshold Bulimia Nervosa (low frequency or limited duration)**
  • All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than for 3 months.

• **Subthreshold Binge Eating Disorder (low frequency or limited duration)**
  • All of the criteria for Binge Eating Disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than for 3 months.

• **Purging Disorder** —Purging without Binge Eating for weight control.
How to weigh yourself correctly...
Obesity—The Problem

- 64.5% of adults in the U.S. are overweight, and 30.5% are obese.
- Being obese or overweight can lead to comorbid health concerns (e.g., heart disease, diabetes).
- Increased body weight can have psychological, economical, and social consequences.
Other ED’s in the media

Drunkorexia/ drunkobulima
Manorexia
Orthorexia
Diabulimia
Pregorexia
Most Important Slide for Clients with ED!!!

Our primary objective is to convince our eating disorder patients that they are starving themselves and can die

*Eating Disorders are illnesses, not choices*

Genetics loads the Gun and the Environment pulls the Trigger
Are Eating Disorders an Addiction???

Yes, No, Maybe???
When an experience produces more pleasure than expected—your brain releases Dopamine (DA)

Drugs of abuse (e.g., cocaine, alcohol, nicotine) release dopamine and other chemicals

Dopamine regulates food intake through the meso-limbic circuitry of the brain— THE PLEASURE CENTER OF THE BRAIN

Starving, bingeing and exercise all serve as a drug delivery devices since they increase circulating levels of β-endorphins that are chemically identical to exogenous opiates.

Endorphins are potentially addictive because of their ability to stimulate DA in the brain’s mesolimbic reward centers.

Moving from Liking to Wanting

Dopamine D2 images of Drug Addiction

Drug abusers have low brain DA activity (shown here using $[^{11}]C$raclopride PET studies) indicating an understimulated reward system.

Decreased Dopamine D2 Receptors in Obese Human, Monkey and Rodent

Human$^1$

Bonnet macaques$^1$

Zucker rat$^2$

BMI = 23

BMI = 23

Weight = 400 g

BMI = 50

BMI = 42

Weight = 650

PET $[^{11}\text{C}]$raclopride

ARG $[^{3}\text{H}]$spiperone

ARG, autoradiography; PET, positron emission tomography

Drugs of abuse vs. food

- **DA** - Reinforcement/orienting. Abused drugs increase extracellular DA each time they are administered
- **ACh** - Aversion. ACh is increased during withdrawal (DA is low)
- **Opioids** - antagonists precipitate withdrawal signs
- **DA** - Motivation to eat. With food, DA release wanes with repeated access
- **ACh** - Satiety. ACh increases during a meal (DA is high)
- **Opioids** - antagonists do not precipitate withdrawal signs
## DOPAMINE

<table>
<thead>
<tr>
<th>Neurotransmitter or Drug</th>
<th>Eating Disorder Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dopamine</strong></td>
<td></td>
</tr>
<tr>
<td>Amphetamine/Cocaine &amp; Nicotine $\uparrow$ DA</td>
<td>$\downarrow$ Eating</td>
</tr>
<tr>
<td>Anorexia/ OCD $\uparrow$ DA</td>
<td>$\downarrow$ Eating</td>
</tr>
<tr>
<td>Purging $\uparrow$ DA</td>
<td>$\downarrow$ Eating</td>
</tr>
<tr>
<td>Antipsychotic $\downarrow$ DA</td>
<td>$\uparrow$ Eating/ Improvement with OCD Behavior</td>
</tr>
<tr>
<td>Obesity $\downarrow$ D2 Receptors</td>
<td>$\uparrow$ Eating</td>
</tr>
</tbody>
</table>
What Contributes to the Development of Substance Use Disorders/ Addiction?

**Genes/Genetic Variation**
Account for about 40-50% of having a substance use problem is genetic. Alcohol liking or disliking is linked—alcohol and aldehyde dehydrogenase.

Males are twice as likely as females to have alcohol or drug addiction.

**Environment**
Family's beliefs and attitudes – Exposure to Parental SUDs
Peer group that encourages drug use

**Adverse Childhood Events**
Trauma, mental health, physical health, household dysfunction

**Age of Onset**
Earlier the age of onset of use...
What Contributes to the Development of Substance Use Disorders/ Addiction?

**Adverse Childhood Events**
Trauma, Mental health, Physical Health, Household Dysfunction
5 or more childhood events are 7-10 times more likely to report illicit drug use and addiction

Individuals seeking treatment for alcohol use disorders show a high prevalence of childhood adversity and PTSD

**Age of Onset**
Earlier the age of onset of use...
40% if onset 14 y.o. or younger
10% if onset is 20 years and older
What Contributes to developing an Eating Disorder?

**Environment**
Environmental factors—media, friends, athletics
Family's beliefs and attitudes
Peer group that encourages dieting, diet pills, weight focused, laxatives and diuretics and SIV

**Genes:** Females are 5-8 times more likely to develop an ED than Males
Account for about 40-60 % of contribution
Genetics: Low self esteem, perfectionism, anxiety, family history

**Journal of Studies on Alcohol and Drugs 8/2013 showed that if you have a gene for alcoholism or alcohol dependence, you are 38-53% at risk for developing bulimia—specifically binge eating and purging with vomiting, laxatives and diuretics**
Drugs used by patients with Eating Disorders

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect on Eating</th>
<th>Effect on Purge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>↓ Eating</td>
<td>↑ Purge</td>
</tr>
<tr>
<td>Amphetamine/ Stimulants</td>
<td>↓ Eating</td>
<td></td>
</tr>
<tr>
<td>Cocaine/ Crack</td>
<td>↓ Eating</td>
<td></td>
</tr>
<tr>
<td>Marijuana</td>
<td>↑ Eating</td>
<td></td>
</tr>
<tr>
<td>Nicotine</td>
<td>↓ Eating</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Roerig, et al 2003
Prevalence of alcohol abuse/dependence, drug use and drug abuse/dependence

<table>
<thead>
<tr>
<th></th>
<th>AN-R N=328</th>
<th>AN-BP N=184</th>
<th>BN-R N=109</th>
<th>BN-P N=110</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse/Dependence</td>
<td>13.7%</td>
<td>19%</td>
<td>23.9%</td>
<td>35.5%</td>
</tr>
<tr>
<td>Drug use</td>
<td>23.2%</td>
<td>29.9%</td>
<td>25.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Drug abuse/Dependence</td>
<td>3.4%</td>
<td>14.1%</td>
<td>17.4%</td>
<td>31.8%</td>
</tr>
</tbody>
</table>

A LARGE PIZZA WITH DOUBLE PRUNES, PLEASE.

TO GO?

WHY ELSE?
“Drugs” used by patients with Eating Disorders

- Caffeine ↓ Eating ↑ Purge
- Diuretics ↑ Purge
- Diet pills ↑ Purge
- Ipecac ↑ Purge
- Laxatives ↑ Purge
- Water ↓ Eating ↑ Purge

Adapted from Roerig, et al 2003
It begins.

This diaper makes my butt look big...
Is Childhood Sexual Abuse a Risk Factor for Bulimia Nervosa?

Conclusion: Current evidence does not support the hypothesis that childhood sexual abuse is a risk factor for bulimia nervosa.

Am J Psychiatry 1992;149:455-463
Harrison Pope, MD and James Hudson, MD
Childhood Sexual Abuse (CSA) has been clearly established as a significant (though nonspecific) risk factor for Eating Disorders and other psychiatric disorders as well (substance abuse, depression, anxiety, panic)

Risk Factor for ED or SUD

Trauma—a continuum of severity:
Big T—sexual abuse, horrific accident
Little T—bullying—people kill themselves after being bullied!!

Trauma Avoidance or Suppression
To “numb out” or feel different
Just wants to “disappear”
Response to PTSD may be linked to availability of norepinephrine transmitter (NET), which is thought to be genetically determined—this clears NE (takes it away)

Norepinephrine plays a central role in the fight-or-flight response—Specific to anxiety arousal symptoms such as hypervigilance

****NET levels were 41% lower in PTSD participants than in healthy controls—i.e. unable to clear the NE quickly

This may help in finding medications for PTSD

This may explain variances in response to trauma
Age of first rape occurred before the age of first binge in:

- 84% of all BN rape cases
- 96% of rapes occurring during adolescence 12-17
- 100% of rapes occurring during childhood < 11

Genetic Contribution for ED/SUD:

Journal of Studies on Alcohol and Drugs 8/2013 showed that if you have a gene for alcoholism or alcohol dependence, you are 38-53% at risk for developing bulimia—specifically binge eating and purging with vomiting, laxatives and diuretics.
Dr. William Osler (1849-1919) stated that “if many treatments are used for a disease, all are insufficient.”
What should be treated first?

- Alcohol/ stimulant / substance abuse/ nicotine dependence (detoxification)
- Eating Disorder—(weight restoration/ stop behaviors)
- Mood Disorders
- Anxiety Disorders (Trauma)
- ADHD

Eating Disorder Care...

First and foremost—Medical Stabilization

Food is medicine!!!
Cardiac Issues/ GI Issues/ Fall Risk
Stop the behaviors
Detox when necessary!!

Then safety—Depression/ SI/SIB
Address Anxiety/ Trauma
Eating Disorders—Nutrition is Key

With starvation ➔ “Survival Mode”
With starvation ➔ increase in anxiety, obsessive compulsive thinking
With starvation ➔ Brain atrophy, hormonal imbalance and cognitive impairment
With starvation ➔ Psychotropic medications do not work well!!

With Nutrition—the brain can recover and so then can the patient, but not until weight restored.
# Co-Morbid Conditions Seen with Eating Disorders

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>NEDDA</th>
<th>REMUDA (through 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>50-75%</td>
<td>89%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>49%</td>
<td>35%</td>
</tr>
<tr>
<td>ADHD</td>
<td>5-10%</td>
<td>8%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>43%</td>
<td>71%</td>
</tr>
<tr>
<td>OCD</td>
<td>10-13%</td>
<td>21%</td>
</tr>
<tr>
<td>PTSD</td>
<td>------</td>
<td>19%</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>50-75%</td>
<td>26%</td>
</tr>
<tr>
<td>Borderline PD</td>
<td>2-60%</td>
<td>10%</td>
</tr>
</tbody>
</table>

*Overall-Statistics from NEDA*
Therapy for Our Patients/ Clients

- 12 Step Recovery Programs
- Dialectical Behavior Therapy (DBT)/ Cognitive Behavior Therapy (CBT)/ Cognitive Processing Therapy (CPT) for PTSD
- Eye Movement Desensitization and Reprocessing (EMDR) for trauma/ Somatic Experiencing Therapy (SE) for anxiety
- Motivational Interviewing (MI)
- Family Therapy/ Family Based Therapy
- Nutrition Therapy
- Exposure Response Prevention (ERP)
Many of my patients just want a pill.....

Sorry, there are no magic pills.
Fluoxetine (Prozac®)—Only FDA Approved Medication for Bulimia

- 20 mg fluoxetine
  - 45% reduction in binge eating
  - 29% reduction in vomiting

- 60 mg fluoxetine
  - 67% reduction in binge eating
  - 56% reduction in vomiting

Fluoxetine Bulimia Nervosa Collaborative Study Group, *Arch Gen Psychiatry* 1992:49(2)139-147.
Psychotropic medications used to treat EDs and co-morbidity:

**Depression** –
- SSRIs (i.e., Prozac, Paxil, Zoloft, Luvox, Celexa, Lexapro)
- Wellbutrin-SR & XL, Effexor-XR

**Anxiety** –
- SSRIs
- Low dose Atypical Antipsychotics (i.e. Seroquel, Geodon and Abilify)
- Try to avoid benzodiazepines - Xanax, Klonopin or Ativan

**Mood Stabilizers**
- Lamictal, Topamax, Gabapentin

**Painful and distorted thinking—body image disturbance**
- Low dose atypical antipsychotics – Zyprexa/ Abilify

**Insomnia**
- Prudent use of Benadryl, Vistaril, Trazodone, Melatonin
Other Meds NOT under study.....

Anxiolytics are not effective for the treatment of ED!!!
(Xanax, Ativan, Klonopin, Valium, Librium)

Often prescribed by their psychiatrist or PCP for anxiety around meals!!

Does not help!! Does give them an Anxiolytic Dependency!!

Now they can be hospitalized for DETOX!!

Medications for Recovery from Substances

Alcohol:
- Naltrexone (ReVia)/ Depot Naltrexone (Vivitrol)
- Acamprosate (Campral)
- Disulfiram (Antabuse)
- Naltrexone (ReVia)

Opiates:
- Naltrexone (ReVia)/ Depot Naltrexone (Vivitrol)
- Buprenorphine/ Subutex
- Buprenorphine + Naloxone/ Suboxone
- Methadone

Nicotine:
- Varenicline (Chantix)
- Buproprion (Wellbutrin/ Zyban)
- Nicotine-gum, patch, lozenge, inhaler
Level of Care Criteria for ED (and SUD) Patients

- Level 1: Outpatient
- Level 2: Intensive Outpatient
- Level 3: Partial Hospitalization
- Level 4: Residential Treatment Center
- Level 5: Inpatient Hospitalization

APA Practice Guideline (2006)
Criteria for Treatment of Substance Use Disorder

For Substance Abuse—use ASAM criteria
Insurance does not like to pay for IP detox except for Alcohol and Benzodiazepines
ASAM Criteria updated for DSM-5 and includes emerging areas of focus—gambling and tobacco use disorders

www.asamcriteriat.org/
Criteria for Hospitalization for ED

The following warrants IP hospitalization—Wt. <85% IBW

- HR < 40 bpm
- BP < 90/60 mm Hg
- Orthostatic BP changes
  - > 20 HR or >10 mmHg drop of diastolic BP
- Temperature <97 degrees F
- Hypokalemia  K< 3mEq/L, electrolyte imbalance, hypophosphatemia, hypomagnesemia
- Poorly controlled diabetes

Treatment of Patients with Eating Disorders,
Screening for Eating Disorder
Eating Attitudes Test (EAT-26)

1. I am terrified about being overweight.
2. I avoid eating when I am hungry.
3. I find myself preoccupied with food.
4. I have gone on eating binges where I feel that I may not be able to stop.
5. I cut my food into small pieces.
6. I am aware of the calorie content of foods that I eat.
7. I particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)
8. I feel that others would prefer if I ate more.
9. I vomit after I have eaten.
10. I feel extremely guilty after eating.
11. I am occupied with a desire to be thinner.
12. I think about burning up calories when I exercise.
13. I other people think that I am too thin.
14. I am preoccupied with the thought of having fat on my body.
15. I take longer than others to eat my meals.
16. I avoid foods with sugar in them.
17. I eat diet foods.
18. I feel that food controls my life.
Eating Attitudes Test (EAT-26) cont.

- 19. I display self-control around food.
- 20. I feel that others pressure me to eat.
- 21. I give too much time and thought to food.
- 22. I feel uncomfortable after eating sweets.
- 23. I engage in dieting behavior.
- 24. I like my stomach to be empty.
- 25. I have the impulse to vomit after meals.
- 26. I enjoy trying new rich foods.

In the past 6 months have you:

- A. Gone on eating binges where you feel that you may not be able to stop?*
- B. Ever made yourself sick (vomited) to control your weight or shape?
- C. Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?
- D. Exercised more than 60 minutes a day to lose or to control your weight?
- E. Lost 20 pounds or more in the past 6 months
- F. Have you ever been treated for an eating disorder?
Screening for Harmful Alcohol and Drug Use

- 1. Screen everyone at risk.
- 2. Use validated screening tools.
- 3. Provide nonjudgmental feedback with their results.
During the last year, how many times have you had _____ or more drinks:
  - > five for men
  - >4 for women
  - > 4 if older than 65

Positive screen is one or more items

Sensitivity 82%, Specificity (unhealthy use) 79%

Smith, PC et al, J Gen Int Med, 2010
### What is a “standard drink”

<table>
<thead>
<tr>
<th>12 oz. of beer or cooler</th>
<th>8–9 oz. of malt liquor (8.5 oz. shown in a 12-oz. glass that, if full, would hold about 1.5 standard drinks of malt liquor)</th>
<th>5 oz. of table wine</th>
<th>3–4 oz. of fortified wine (such as sherry or port) (3.5 oz. shown)</th>
<th>2–3 oz. of cordial, liqueur, or aperitif (2.5 oz. shown)</th>
<th>1.5 oz. of brandy (a single jigger)</th>
<th>1.5 oz. of spirits (a single jigger of 80-proof gin, vodka, whiskey, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 oz.</td>
<td>8.5 oz.</td>
<td>5 oz.</td>
<td>3.5 oz.</td>
<td>2.5 oz.</td>
<td>1.5 oz.</td>
<td><strong>1.5 oz.</strong> (a single jigger of 80-proof gin, vodka, whiskey, etc.) Shown straight and in a highball glass with ice or show level before adding mixer*</td>
</tr>
</tbody>
</table>
## AUDIT

10 questions  
Less than 5 minutes


Just look up AUDIT Alcohol
AUDIT—Alcohol Use Disorders Identification Test

- Developed by WHO
- 10 questions
- Valid across cultures. Sensitivity/Specificity varies with population
- Takes 5 minutes
- Positive score: > 7 for men up to 60
  > 4 for women or men > 60
Summary

• Evaluation of the ED patient should always carefully screen for **SUBSTANCE ABUSE**

• Evaluation of the SUD patient should always carefully screen for an **EATING DISORDER**

• Substance abuse is common with ED’s

• Use of substances along with an ED increase the morbidity and mortality to the patient