Comorbid Conditions Need Integrated Treatment

BY KATE JOHNSON
Montreal Bureau

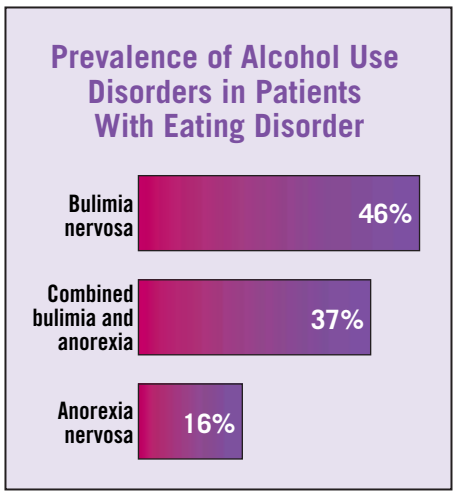
MONTREAL — Comorbid eating disorders and substance abuse are intertwined behaviorally and biologically, so the treatment of both problems must be an integrated effort, Cynthia M. Bulik, Ph.D., said at an international conference sponsored by the Academy for Eating Disorders.

And with growing numbers of middle-aged women presenting to eating disorder programs, substance abuse comorbidity is being seen more frequently than in the teenage population, she said.

"We don't have sufficient integrated treatment programs, so often patients will go to substance abuse programs which either ignore or are ill equipped to deal with their eating disorder, and then they are sent to an eating disorders program without necessarily the proper follow-up for their substance abuse," said Dr. Bulik, professor of eating disorders and nutrition at the University of North Carolina, Chapel Hill.

Although the abuse of certain substances, such as laxatives or diet pills, may have superficial connections to the desire for weight loss, the abuse is almost always intertwined with other complex psychiatric issues, Dr. Bulik explained.

"If we try to discourage a patient from abusing laxatives by pointing out that they are ineffective as weight loss agents, we are missing the mark clinically, because there's a real self-harm component to this behavior," she said in an interview. "When a person takes 50 laxatives a day, it hurts, there's incredible cramping and diarrhea, it keeps them up at night, and it's very painful. If we fail to address this whole self-punishing aspect, we're really not addressing their needs."



Indeed, she and her associates have found that laxative abuse, most common among patients with purging anorexia (72%) and combined anorexia and bulimia nervosa (59%), is associated with a significantly higher prevalence of borderline personality disorder—characterized particularly by feelings of suicidality, self-harm, emptiness, and anger, she reported.

In another study, they found that alcohol abuse is more prevalent in patients with bulimia nervosa (46%) and combined bulimia and anorexia nervosa (37%), compared with those with anorexia (16%) alone (J. Clin. Psychiatry 2004;65:1000-6). Other studies have suggested anywhere from two to six times the risk of alcohol dependency in the eating disordered population, compared with the general population, she said.

As with laxative abuse, alcohol abuse in patients with eating disorders occurs with other psychiatric comorbidities such as major depressive disorder, obsessive compulsive disorder, posttraumatic stress disorder, social phobia, borderline personality disorder, and perfectionism—all of which need to be evaluated and treated, Dr. Bulik said.

In addition, other drugs such as nicotine and caffeine should be considered more problematic in patients with eating disorders than in healthy individuals, she said. In such patients, these drugs can actually be part of the eating disorder.

Research suggests that smoking can significantly increase resting energy expenditure, making it counterproductive to treatment because it can interfere with the treatment goal of weight restoration; caffeine is used to overcome some of the fatigue caused by undernourishment.

"There's both a cognitive component and a physiologic component to this kind of drug use. Patients know that nicotine increases their metabolism, and they know that caffeine might be giving them false energy when they are not eating," she said.

In addition, cravings for all drugs are enhanced with food deprivation, a neurobiologic factor that could interfere with drug abuse rehabilitation.

"People need reinforcers, and food is the major reinforcer. Just like in laboratory animals, when you take food away, they often turn to other substances," Dr. Bulik said.

Careful attention to patterns and changes in patients' substance abuse can offer important insight when tracking their eating disorder, and vice versa. It can also help in the prediction or prevention of relapse.

As an example, she described a person who may have gained control of her eating disorder but not her alcohol abuse. Because alcohol disinhibits appetite, it could trigger binge eating that could trigger a relapse of the eating disorder. Similarly, if a patient is unable to decrease her nicotine consumption, this could be an indication that her eating disorder is not well controlled.

"We need to focus on integrated treatments where we are dealing with both things at the same time, looking at how they interrelate, understanding what some of the overarching integrators might be, and exploring how substances can influence relapse," Dr. Bulik said. ■

In Primary Care, One Question Could Reveal Alcohol Abuse

BY ALICIA AULT
Contributing Writer

As many as one-fourth of patients in primary care settings could be engaging in hazardous or harmful drinking, and discerning that through careful screening—especially in trauma cases—can lead to better care and more accurate flagging of those who abuse alcohol.

According to a study published online, 17.6 million adults abuse alcohol or are alcohol dependent, and 85,000 deaths may be attributable to alcohol each year.

"With brief interventions, primary care clinicians can help 40% of them (compared with 20% in control groups) reduce their drinking to safe levels," according to Andrea Canagasaby and Dr. Daniel C. Vinson of the department of family and community medicine at the University of Missouri–Columbia (Alcohol Alcohol. 2005;40:208-13).

Physicians in emergency departments or family practice settings generally ask two screening questions: How often do you drink, and on those days, how much do you drink on average? But these have been shown to be somewhat inaccurate for identifying alcohol-use disorder, Dr. Vinson said in an interview with this newspaper. It's hard for people to say how much they drink on average when they might consume two drinks each weeknight but a six-pack on the weekend, he said. So physicians might miss some people who abuse alcohol by asking only about frequency and quantity.

Dr. Vinson, who is a professor in the department of family and community medicine and lead author of the study, found that asking, "When was the last time you had more than five drinks in 1 day [or four for a woman]?" flagged people who should be further queried.

The study comprised interviews with 1,537 patients presenting to the ED for an acute injury, 1,151 who came to the ED due to illness, and 1,112 persons randomly phoned in the community to serve as controls.

They were first asked about tobacco use, and then about number of drinks consumed in a day. A yes to four or five drinks in the past 3 months was considered a positive screen. Those patients were then asked to review, day-by-day, their drinking behavior during the previous 28 days, and to answer questions about the quantity and frequency of alcohol use from the Diagnostic Interview Schedule (DIS).

Hazardous drinking was defined as drinking more than four drinks in 1 day or more than 14 in a week for men, and more than three in a day or seven in a week for women, according to National Institute on Alcohol Abuse and Alcoholism criteria.

The investigators calculated results by estimating the area under the receiver operating characteristic (ROC) curve with 95% confidence intervals. The area under the ROC curve is commonly used as a summary measure of diagnostic accuracy. They compared the ability to identify hazardous drinking or alcohol-use disorders for the three approaches: the single question developed by Dr. Vinson, the quantity–frequency responses to the DIS questions, and a question solely about average quantity consumed.

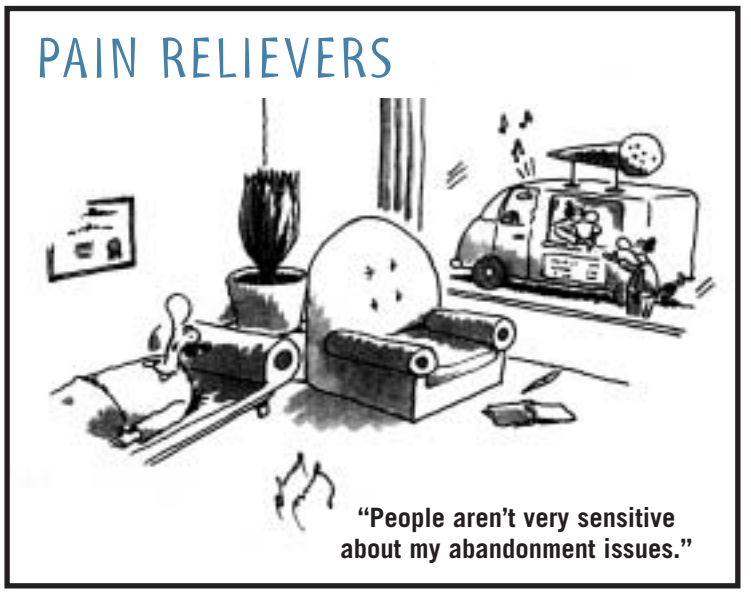
The ROC area for the quantity–frequency questions was slightly higher than for the single question devised by Dr. Vinson, which in turn was higher than the quantity question alone.

But, Dr. Vinson told this newspaper, physicians in busy EDs or primary care practice settings might not always have the time to go through the quantity–frequency questions, and these questions may not be sensitive enough to detect an alcohol-use disorder. A threshold of three or more drinks per occasion has a sensitivity of 77%, but that declines when a threshold of four or more drinks is used. And the scores can be confusing: A quantity–frequency score of 6 could be derived from six drinks less than once a month, three drinks 1-3 days a month, or two drinks once or twice a week.

The single question could be used as a quicker, more efficient screen, although any of the approaches would be better than nothing, he said. One-third of all ED injuries are caused by people who have harmed themselves while drinking, and 10% of people seen in EDs have been harmed by others who were drinking, Dr. Vinson said in the interview.

Identification can lead to treatment and intervention, which inevitably are cost effective, he said. "We can reduce that person's risks for being reinjured just by talking to that person."

Dr. Vinson's study was funded by the National Institute on Alcohol Abuse and Alcoholism. ■



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