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Substance Use, Recovery and Eating Pathology

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The relationship between eating pathology and substance use is well known.[1] Eating pathology is a class of distinct behaviors relevant to eating disorders such as binge eating, purging, unhealthy dieting practices and other unhealthy weight control behaviors. Up to 50% of people with eating disorders use alcohol or illicit drugs (five times higher than the general population). Likewise, up to 35% of people dependent on alcohol or other drugs have also had eating disorders (11 times greater than the general population).[2]

When substance use and eating disorders co-occur, it's often unclear which might be the primary, underlying problem. Furthermore, subclinical eating pathology and disordered eating (i.e., unhealthy eating behaviors that don't meet the criteria for a diagnosable illness) often develop or resurface during recovery from substance use. As such, conceptualizing, assessing and treating substance use, eating pathology and body image simultaneously is often warranted.

Food consumption relies on internal hunger cues, which are often impaired when someone stops using drugs. These biochemical changes during recovery may result in increased appetite, since hunger cues become irregular causing overeating and other eating disturbances, as well as unwanted weight gain.[3]

Diet, food and exercise also have similar physiology and psychology with substance use. Like substance use disorders, a chronic eating disorder can look like an addiction to the body's production of internal opioids. Extreme exercise and food deprivation can activate the dopamine reward pathway of the brain much like substance use. As such, people in recovery frequently experience cravings that lead to high consumption of simple sugars and emotional eating (a self-medication for pain) and further episodes of binge eating.

For women, particularly those who used stimulants, recovery is a vulnerable time. Often driven by desperation to achieve a thin, idealized physical appearance, highly body dissatisfied women may look to return to illicit substances or develop more severe eating pathology because of frustration around recovery-related weight gain and ineffective weight loss methods.

Eating disorders are "behavioral conditions characterized by severe, persistent disturbance in eating behaviors and is associated with distressing emotions and thoughts" (DSM-5). The specific DSM-5 diagnoses and their primary symptoms are the following:

Anorexia Nervosa – An intense fear of gaining weight or becoming "fat" accompanied by persistent and severe caloric restriction and other behaviors that inhibit weight gain (e.g., excessive movement, avoidance of activities surrounding food). This is typically accompanied by a distorted view in self-perceived weight or shape.

Bulimia Nervosa – Recurrent episodes of binge eating, generally defined as eating a large amount of food in a short amount of time while feeling out of control or unable to stop. Binge eating is followed by compensatory behaviors to prevent weight gain and "rid themselves of the calories," such as self-induced vomiting; misuse of laxatives, diuretics or other medications; fasting; or excessive exercise. Behaviors are influenced by body shape and weight.

Avoidant Restrictive Food Intake Disorder (ARFID) – A disturbance in eating habits, such as a lack of interest in eating, avoidance of food due to sensory characteristics, and concern around trying new foods. This coincides with significant weight loss or difficulty gaining expected weight, nutritional deficiencies, dependence on oral nutritional supplements or feeding tubes, or interference with mental well-being.

Other Specified Feeding and Eating Disorder (OSFED) or Disordered Eating – Characteristics of an eating disorder that cause significant distress or impairment in important areas of life. The behaviors are similar or identical to those with an eating disorder, but do not meet the full criteria to be clinically diagnosed (e.g., weight is too high, or frequency and duration of behaviors is too low; night eating; etc.)

Recognize the symptoms

Common symptoms for disordered eating include:

- Compensatory behaviors that counteract effects of eating (e.g., purging, fasting, overexercising, misuse of laxatives, dieting, skipping meals, etc.)
- Notable undereating or overeating
- Cutting out certain foods for nonmedical reasons
- Eating in the middle of the night
- Repeated discussions around:
  - Fad diets, diet pills and over-the-counter supplements
  - Extreme fixation on healthy eating, cleanses or use of phrases such as "clean" eating (Orthorexia)
  - Forbidden foods or rigid rules around eating
- Extreme weight loss, cycles of gaining and losing weight, constant scalewatching
- Heightened focus on appearance, mirror checking, extreme use of social media, comparing oneself

Effective communication with those struggling

Disordered eating interventions typically focus on modifying specific factors known to increase individual risk. These include strong internalized cultural beliefs that reflect a thin-ideal (called thin-ideal internalization), perceived pressure to be thin, body dissatisfaction, chronic dieting, and negative effect (e.g., depressive symptoms). While these may not be driving mechanisms or primary outcomes during recovery, nutrition educators and other professionals should be aware of these behaviors and use language that does not harm individuals.

Some practical suggestions to help those in recovery include:

- Validating weight concerns (without promoting weight loss or encouraging weight related outcomes)
- Practicing empathy, understanding and positive language
- Minimizing triggering language such as:
  - Discussions on counting calories and grams of sugar or fat
  - Describing foods and habits as "bad," "good," or "clean"
  - Terms such as "portion sizes" or "portion control" (instead, use phrases such as "reasonable amounts")
  - Conversations related to fad diets or weight talk
- Discouraging frequent weighing (e.g., less than once a week)
- Discouraging restrictive eating, removing "forbidden" foods from the diet
- Promoting the value of adding healthy foods to the diet
- Focusing on balanced meals, variety and the nutrient value of food
- Promoting mindful eating and helping participants relearn internal hunger/fullness cues
- Helping individuals create boundaries because, unlike many addictions, you can't quit food, so individuals must learn to develop healthy relationships with their food, physical activity, body and weight

Tools to help with identification and referral

Though not for diagnostic purposes, some easily administered, validated tools to help identify those with potential, more serious concerns that may also need a referral to a professional are the:

- BASE 10,[4] a 10-question self-assessment screening tool
- EAT-26, (eat-26.com) a lengthier 26-question screening tool and the 28-item Eating Disorder Examination Questionnaire (EDE-Q)[5]

The National Eating Disorder Association also provides helpful tools and educational information for practitioners to help them understand and identify eating disorders, as well as helpful information for those suffering from various eating pathologies https://www.nationaleatingdisorders.org

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