BULIMIA NERVOSA AND SUBSTANCE USE DISORDERS:

COMORBIDITY AND TREATMENT

By

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ABSTRACT

BULIMIA NERVOSA AND SUBSTANCE USE DISORDER:

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This paper will demonstrate the connection in the professional literature that individuals who suffer from bulimia nervosa also have a high chance of suffering from a substance use disorder. Although, the literature supports this comorbidity issue, there is a lack of research on the treatment of both disorders simultaneously. The purpose of this study is to determine if clinical professionals are screening for substance use disorders among their clients who are being treated for eating disorders.

The primary questions for this research project are: 1) What portion of eating disorder professionals recognize substance use disorders when treating clients who are suffering from bulimia nervosa? 2) What portion of eating disorder professionals diagnose substance use disorders when treating clients who are suffering from bulimia nervosa? 3) What portion of eating disorder professionals treat substance use disorders when treating clients who are suffering from bulimia nervosa?"

The researcher conducted an online survey to determine if clinicians who are treating clients with eating disorders diagnose and treat substance use disorders simultaneously. The survey was sent to 407 professionals. Eighty-four clinicians participated in the survey.

Information was gathered on the clinician's demographic and clinical background. Additionally, questions were used to determine their primary treatment approaches. Moreover, data was gathered about the clinician's general clientele including, age, gender, type of eating disorder, etc.

Upon completion, the researcher analyzed and compiled the information to determine the following results. The ages of the clinicians ranged from age 26-72, with an average age of 46. Over 96% of the participants were Caucasian females. Just over 90% stated that their primary employment setting is Private Practice..

Clinicians were asked, "Which eating disorder is most prevalent among your clients?" The answers to this question were evenly distributed across three types of eating disorders, anorexia nervosa (25%), bulimia nervosa (26.1%), and EDNOS (eating disorder not otherwise specified) (39.8%).

Finally, 77% of clinicians stated that they screen eating disorder clients during the first session to determine if they also have a substance use disorder. Of the participants, 15.5% believe that they are "very skilled" and are an expert at treating substance use disorder. In addition, the majority (67.9%) said that they are "somewhat skilled" and 16.7% said that they were "not skilled" at treating substance use disorders. The results of this survey showed that over half (57.1%) of the clinicians say that they treat both bulimia and substance use disorders at the same time.

The information from this survey provided valuable information to the field of eating disorders. This information includes: 1) the eating disorder EDNOS is a growing diagnosis, 2) individuals who are diagnosed with eating disorders are either younger (5-10 years old) or older (30-40 years old) individuals. Finally, eating disorders are also affecting more men. The findings of this study suggest that there is a need for more education, training and screening tools when dealing with the comorbid issue of eating disorders and substance use disorders.

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INTRODUCTION

1.1 Purpose of the Study

Research shows that individuals who suffer from bulimia nervosa also have a high chance of suffering from substance use disorder (Del Castanar Garcia-Gomez, Gonzalez, Del Barrio, & Garcia, 2009). Although, the literature supports this comorbidity issue, there is a lack of research on the treatment of both disorders simultaneously. The purpose of this study is to determine whether clinical professionals who treat eating disorders screen for substance use disorders among their eating disorder clients. Since the literature shows that this is a comorbid problem, there is a need for the dual treatment of bulimia and substance use disorders (Dunn, Larimer, & Neighbors, 2002). This study will bring awareness to the need for eating disorder clinicians to be dual specialist in the treatment of substance use and eating disorders. As research shows, treating both disorder simultaneously allows clients to heal faster. (Sysko & Hildebrandt, 2009)

The primary questions for this preliminary research project are: 1) What portion of eating disorder professionals, in a limited sample, recognize substance use disorders when treating clients who are suffering from bulimia nervosa? 2) What portion of eating disorder professionals diagnose substance use disorders when treating clients who are suffering from bulimia nervosa? 3) What portion of eating disorder professionals treat substance use disorders when treating clients who are suffering from bulimia nervosa?" This question leads to several sub-questions such as a) If eating disorder professionals do treat bulimia and substance use disorder, do they treat them simultaneously" and b) If eating disorder professionals do not treat substance use disorders, do they refer the clients somewhere else?

1.2 Definition of Terms

ANOREXIA NERVOSA – Anorexia nervosa is characterized by extreme leanness, a persistent goal to be thin, refusal to maintain a healthy weight, presence of body distortions and an extreme fear of weight gain. Individuals diagnosed with anorexia nervosa also demonstrate a lack of menstruation cycles among women and girls and extremely disturbed eating behavior (National Association of Anorexia Nervosa and Associated Disorders, 2012).

BULIMIA NERVOSA – Individuals who suffer from bulimia nervosa will have frequent and repeated episodes of binge eating. These binge eating sessions are when individuals consume abnormally large quantities of food in one setting. They usually feel a lack of control during the binge. Acts such as purging, fasting and/or exercising are used to compensate for the amount of food consumed during the binge eating (National Association of Anorexia Nervosa and Associated Disorders, 2012).

EATING DISORDER NOT OTHERWISE SPECIFIED (EDNOS) – Individuals who do not meet the full diagnosis of a particular eating disorder are considered to have EDNOS. (American Psychiatric Association, 1994)

CHAPTER 2

LITERATURE REVIEW

2.1 What Is an Eating Disorder? What Are the Different Types?

An individual who suffers from an eating disorder has a damaging relationship with food and their weight. This disorder affects the individual's life in a number of ways: 1) they can have unhealthy expectations for their body image; 2) their eating patterns can disturb their day to day activities. (National Association of Anorexia Nervosa and Associated Disorders, 2012) Most individuals who suffer from eating disorders engage in the behaviors due to avoidance coping (i.e. the eating disorder allows them to avoid coping with issues unrelated to eating) (Cockell, Zaitsoff, & Geller, 2004).

There are four types of eating disorders, anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED), and eating disorder not otherwise specified (EDNOS). Additionally, anorexia and bulimia have subcategories that can be used during diagnosis. Anorexia nervosa has two sub-categories: 1) binge-purge and, 2) restricting. Bulimia nervosa diagnosis consists of the two sub-categories: 1) purging or, 2) non-purging (Wifley, Bishop, Wilson, & Argra, 2007). EDNOS is used for diagnosing patients who have eating disorder patterns, but they do not meet the full diagnosis for either anorexia nervosa or bulimia nervosa. (Wifley, et al., 2007).

In the United States, up to 24 million people suffer from one of three types of eating disorders (anorexia nervosa, bulimia nervosa and binge eating disorder.) Ninety-five percent of the eating disorder population is between the ages of 12 and 25 (National Association of Anorexia Nervosa and Associated Disorders, 2012). It is estimated that up to 3.7% of women will suffer from anorexia nervosa at some point in their life, up to 4.2% will suffer from bulimia nervosa and up to 5% will suffer from binge-eating disorder within a six month period (National Association of Anorexia Nervosa and Associated Disorders, 2012).

2.2 Who Suffers from Eating Disorders?

2.2.1 Population in which Eating Disorders are Most Prevalent

A number of studies conclude that there is a significant age range in which eating disorders usually manifest. Eating disorders affect approximately 10% of women (Dunn et al., 2002). The common age range from these studies is from age 15-30 (Dunn et al., 2002). These women usually begin showing symptoms of the eating disorders between 18-20 years of age. Stressful life events have been associated with the onset of eating disorders, such as leaving home for college (Dunn et al., 2002).

The most common onset of eating disorders occurs during puberty. (Day et al., 2011) Individuals who suffer from bulimia typically begin showing patterns of binge-eating at the age of 16, while the act of purging starts around 18 years of age (Day et al., 2011). It is important to note that symptoms of disordered eating begin around adolescence. On the other hand, there has been very little research regards to this population (Day et al., 2011).

Female college students are at the highest risk for eating disorders. In 2011, 61% of college women reported that they binge-eat and compensate with purging (Kelly-Weeder, 2011). Many female college students will go to extreme behaviors in an effort to lose or control their weight. Sixty-nine percent of these women said that they will control their weight by using diet pills, diuretics, fasting or purging (Kelly-Weeder, 2011).

2.2.2 Factors found to Cause or Lead to Eating Disorders and Substance Use Disorders

Many individuals who suffer from one type of disorder will likely suffer from a second (Baker, Mazzeio, & Kenler, 2007). Some researchers believe that certain types of personalities can play a role in leading to multiple disorders (Del Castanar Garcia-Gomez, Gonzalez, Del Barrio, & Garcia, 2009). Two common personality traits found in eating disorder clients and clients who abuse alcohol are addictive and impulsive personalities. It has been suggested that individuals with these two personality traits may be predisposed to eating disorders and alcohol abuse (Del Castanar Garcia-Gomez et al., 2009).

As with other mental disorders, the individual's family history can play a significant role in their disease. (Carbaugh & Sias, 2010 pg.127) Bulik and Sullivan (1993) "found that 76.5% of 17 women diagnosed with bulimia and alcohol abuse or dependence reported having one or more relatives with an alcohol disorder" (pg.54). They determined that not only do first degree family members (i.e. parents, full blood siblings, or children) but second degree family members such as grandparents, aunts, and uncles can have an impact on bulimic individuals. Moreover, they concluded that women who suffer with bulimia are more likely to have a first degree relative who suffers from alcoholism. Additionally, if a woman is suffering from bulimia and alcohol abuse, then they are more likely to have one or more relatives (either first or second degree) who have alcoholism (Bulik & Sullivan, 1993).

2.3 How Common is Bulimia and Substance Use Disorder?

One of the primary issues that women with bulimia and substance use disorders face is that they may seek treatment for their eating disorders, but they are not diagnosed for their substance use disorder. There are a large number of studies that have determined that there is a significant link between eating disorders and substance use disorders (Glasner-Edwards et al, 2011). However, substance use disorders continue to be under-diagnosed in eating disorder patients (Glasner-Edwards et al., 2011). Research shows that there is a high risk of substance use in women who seek treatment for their eating disorders (Dunn, Larimer, & Neighbors, 2002). Samples from a study of treatment-seeking women with bulimia nervosa found prevalence rates for substance use that range from 30% to 50% (Dunn et al., 2002).

There is also a risk of eating disorders among female clients who seek treatment for substance use disorders. In fact, 24% of women who sought treatment for their substance use disorders reported that they also had an eating disorder (Dunn et al., 2002). Alcohol is the most common substance of choice for clients with bulimia. However, 21.4 % of women with bulimia reported that they have a current or past history of drug use (Baker, Mazzeo, & Kendler, 2007).

There is a high prevalence of eating and substance use disorders (Glasner-Edwards, Mooney, Marinelli-Casey, & Hillhouse, 2011). Individuals who suffer from bulimia nervosa are more likely to have a substance use disorder than some other forms of eating disorders. Additionally, individuals who suffer from anorexia nervosa of the bingeing/purging type are more likely to have a substance use disorder in comparison to individuals who suffer from anorexia nervosa of the restrictive type (Ram, Stein, Sofer, & Kreitler, 2008).

Comorbid disorders can be deadly. When studying all mental disorders, substance abuse and eating disorders made up the highest mortality risks (Carbaugh & Sias, 2010). In addition, women who suffer from both bulimia and alcohol dependence are also more likely to attempt suicide. (Bulik & Sullivan, 1997)

2.4 Connection Between Eating Disorders and Substance Use Disorders

Most of the general public does not view food as an addictive substance. However, when dealing with eating disorders, this is very much the case. Bulimia nervosa and substance use disorders consist of individuals having intense cravings for their substance. If the individuals are not able to control their cravings, usually a severe uncontrolled reaction follows (Ram, Stein, Sofer, & Kreitler, 2008).

There are a number of common characteristics between those who suffer from eating disorders and those who suffer from substance use disorders. Some of the shared characteristics include: (1) reports of 'craving' and 'loss of control,' and preoccupation with substance of choice; (2) repeated attempts to stop binge eating and purging or using substances; (3) both disorders impair physical and social functioning and (4) both disorders involve denial and secrecy (Sysko & Hildebrandt, 2009).

2.5 How Substance Abuse Affects Eating Disorders

Use of substances can affect one's life in many ways. This is also true for individuals suffering from eating disorders and substance use disorders simultaneously. Researcher found that bulimic clients with comorbid substance use disorders were more open to treatment when

the clients terminated the use of substances (Carbaugh & Sias, 2010). Additionally, these clients saw a reduction in their bulimic symptoms without the presence of substances (Carbaugh & Sias, 2010)

In order to completely heal, bulimic patients need to deal with their substance use. However, many of the women who suffer from bulimia are not assessed or diagnosed for a substance use disorder (Carbaugh & Sias, 2010). If it is treated, it is not treated simultaneously (Carbaugh & Sias, 2010)

2.6 How Eating Disorders are Primarily Treated

Many different therapeutic techniques can be used to treat eating disorders. However, Cognitive Behavioral Therapy (CBT) has been the most intensively researched and for this reason is currently the primary treatment choice (Sysko & Hildebrandt, 2009). Cognitive Behavioral Therapy is used to change maladaptive thoughts that lead to negative behaviors (Sysko & Hildebrandt, 2009).

An example of a maladaptive thought is when a female with anorexia looks in the mirror; she may see herself as fat when in reality she is significantly underweight. Therefore, this female will continue to restrict her food intake in order to lose or maintain her weight. On the other hand, an individual with anorexia may know that he or she is significantly underweight, but they do not see the severity of the situation and the health risks that he or she is facing (National Association of Anorexia Nervosa and Associated Disorders, 2012).

Bulimic behaviors can continue in an individual for a number of reasons. CBT helps to eliminate these behaviors by addressing multiple factors: 1) interpersonal functioning, 2) low self esteem, 3) clinical perfectionism (Sysko & Hildebrandt, 2009). Carbaugh and Sias (2010) concluded that if an individual is being treated concurrently for both an eating and substance use disorder, both cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) are effective treatments. In fact, CBT and DBT are considered the top treatment approaches for

clients suffering from substance use disorders and clients with eating disorders. (Carbaugh & Sias, 2010)

2.7 Simultaneous Treatment

It is common for treatment program and clinicians to specialize in either the eating disorder or the substance abuse disorder. Rarely are these issues addressed simultaneously (Carbaugh & Sias, 2010). While it is great that professionals are specialist in certain areas, there is a tremendous need for these professionals to be dual specialists.

There are currently no controlled studies that determine if simultaneous treatments of bulimia nervosa and substance use disorders are more efficient than treating one disorder at a time. However, a significant number of patients report that they would prefer simultaneous treatment of both disorders. In fact, 84% of patients reported that they would choose an integrated treatment approach (Sysko & Hildebrandt, 2009).

2.8 Gaps in Literature

The current literature answers a number of questions that pertain to clients with Eating Disorders. According to the National Association of Anorexia Nervosa and Associated Disorders (2012), 1 in 10 men and women who suffer from an eating disorder will receive treatment. However, there is no current information on the reason that clients who are suffering from eating disorders seek treatment.

Research points to the fact that most clinicians do not diagnose and treat eating disorders and substance use disorders simultaneously (Carbaugh & Sias, 2010). One reason that eating disorder clinicians do not diagnose and treat substance use disorders is that the clinicians do not feel that they have the adequate knowledge to determine if a client has a substance use disorder or they do not have the knowledge to treat it (Carbaugh & Sias, 2010).

There are a number of gaps in literature when addressing eating disorders and substance use disorders. When specifically researching the comorbidity of eating disorders and substance use disorders, there are very little studies demonstrating the range of treatment

techniques used when treating disorders simultaneously. Researchers agree that there is empirically supported evidence on the treatment of bulimia nervosa. However, there is no evidence that shows that the same techniques for treating clients with only bulimia is effective for clients with both bulimia and substance use disorders (Sysko & Hildebrandt, 2009).

It is clear that the comorbidity of eating disorders and substance use disorders exists, but there has not been enough research done at this time to clearly state the best treatment model. What we do know, is that the issue exists and the clients prefer a simultaneous treatment model.

CHAPTER 3

METHODOLOGY

3.1 Purpose of the Study

The purpose of this study will be to determine if a small sample of clinical professionals in the United States who treat eating disorders, simultaneously diagnose and treat substance abuse disorders. This sample study will also determine what treatment approaches the clinicians use when treating clients with eating disorders. Finally, the study will obtain demographic information about the clinicians and their clients.

3.2 Approach

The researcher used a multi-stage sampling approach when collecting the sample for the survey. The first step was collecting a sample of eating disorder clinicians from across the United States that subscribed to a referral website. The researcher compiled a list of contact information for each clinician. This list contained clinician's name, email address, and the state that they are practicing in.

The second stage of the process was to narrow down the sample to only clinicians that supplied their personal email addresses. Emails that were for general information (i.e. info@ ABCclinic.com) were not used. General information emails were excluded because there was no way to know if the eating disorder clinician had direct access to those emails.

3.3 Data Gathering Method

The researcher began by researching online surveys that have previously been done regarding eating disorders. Additionally, the researcher looked at previous theses and dissertations focused on eating disorders in order to determine valuable questions and missing information. Once the researcher had a good idea about previous research, she interviewed a clinical therapist who specializes in treating individuals with eating disorders. Finally, the researcher extensively read the literature in the area of eating and substance use disorders to create the survey questions.

Based on all of this information, the researcher compiled approximately 20 questions and presented them to her thesis committee. The committee members helped to make the questions stronger and offered their opinion on additional questions. The researcher then used the survey template and data analysis website "survey monkey." The researcher designed and created the survey consisting of 40 questions. (See Appendix A) The questions were a combination of multiple choice questions and short answer.

The researcher used an eating disorder referral website (www.edreferral.com) in order to compile a list of email addresses for potential participants. The website lists professionals in the field of eating disorders all over the United States. The researcher sent the survey to clinicians that listed their personal email addresses on the directory. The thesis committee determined that the researcher needed to receive 100-200 responses. Therefore, the researcher oversampled by sending the survey to 300 professionals across the country. A month later, the researcher sent the survey to an additional 107 participants to try and increase the number of responses.

As per Institutional Review Board, the first question of the survey required participants to check the "accept" box if they agreed to give their informed consent. In order for the participant to move on to the following question, they had to choose "accept" or "decline." If they chose "decline" then they were excluded from the survey.

CHAPTER 4

RESULTS

4.1 Sample

The researcher sent the survey to a total of 407 potential participants. Eighty-four professionals responded to the survey. The following results were compiled and analyzed.

The ages of the clinicians ranged from 26-72 years old, with an average age of 46. Of the sample, 8% were between the ages of 26-30, 28% between the ages of 31-40, 29% ages 51-60, and 15% were between the ages of 61-75. Over 96% of the participants were White females. The following professions were represented: Psychologist (30%), Dietician (24%), Social Worker (18%), Licensed Professional Counselor (14%), Psychotherapist (10%), and Licensed Mental Health Counselor (4%). Over 90% of participants were in private practice. The results showed that 55.6% of participants have not had an eating disorder in the past, while 44.4% reported that they have had an eating disorder at one time

In regards to these clinician's education, the majority of the participant's had Master's Degree (60.2%), and 23.9% had a PhD. Additionally, just over half of the participants (52.8%) reported that they have worked in the Eating Disorder field for 5-15 years, while 37.1% have worked in the field for 15+ years.

The sample was pulled from across the United States; however, the majority of the participants that responded practice in the Northeast and the South. Forty-one percent are licensed in the Northeast, 32% in the South, 17% in the Midwest, and 10% in the West.

4.2 Patient Demographic

Clinicians were asked about the average age of their eating disorder clients. The majority (61.8%) said that their clients ranged from 21-30 and 18% said between the ages of 16-18. Almost every clinician (98.9%) stated that the primary race of their clients is Caucasian and 92.1% stated that the primary gender of their eating disorder clients is female. (See Figure 1)

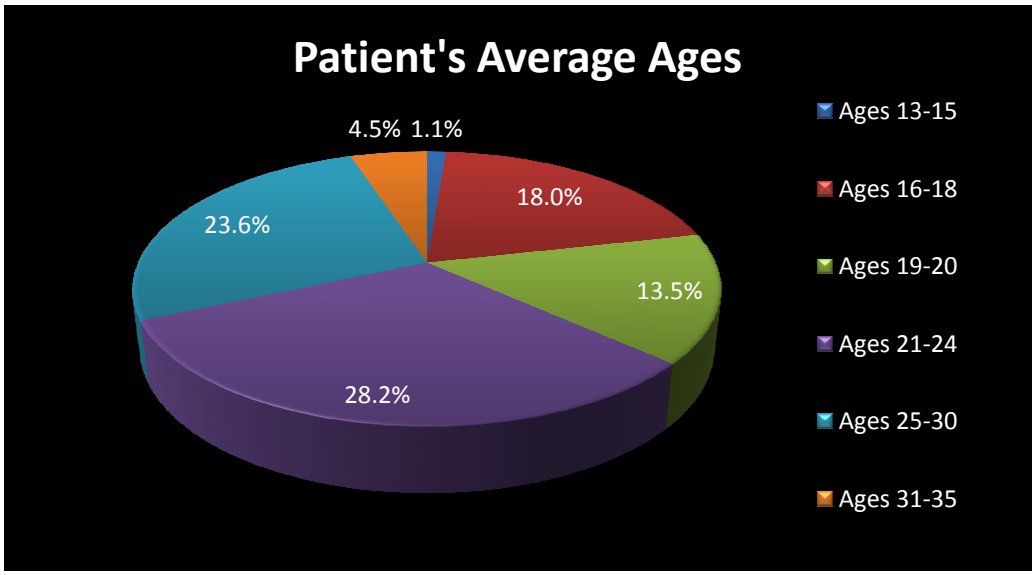

Figure 1 Patient's Average Ages

Clinicians were asked, "Which eating disorder is most prevalent among their clients?" The answers to this question were evenly distributed across three types of eating disorders, anorexia nervosa (25%), bulimia nervosa (26.1%), and EDNOS (Eating Disorder Not Otherwise Specified) (39.8%).(See Table 1.2) Only 9.1% of clinician reported that binge eating was the primary eating disorder that they see among their clients. (See Figure 2)

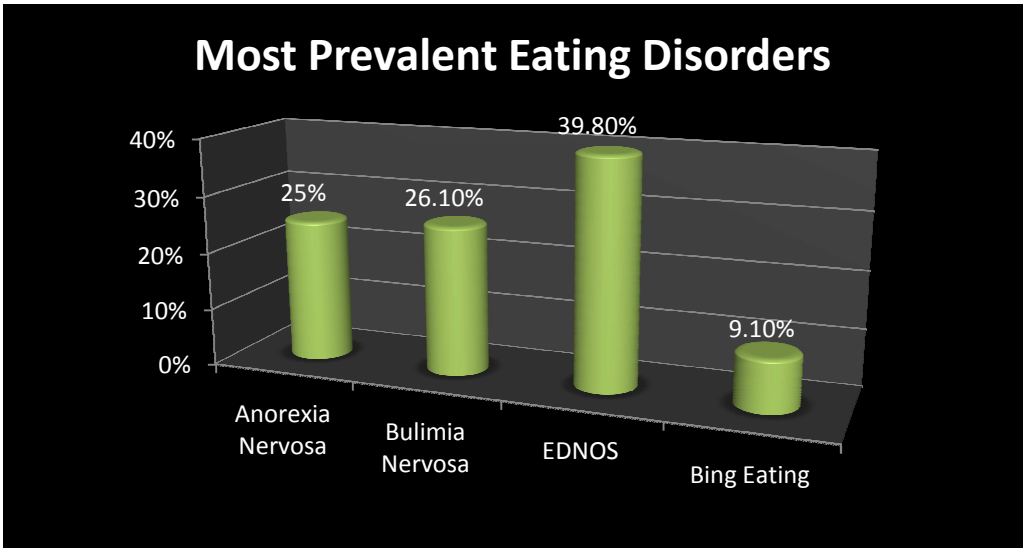

Figure 2 Most Prevalent Eating Disorders

There are a number of reasons that clients choose to seek treatment. Clinicians stated that 62.9% of that their clients chose to seek treatment because they knew that they had a problem and wanted to get help. Additionally, 27% report that their clients sought treatment because they felt pressure from their family members, and 10.1% were referred by their physician because their health was in jeopardy due to the eating disorder. On the other hand, none of the clinician stated that individuals sought treatment because of peer pressure.

Thirty-two percent of the clinicians indicated that only 0%-10% of their clients suffer from both disorders,29.5% said 10%-20%, 14.8% said 20%-30%, 10.2% said 30%-40%, and 13.6% said that 40% or more of their clients suffer from both bulimia and a substance use disorder.(See Figure 3) Alcohol is clearly the substance of choice for the participant's patients who suffer from both bulimia and substance use disorder. In fact, 85.5% of participants stated that alcohol is the primary substance that their bulimic clients abuse.

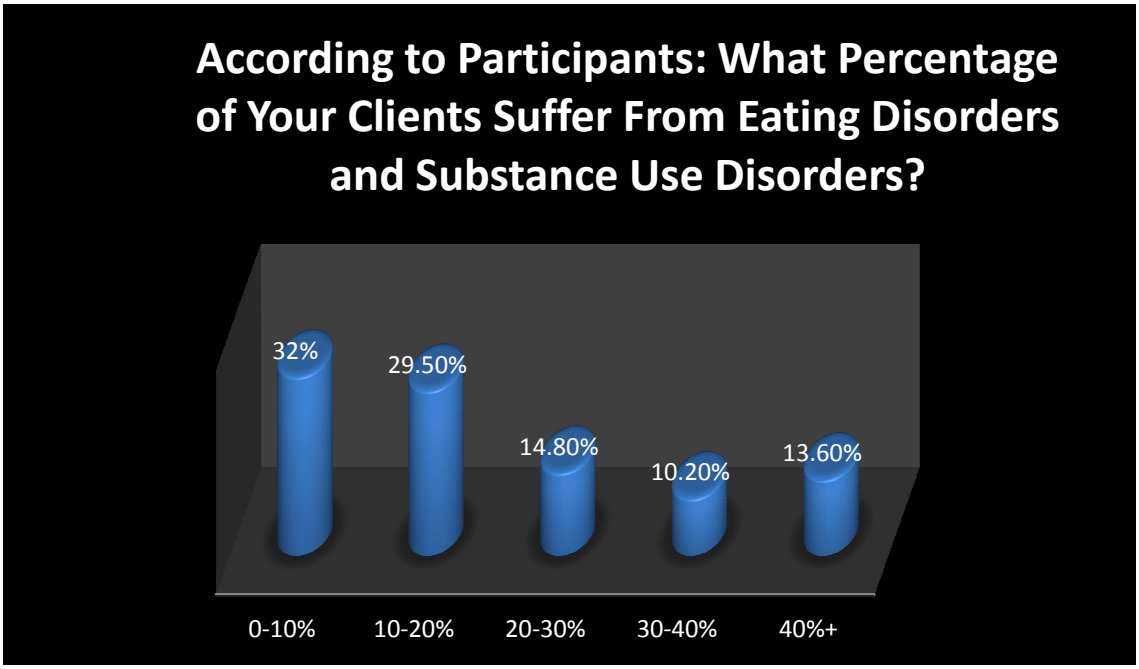

Figure 3 According to Participants: What Percentage of Your Clients Suffer From Eating Disorders and Substance Use Disorders?

4.3 Treatment Results

The greater part of the participants reported that they spend between 6-20 hours a week treating clients with eating disorders (20.2% reported 6-10 hours, 20.2% reported 11-15 hours, and 19.1% reported 15-20 hours).Over 80% of clinicians stated that they spend the same amount of time with general clients as they do with clients who are being treated for an eating disorder (45-60 minutes). Just over 66% of general clients seek treatment between 3-5 times a month, while 76.7% of clients with eating disorders seek treatment 3-5 times a month. Furthermore, 43.8% of clinicians said that a general client will remain in treatment for 6-12 months. However, 68.5% of clinicians said that clients with eating disorders will remain in treatment from 1-3 years.

Participants were asked if they use a "team approach" when treating their clients. An overwhelming majority (93%) stated that they do use a team approach. The most common team members stated were, Medical Doctor, Psychiatrist, Dietician, and Therapist. When asked what theoretical model they primarily use when treating clients, the majority (51.2%) indicated that they use Cognitive/Behavioral Therapy to treat clients with an eating disorder. On the other hand, 26.2% selected "other." Of those that chose "other," 41% stated that they use an integrated approach, 22% said that they use Family Based Treatment, 15% DBT, 11% ACT, and 11% Feminist theory. (See Figure 4)

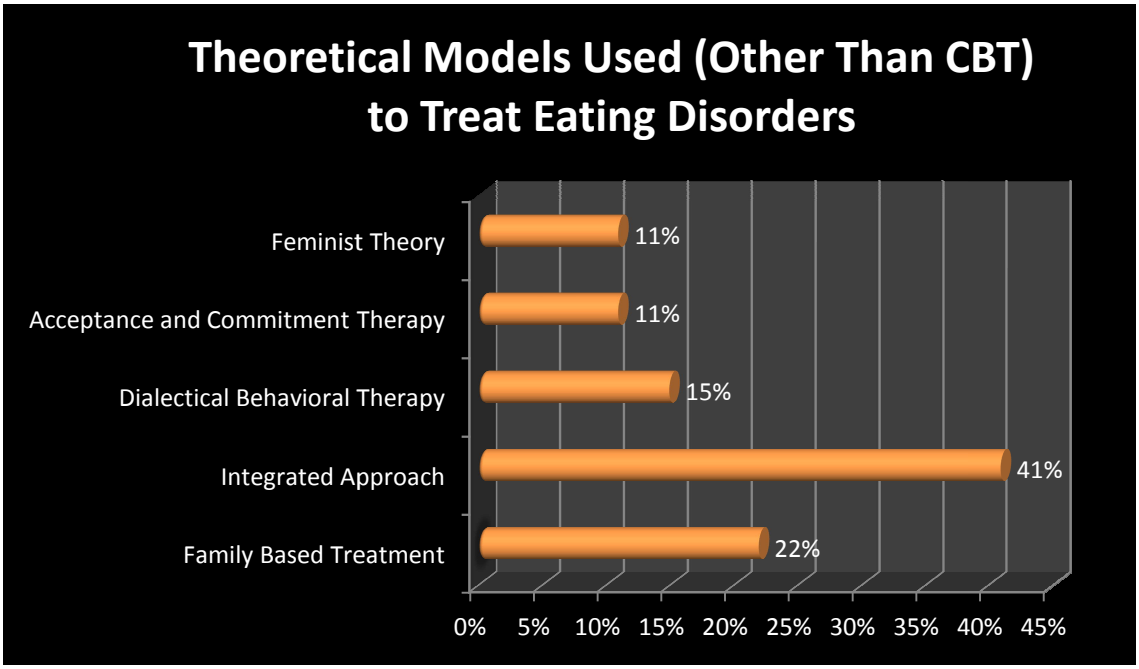

Figure 4 Theoretical Models Used (Other Than CBT) to Treat Eating Disorders

Almost 77% of participants reported that they screen for substance use disorder during the first session with a client who is suffering from bulimia. However, 14% said that they sometimes screen for substance use disorders and 7% said that they do not screen at all for substance use disorders.

The researcher asked questions throughout the survey to determine how skilled the participants believe that they are in treating substance use disorder. Of the participants, 15.5% believe that they are "very skilled" and are an expert at treating substance use disorder. In addition, the majority (67.9%) said that they are "somewhat skilled" and 16.7% said that they were "not skilled" at treating substance use disorders. The results of this survey showed that over half (57.1%) of the clinicians say that they treat both bulimia and substance use disorders at the same time.

Clinicians were asked "Where they would refer a client with a substance use disorder? Thirty-nine percent said a treatment center, 29% substance specialist, 14% Alcoholics Anonymous (AA), 9% said that it depends on the substance and the prevalence of use, 6% said

they would use a colleague, 1% said they were not sure, and 1% said that they are dual specialist in both eating disorders and substance abuse so they would treat the client and not refer.

Many of the clinicians stated that they would like to have more training in treating substance use disorders (59%) in order to be better prepared to treat their clients with both issues. Some of the clinicians (10%) stated that a "screening tool" would be beneficial to use when they are initially meeting with a client with an eating disorder to determine if they have a substance use disorder. Other clinicians said that more practice (9%) would help them feel better equipped to address substance use disorders and 21% said that they would like to have more referral options.

In this survey, participants were asked about the growing trends they see. Participants indicated that: The age range of clients is growing. Clinicians reported that they are seeing younger children (20%) and older women (11%) seeking treatment. There is a growing trend of men (13%) seeking treatment for eating disorders, when previously most believed this to be a "woman's" problem. Additionally, 5% of clinicians said that there is a growing trend with self harm by clients. Funding and insurance coverage is also an issue, according to 9% of the clinicians. In addition, participants also mentioned therapeutic trends arising. They indicated that: Six percent say that there is more Mindfulness Awareness Techniques being used; Nine percent said that they are seeing more Family Based Treatments in practice; Seven percent say that there is an overuse of medication being used to treat clients with eating disorders. Five percent of clinicians said that they are seeing more comorbid disorders; Three percent said they are seeing more EDNOS, and Nine percent said that binge eating is on the rise. (See Figure 5)

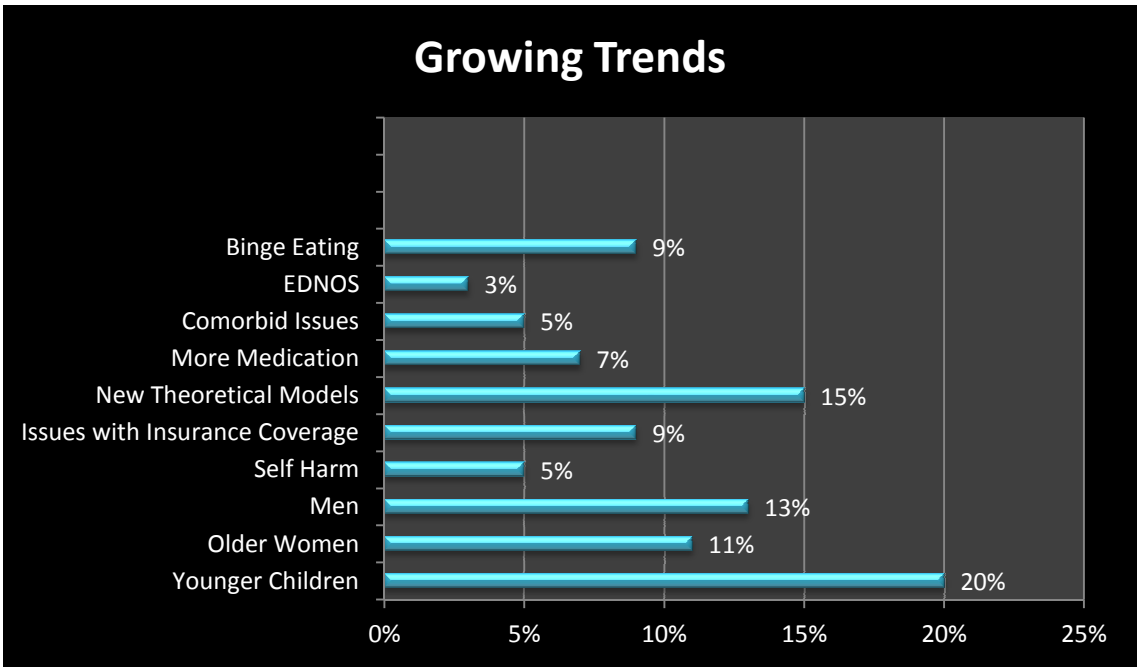

Figure 5 Growing Trends

Finally, participants were asked "If you had all of the money in the world to treat eating disorders, how would you use the money?" The issue of funding for clients was the most common response with 40%. The funding issue also included complaints about insurance companies not understanding the disease and cutting patient's treatment short based on financing. Clinicians (30%) voiced a need for more Intensive Out Patient (IOP) facilities. There seems to be a gap between In Patient Treatment and Out Patient Treatment. Participants stated that IOP's are needed to help gradually transition In Patient clients back into their "real life." Thirteen percent of clinicians said that they would like to see more Long Term Residential Treatment Centers. Finally, 17% of clinicians said that they would use the money for training, education, and prevention.

CHAPTER 5

DISCUSSION AND IMPLICATIONS FOR PRACTICE

Clinicians stated that the average age of their clients with an eating disorder range from 21-30. This is a little smaller age range than the literature states, which is 15-30 years (Dunn, et al., 2001). This study revealed that there is a growing trend among younger population, it is affecting older clients, and there are more men seeking treatment for eating disorders.

It is evident that the eating disorder population is changing. This is no longer just a "mid 20's, white, female" problem. Clinicians are seeing younger clients seeking treatment for eating disorders. They are also seeing this disorder affect older women (in their 40's), and more men are seeking treatment. The issue of older women suffering from eating disorders greatly differs from the literature, which states that it rarely occurs in women ages 40 and over (Dunn, et al., 2001). Some reasons that women are experiencing eating disorders later in life are due to their life experiences, including; 1) grief due to the loss of a loved one, 2) more awareness of their bodies changing and aging, 3) divorce 4) medical illnesses that cause them to lose weight and then they continue to restrict in order to maintain (Disordered eating in midlife and beyond, 2012). It is important for clinicians to be aware of this growing trend among middle age women so that they are more likely to recognize the disorder. Additionally, a few of the clinicians did say that they are seeing more ethnic groups affected by eating disorders. There needs to be more research and studies conducted to better understand what other races and ethnic groups are suffering from eating disorders.

The literature states that prevalence rates for bulimia and substance use ranges from 30% to 50% (Dunn et al., 2002). However, only 15.9% of clinicians in this survey reported that 30%-50% of their bulimic clients also suffer from substance use disorders. In fact 76.1% of clinicians believe that only 0%-30% of their bulimic clients also has a substance use disorder. This discrepancy is important because it could mean that clinicians are not educated to recognize substance use disorders in their clients. Additionally, clinicians may not be aware of

the prevalence of both issues and therefore do not look for signs of substance use during treatment.

In this study, most clients were between the ages of 21-30. Therefore, it is not surprising that alcohol is the substance of choice among eating disorder clients since the legal drinking age in America starts at age 21. The evidence is clear that women who engage in dieting behaviors have increased use of alcohol (Heidelberb and Correia, 2009). This is important for clinicians to be aware of so that they can determine if their client's are consuming or abusing alcohol while engaging in their eating disorder behaviors.

It is interesting to note that not one clinician said that the reason their clients seek treatment is because of pressure from their friends to get help. This could be because either their friends are not aware of the issue or their friends know, but do not say anything because it is socially acceptable. The media can play a significant role in sculpting a young woman's idea of what constitutes beauty (National Association of Anorexia Nervosa and Associated Disorders, 2012). Media outlets place a strong emphasis on thinness equating beauty. This results in young women believing that being thin is not only socially acceptable, but preferable (National Association of Anorexia Nervosa and Associated Disorders, 2012). The media does not simply put an emphasis on being thin, but it paints an unattainable goal due to the use of airbrushing (Lopez-Guimera, Levine, Sanchez-Carracedo, & Fauquet, 2010). Therefore, young women are trying to emulate the images they see, while they are starving themselves in order to reach a goal that even the models have not achieved. Based on this information, there is a significant need for media images to be realistic.

The most common eating disorder that clinicians report among their clients is EDNOS (39.8%). On the other hand, literature indicates that EDNOS is used more than the study participants acknowledged. Patients diagnosed with EDNOS, in specialty clinics, make up 40%-60% of the units (Thomas, Vartanian, & Brownell, 2009). The EDNOS category is reserved for patients who do not meet full diagnosis for bulimia nervosa or anorexia nervosa.

The question arises, why is EDNOS so highly diagnosed? One explanation is that the EDNOS diagnosis is most frequently used with populations that have not received as much attention and research; 1) ethnic minorities 2) men 3) young children 4) the elderly (Thomas, et al., 2009). This is especially interesting because these same groups of people are included in the growing trends among the eating disorder population. It is possible to conclude that if clinicians are more educated on the new eating disorder population, there may be less EDNOS diagnosis. There is a need to better understand the growing EDNOS category. There are still questions as to why EDNOS is highly diagnosed, but it is clear that this category of eating disorders is growing.

It is evident, from this study, that clients with an eating disorder seek treatment more times a week than general clients do. In addition, clients with eating disorders stay in treatment much longer (1-3 years) than general clients (6-12 months). It is well understood that recovery from an eating disorder is a long process. Part of the reason that the process takes so long is that eating disorder affect many aspects of a client's life. An eating disorder impacts the client's physical health, psychological health, and social systems (Cockell, Zaitsoff, & Geller, 2004). All of these factors must be addressed to fully recover (Cockell, Zaitsoff, & Geller, 2004).

There seems to be a growing trend in using Family Based Treatment techniques among clinicians. Family Based Treatment was mentioned multiple times as the primary treatment model by clinicians and it was also brought up when asked about growing trends in treating eating disorder. It can be assumed that clinicians are realizing that eating disorders affect more than just their client, but that the whole family system needs addressing. One study conducted an interview with women who suffered and recovered from bulimia nervosa. The purpose of the study was to determine what factors hindered their recovery process. The primary response was that lack of understanding from their partners, family members, and friends were a large barrier to their recovery (Cockell, Zaitsoff, & Geller, 2004).

Finally, 77% of clinicians stated that they screen eating disorder clients during the first session to determine if they also have a substance use disorder. This result from the sample survey is higher than the literature would suggest. One explanation for the high number is that clinicians may be screening for substance use disorders simply by using standard questionnaires for first time clients. While this tool will help clinicians to determine if a client has a substance use disorder, it does not give the clinician adequate knowledge in treating the disorder. On the other hand, 69% of clinicians stated that they would like more training, education, or screening tools to feel better equipped to treat clients with both disorders. While it is assuring to see that such a high number of clinicians are looking for substance use disorders, it is evident that more training and education is needed to ensure that the clinicians are knowledgeable in treating both disorders simultaneously.

CHAPTER 6

LIMITATIONS

There were some limitations to this survey. The template of the survey did not allow some questions to be answered exactly. For instance, there was at least one question that gave the option of choosing “Other” and having the participant write in an answer. However, the template mandated that the user would have to choose one of the multiple choice answers before being able to write in their response. This made the statistics on those questions unreliable.

Another limitation to the survey is that some people started the survey, but did not answer all of the questions. Therefore, some of the earlier questions have more responses than the later questions. This contributed to some of the data being less reliable.

Social desirability may have played a role in some of the responses by the sample clinicians. For instance, a high number of clinicians said that they were at least somewhat skilled in treating substance use disorder. However, the number of clinicians lessened when asked if they treat both disorders.

Due to the fact that over 90% of the patient information is in regards to White females, this information is not applicable for other races or genders. Also, the sample was pulled from an eating disorder referral website. This means that a large number of eating disorder specialist were not included in the sample because they are not on the directory that was used.

CHAPTER 7

CONCLUSION

The information from this survey provided some valuable information for the field of eating disorders. Some of this information is that the eating disorder EDNOS is a growing diagnosis and the eating disorder population is growing and reaching younger and older individuals as well as men. Additionally, the clinicians from this survey responded that there is a need and desire for more education, training and screening tools when dealing with the comorbid issue of eating disorders and substance use disorders.

APPENDIX A

SURVEY

Understanding Eating Disorders and Substance Use Disorders

Informed Consent

PRINCIPAL INVESTIGATOR: Kara Cunningham
FACULTY ADVISOR: Dr. Joan Blakey

TITLE OF PROJECT: Understanding Eating Disorders and Substance Use Disorders

INTRODUCTION
You are being asked to participate in a research study. Your participation is voluntary. Please ask questions if there is anything you do not understand.

PURPOSE
The primary question for this research project is:
1) What portion of eating disorder professionals recognize substance use disorders when treating clients who are suffering from bulimia nervosa?
2) What portion of eating disorder professionals diagnose substance use disorders when treating clients who are suffering from bulimia nervosa?
3) What portion of eating disorder professionals treat substance use disorders when treating clients who are suffering from bulimia nervosa?"
This question leads to several sub-questions such as a) if eating disorder professionals do treat both bulimia and substance use disorder, do they treat them simultaneously" and b) if eating disorder professionals do not treat substance use disorders, do they refer the clients somewhere else?

DURATION
Participation in this study will last approximately 15-20 minutes.

NUMBER OF PARTICIPANTS
Anticipated number of participants for this survey is 500.

PROCEDURES
The procedures which will involve you as a research participant include:
1.Giving informed consent by reading and acknowledging the informed consent form prior to beginning the survey.
2.Completing the survey to the best of your ability by answering all questions honestly and thoroughly.
3.Completing the survey in the designated amount of time. (There is a two week window for completion of the survey)
4.Returning the survey to the primary research investigator.

POSSIBLE BENEFITS
Although you will not receive any monetary compensation, you will receive the survey results upon completion and compilation of the results. This information will be extremely beneficial to you as a clinician. Depending on the results, you may come to the realization that you are not treating clients with bulimia nervosa and substance use disorder to the same degree that other fellow clinicians in the eating disorder field. On the other hand, results may show you that there are certain regions in the nation who are treating both disorders simultaneously while other areas are not. This study can help to bring awareness of the current treatment of bulimia nervosa and substance use disorder.

POSSIBLE RISKS/DISCOMFORTS
There are no perceived risks and/or discomforts that are foreseeable in participating in this survey.

COMPENSATION
There will be no monetary compensation. By participating in this survey, you will be contributing to the larger body of knowledge about Eating Disorders and Substance Use Disorders; results of the study will be provided to participants as well as professionals in this field.

ALTERNATIVE PROCEDURES
There are no alternative procedures offered for this study. However, you can elect not to participate in the study or quit at

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any time at no consequence.

VOLUNTARY PARTICIPATION
Participation in this research study is voluntary and participants are free to withdraw consent and to discontinue participation at any time without penalty.

CONFIDENTIALITY

Every attempt will be made to see that your study results are kept confidential. A copy of this signed consent form and all data collected from this study will be stored at 211 S. Cooper Street, Building A Room 112C, Arlington, Texas 76019 for at least three (3) years after the end of this research. The results of this study may be published and/or presented at meetings without naming you as a participant. Additional research studies could evolve from the information you have provided, but your information will not be linked to you in anyway, you will be anonymous. Although your rights and privacy will be maintained, the Secretary of the Department of Health and Human Services, the UTA Institutional Review Board (IRB), and personnel particular to this research have access to the study records. Your records will be kept completely confidential according to current legal requirements. They will not be revealed unless required by law, or as noted above. The IRB at UTA has reviewed and approved this study and the information within this consent form. If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, the University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law.

CONTACT FOR QUESTIONS
Questions about this research study may be directed to Kara Cunningham at 214-693-3063 (Principal Investigator) or Dr. Joan Blakey at 773-972-7703 (Faculty Advisor). Any questions you may have about your rights as a research participant may be directed to the Office of Research Administration; Regulatory Services at 817-272-2105 or regulatoryservices@uta.edu.

CONSENT

By selecting "accept", you confirm that you are 18 years of age or older and have read or had this document read to you. You have been informed about this study's purpose, procedures, possible benefits and risks.

***1. You voluntarily agree to participate in this study. By clicking "accept", you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.**

- ◯ Accept
- ◯ Decline

Clinician Demographics

***2. What is your age?**

Understanding Eating Disorders and Substance Use Disorders

***3. What is your gender?**

- ◯ Female
- ◯ Male

***4. What race do you consider yourself?**

- ◯ American Indian/Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White
- ◯ Other

Please specify

***5. What is your professional role?**

- ☐ Psychiatrist
- ☐ Nurse
- ☐ Physiotherapist
- ☐ Social Worker
- ☐ General Practitioner
- ☐ Dietitian

If not listed, please specify

***6. What is the highest degree received?**

- ◯ Masters
- ◯ PhD
- ◯ Psy D
- ◯ Ed.D
- ◯ Other

Please specify

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*7. What college or university was your highest degree earned?

*8. Have you had an Eating Disorder in the past?

- Yes
- No

*9. How long have you worked in the field of Eating Disorders?

- 0-2 Years
- 2-5 Years
- 5-15 Years
- Over 15 Years

*10. Do you use a team approach when treating clients with Eating Disorders?

- Yes
- No

*11. If you do use a team approach, who is on your team?

- [ ] Not Applicable
- [ ] Medical Doctor
- [ ] Dietitian
- [ ] Therapist
- [ ] Psychiatrist
- [ ] Nutritionist
- [ ] Other

Please specify

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***12. What theoretical model do you primarily use to treat Eating Disorders?**

- ◯ Humanistic/Experiential
- ◯ Cognitive/Behavioral
- ◯ Family Systems
- ◯ Psychodynamic
- ◯ Other

Please Specify

***13. What is the average number of hours a week that you spend treating clients with eating disorders?**

- ◯ 1-5 Hours
- ◯ 6-10 Hours
- ◯ 11-15 Hours
- ◯ 16-20 Hours
- ◯ 21-25 Hours
- ◯ 26-30 Hours
- ◯ 31-35 Hours
- ◯ 36-40 Hours
- ◯ 41-45 Hours
- ◯ 46+ Hours

***14. How much of that time is spent with clients who have bulimia?**

- ◯ 0%-10%
- ◯ 10%-20%
- ◯ 20%-30%
- ◯ 30%-40%
- ◯ 40%-50%
- ◯ 50%-60%
- ◯ 60%-70%
- ◯ 70%-80%
- ◯ 80%-90%
- ◯ 90%-100%

Understanding Eating Disorders and Substance Use Disorders

*** 15. How long are your sessions with a client in general?**

- 0-15 Minutes
- 15-30 Minutes
- 30-45 Minutes
- 45-60 Minutes
- 60-75 Minutes
- 75-90 Minutes
- 90+ Minutes

*** 16. For clients who have eating disorders, how long are your sessions?**

- 0-15 Minutes
- 15-30 Minutes
- 30-45 Minutes
- 45-60 Minutes
- 60-75 Minutes
- 75-90 Minutes
- 90+ Minutes

*** 17. How often do you meet with a client in general?**

- 0-1 Times a Month
- 1-2 Times a Month
- 2-3 Times a Month
- 3-4 Times a Month
- 4-5 Times a Month
- 5-6 Times a Month
- 6-7 Times a Month
- 7-8 Times a Month
- 8+ Times a Month

Understanding Eating Disorders and Substance Use Disorders

*** 18. For clients who have an Eating Disorder, how often do you meet with them?**

- 0-1 Times a Month
- 1-2 Times a Month
- 2-3 Times a Month
- 3-4 Times a Month
- 4-5 Times a Month
- 5-6 Times a Month
- 6-7 Times a Month
- 7-8 Times a Month
- 8+ Times a Month

*** 19. On average, how long does a client in general remain in treatment?**

- 0-6 Months
- 6-12 Months
- 1-1 1/2 Years
- 1 1/2-2 Years
- 2 1/2- 3 Years
- 3 1/2--4 Years
- 4 1/2-5 Years
- 5+ Years

*** 20. On average, how long does a client who is suffering from an Eating Disorder remain in treatment?**

- 0-6 Months
- 6-12 Months
- 1-1 1/2 Years
- 1 1/2-2 Years
- 2 1/2- 3 Years
- 3 1/2--4 Years
- 4 1/2-5 Years
- 5+ Years

Understanding Eating Disorders and Substance Use Disorders

*** 21. What is your primary employment setting?**

- Private Practice
- Hospital
- Clinic/Community Mental Health Center
- In/Out Patient Eating Disorder Facility

Other or Combination, please specify

*** 22. In what state or states are you CURRENTLY practicing?**

Patient Demographic

*** 23. What is the average age of the clients that you treat for Eating Disorders?**

- 0-9 Years Old
- 10-12 Years Old
- 13-15 Years Old
- 16-18 Years Old
- 19-20 Years Old
- 21-24 Years Old
- 25-30 Years Old
- 30-35 Years Old
- 35-40 Years Old
- 40+ Years Old

Understanding Eating Disorders and Substance Use Disorders

*** 24. What is the primary race of your clients?**

- ◯ American Indian/Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White
- ◯ Other

Please specify

*** 25. What is the primary gender of your clients?**

- ◯ Female
- ◯ Male
- ◯ Equally Female and Male

*** 26. Which Eating Disorder is most prevalent among your clients?**

- ◯ Anorexia Nervosa
- ◯ Bulimia Nervosa
- ◯ Binge Eating
- ◯ EDNOS (Eating Disorder Not Otherwise Specified)

*** 27. What is the deciding factor that leads most of your clients to seek treatment?**

- ◯ Themselves- They know they have a problem and they want to fix it.
- ◯ Family- They feel pressure from their family.
- ◯ Friends- They feel peer pressure from their friends.
- ◯ Doctor- They are referred by their physician because their health is in jeopardy due to the eating disorder.

*** 28. What percentage of your clients do you treat for bulimia nervosa?**

- ◯ 0%-10%
- ◯ 10%-20%
- ◯ 20%-30%
- ◯ 30%-40%
- ◯ 40%-50%
- ◯ 50%-60%
- ◯ 60%-70%
- ◯ 70%-80%
- ◯ 80%-90%
- ◯ 90%-100%

Understanding Eating Disorders and Substance Use Disorders

***29. What percentage of your clients with bulimia also has a substance use disorder?**

- ○ 0%-10%
- ○ 10%-20%
- ○ 20%-30%
- ○ 30%-40%
- ○ 40%-50%
- ○ 50%-60%
- ○ 60%-70%
- ○ 70%-80%
- ○ 80%-90%
- ○ 90%-100%

***30. What is the primary substance of choice that your bulimic clients suffer from?**

- ○ Alcohol
- ○ Illicit Drugs (Cocaine, Methamphetamine, etc.)
- ○ Marijuana
- ○ Prescription Drugs
- ○ Other

Please specify

***31. What are the substances of choice if multiple substances are used? (Please check all that apply)**

- ☐ Alcohol
- ☐ Illicit Drugs (Cocaine, Methamphetamine, etc.)
- ☐ Marijuana
- ☐ Prescription Drugs
- ☐ Cigarettes
- ☐ Other

Treatment Questions

32. When treating a client with bulimia nervosa, do you initially screen for Substance Use Disorder?

- ○ Yes, it is something that I always ask about during the first session.
- ○ Sometimes, if it comes up.
- ○ No, I focus on the treatment of the Eating Disorder only.

Understanding Eating Disorders and Substance Use Disorders

33. How skilled are you in diagnosing and treating Substance Use Disorders?

- ◯ Very Skilled- I am an expert in Substance Use Disorder
- ◯ Somewhat Skilled- I have some experience, but it is not my expertise.
- ◯ Not Skilled- I do not have enough experience with Substance Use Disorders to treat them.

34. If your client is suffering from bulimia and Substance Use Disorder, do you treat them for both?

- ◯ Yes, I treat both the Eating Disorder as well as the Substance Use Disorder.
- ◯ Sometimes, if the Substance Use Disorder is minor than I will treat it. However, if it is a major problem than I would refer the patient to a Substance Use Disorder specialist.
- ◯ No, I treat only the Eating Disorder and I refer the client elsewhere for the Substance Use Disorder.

35. When treating both bulimia and Substance Use Disorder, do you treat them simultaneously?

- ◯ Yes, I treat both issues concurrently.
- ◯ No, I treat the Eating Disorder first and then we address the Substance Use Disorder.
- ◯ No, I treat the Substance Use Disorder first and then we address the Eating Disorder.
- ◯ Not Applicable, I do not treat Substance Use Disorders.
- ◯ Not Applicable, I do not treat Substance Use Disorders as I refer clients to a Substance Use Disorder specialist.

36. Where would you refer a client with a Substance Use Disorder?

***37. In your opinion, what percentage of bulimic clients also suffer from substance use disorders?**

- ◯ 0%-10%
- ◯ 10%-20%
- ◯ 20%-30%
- ◯ 30%-40%
- ◯ 40%-50%
- ◯ 50%-60%
- ◯ 60%-70%
- ◯ 70%-80%
- ◯ 80%-90%
- ◯ 90%-100%

38. What do you think would help you feel better equipped to address Substance Use Disorder with your clients?

Understanding Eating Disorders and Substance Use Disorders

39. What growing trends do you see with the treatment of eating disorder?

40. If you had all of the money in the world to treat eating disorders, how would you use the money?

APPENDIX B

SURVEY RESULTS

Figure B.1 Informed Consent

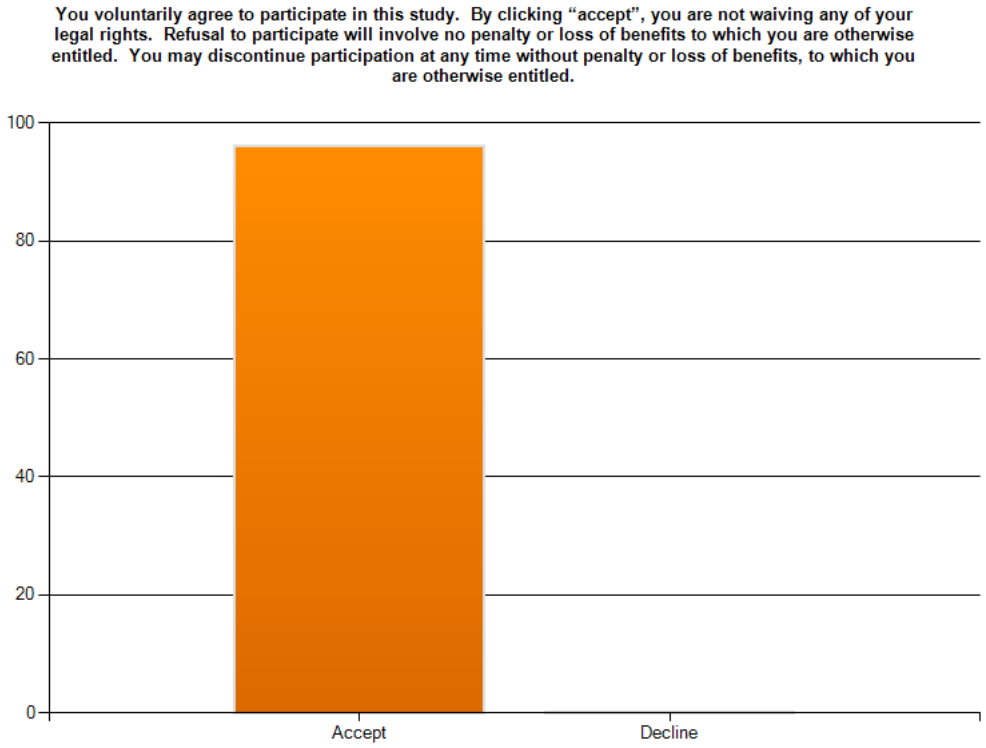


Figure B.2

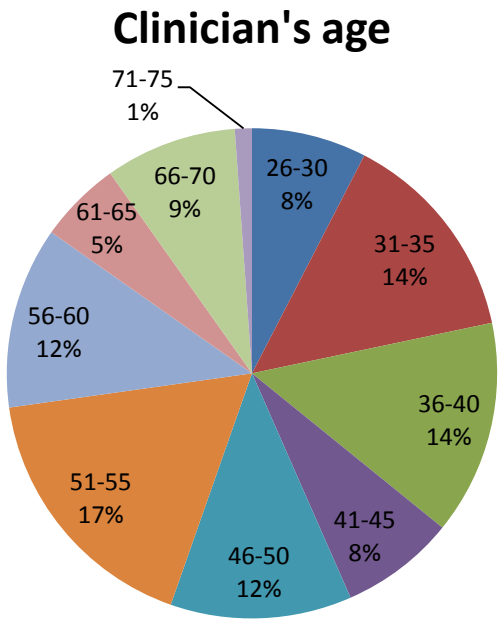


Figure B.3

Gender of Clinicians

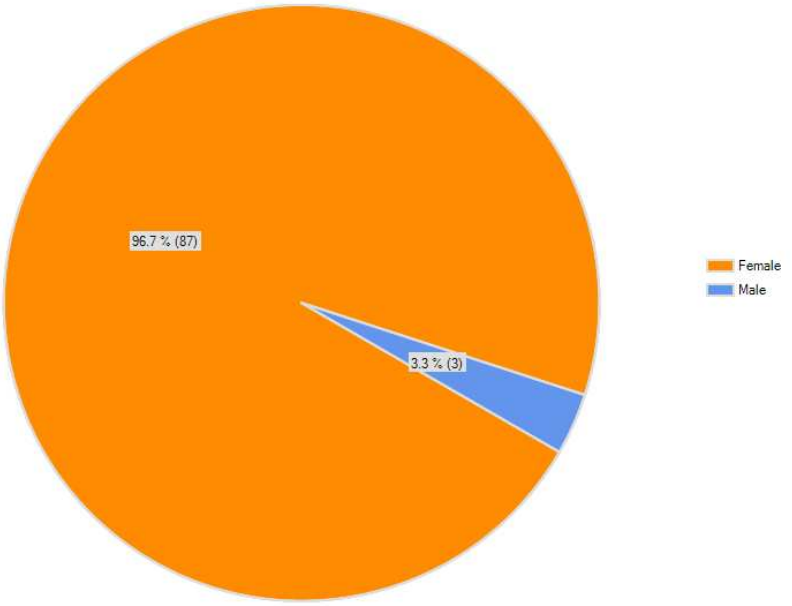


Figure B.4

Race of Clinicians

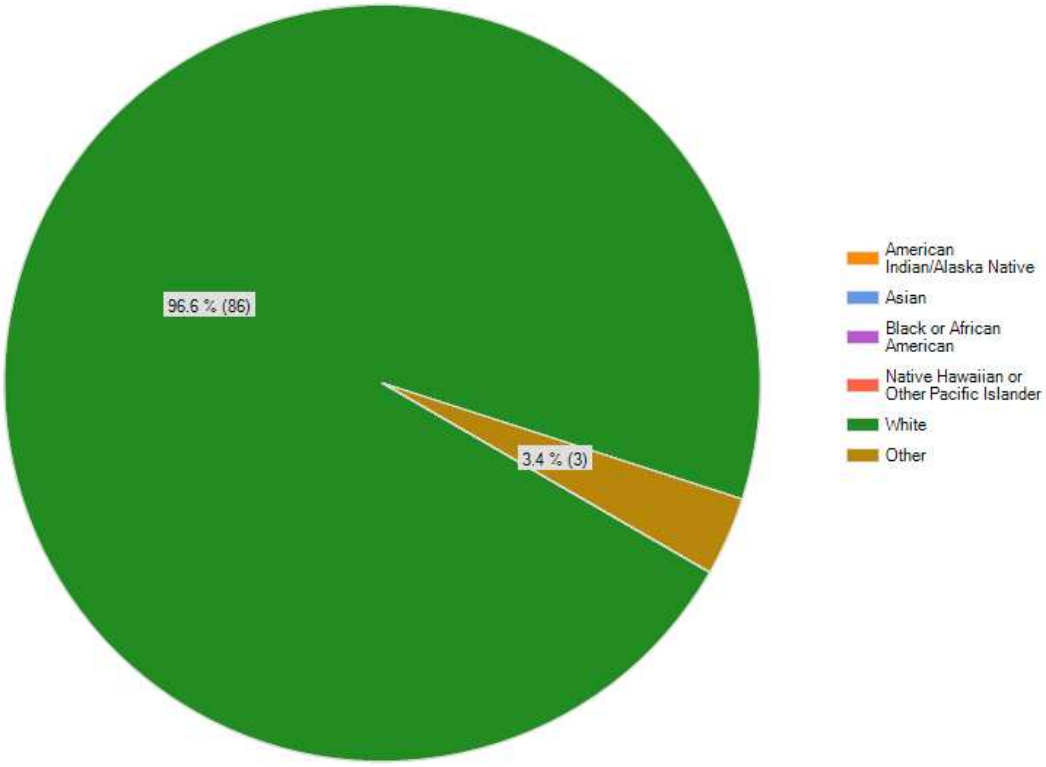


Figure B.5

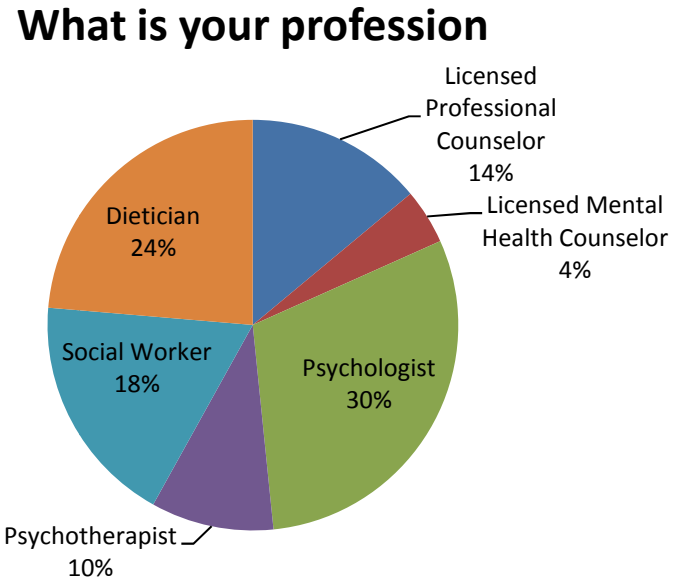


Figure B.6

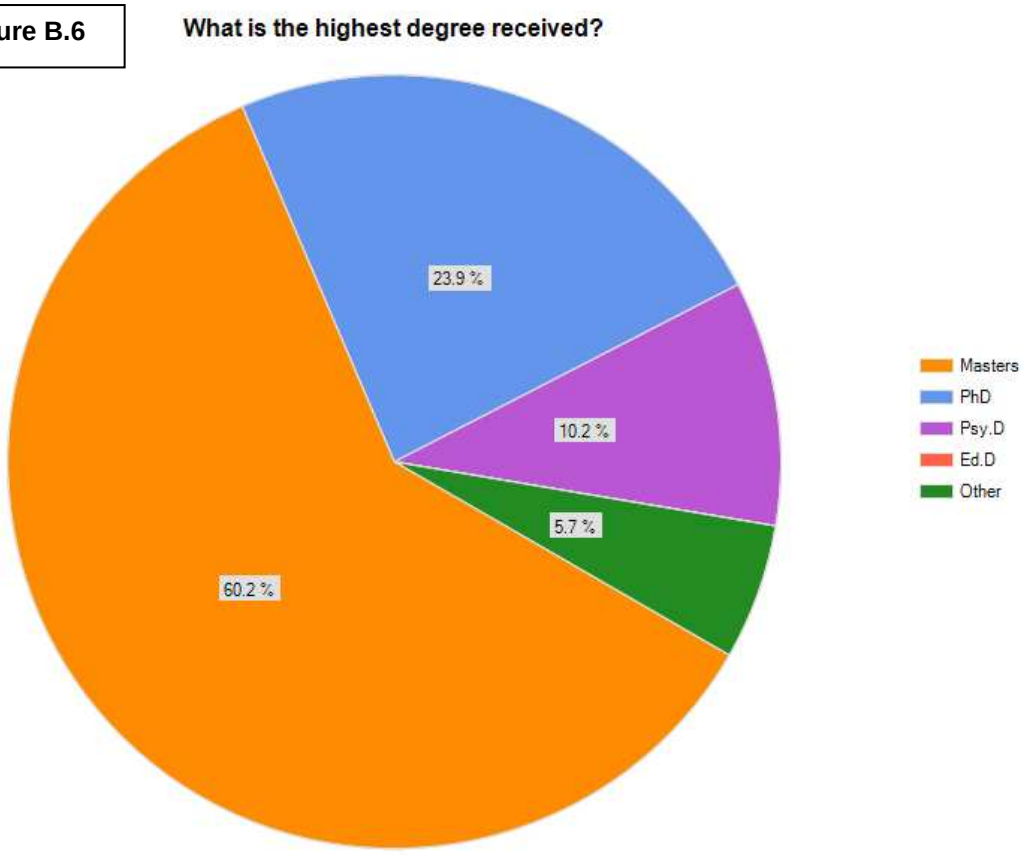
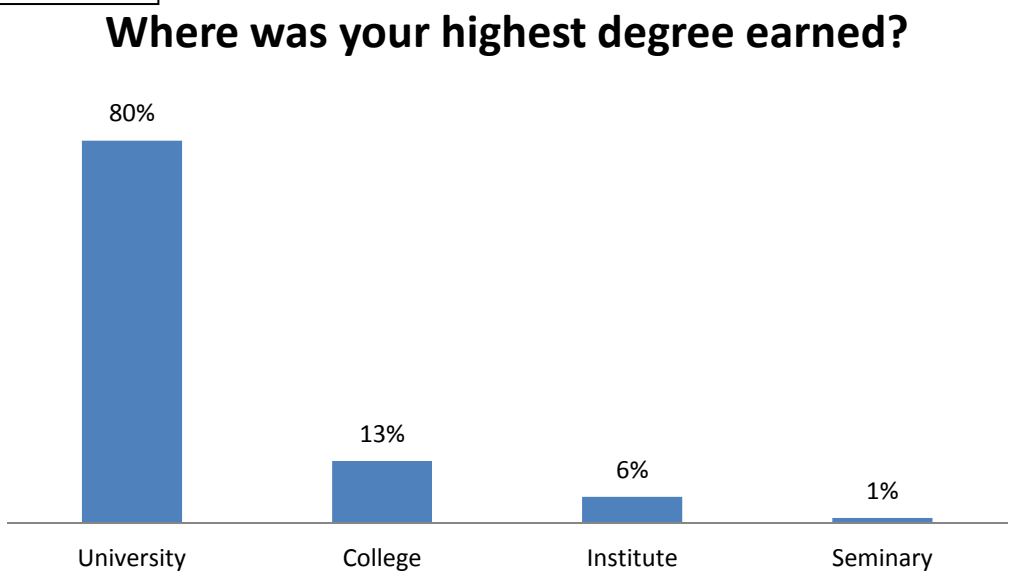


Figure B.7



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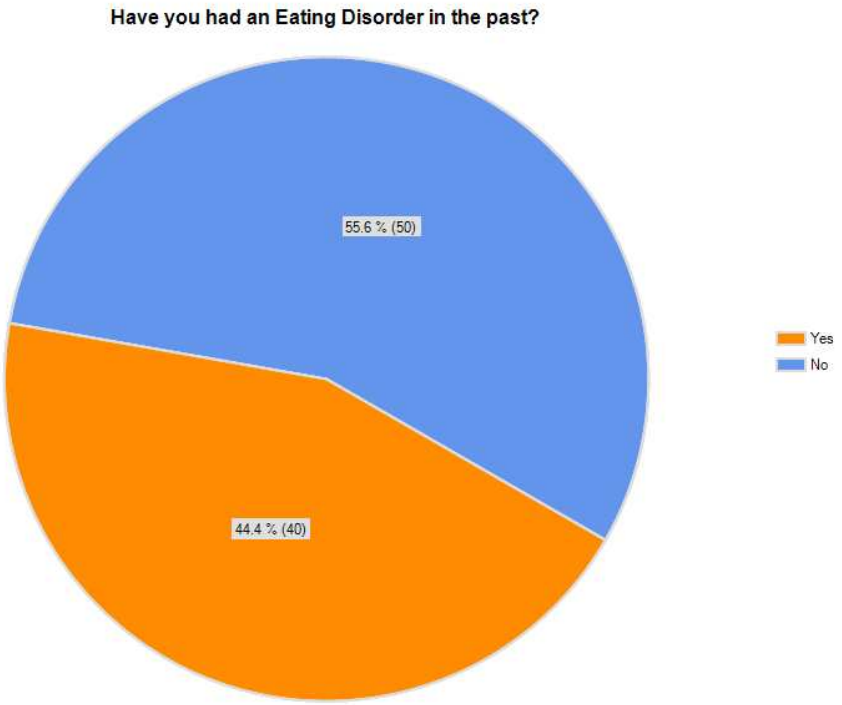


Figure B.9

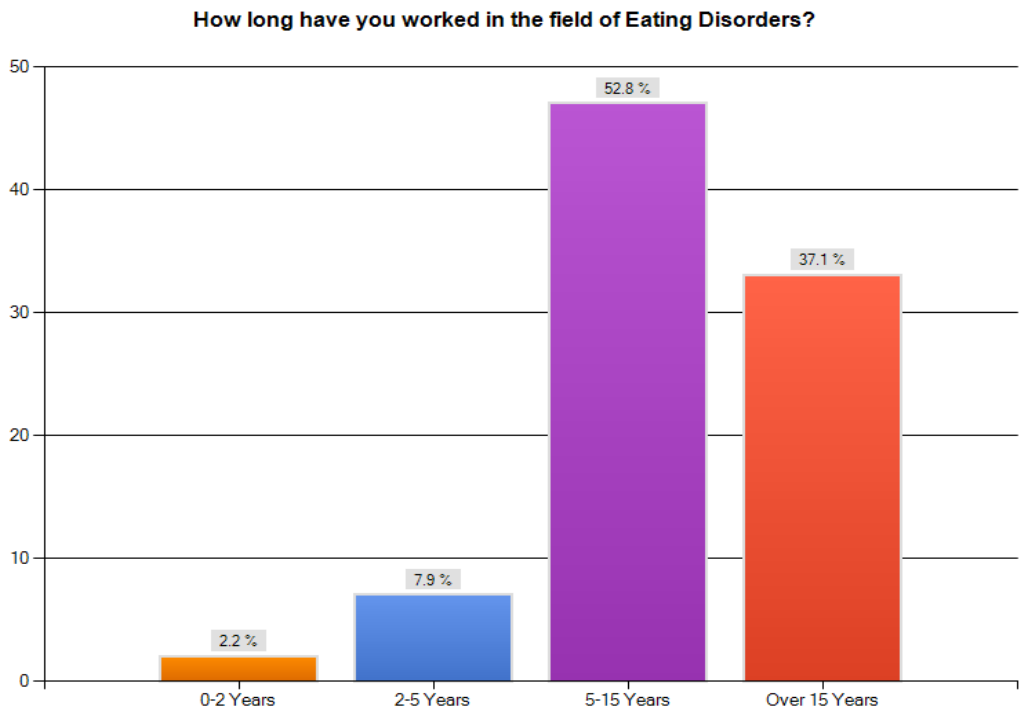


Figure B.10

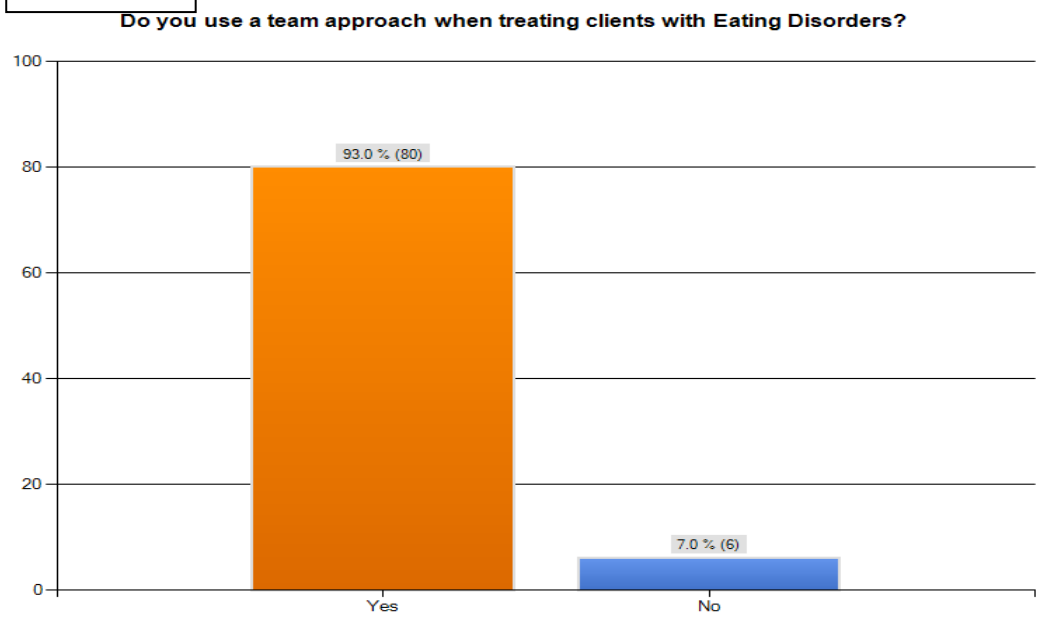
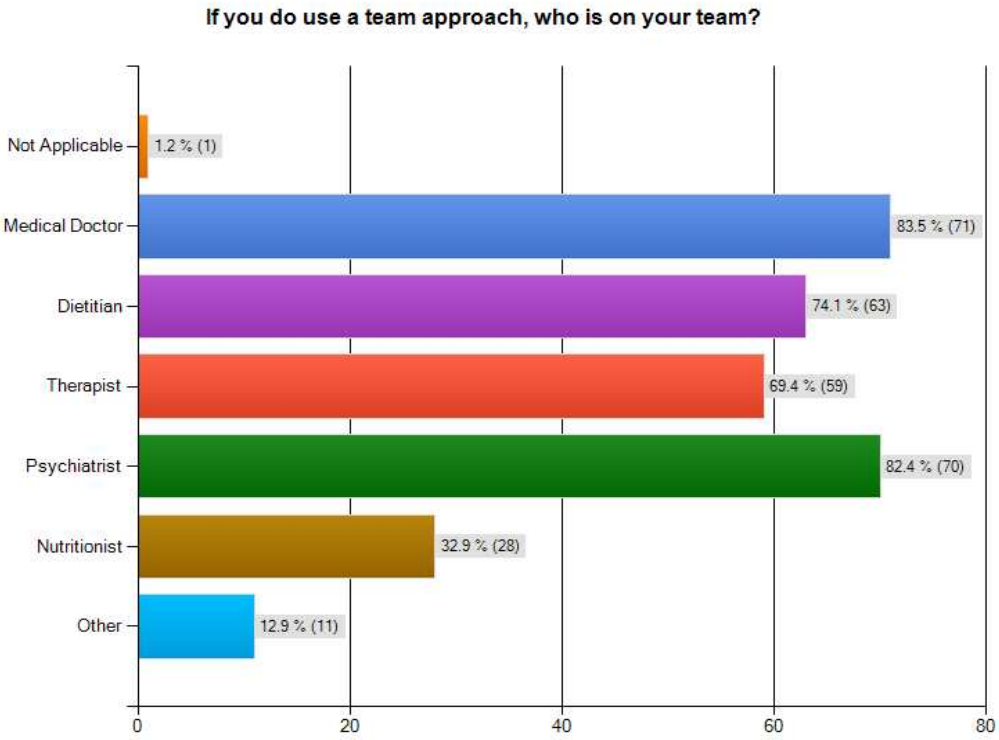


Figure B.11



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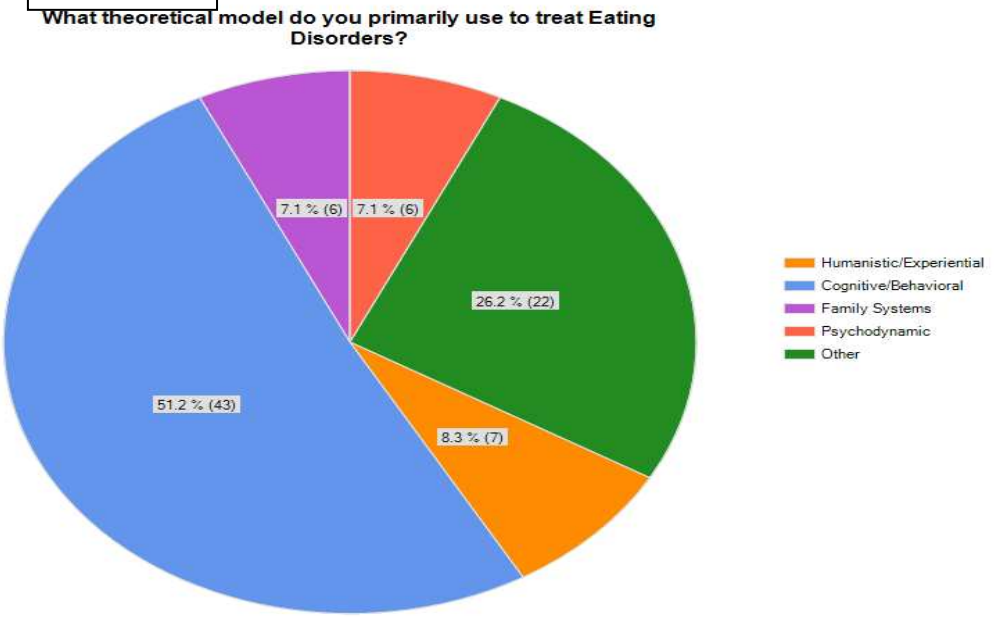


Figure B.13

What is the average number of hours a week that you spend treating clients with eating disorders?

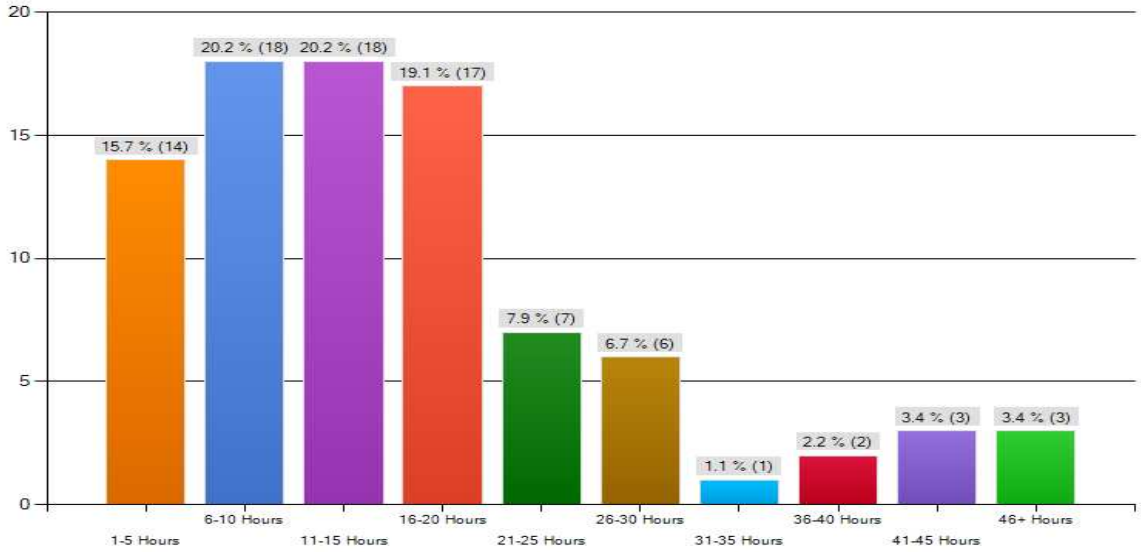


Figure B.14

How much of that time is spent with clients who have bulimia?

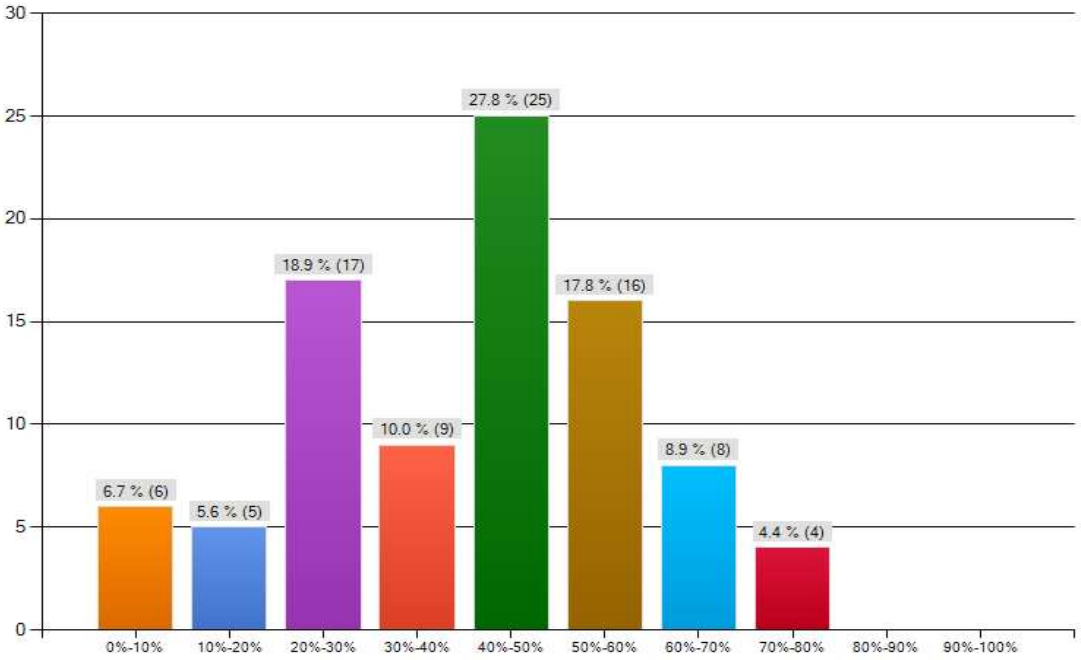


Figure B.15

How long are your sessions with a client in general?

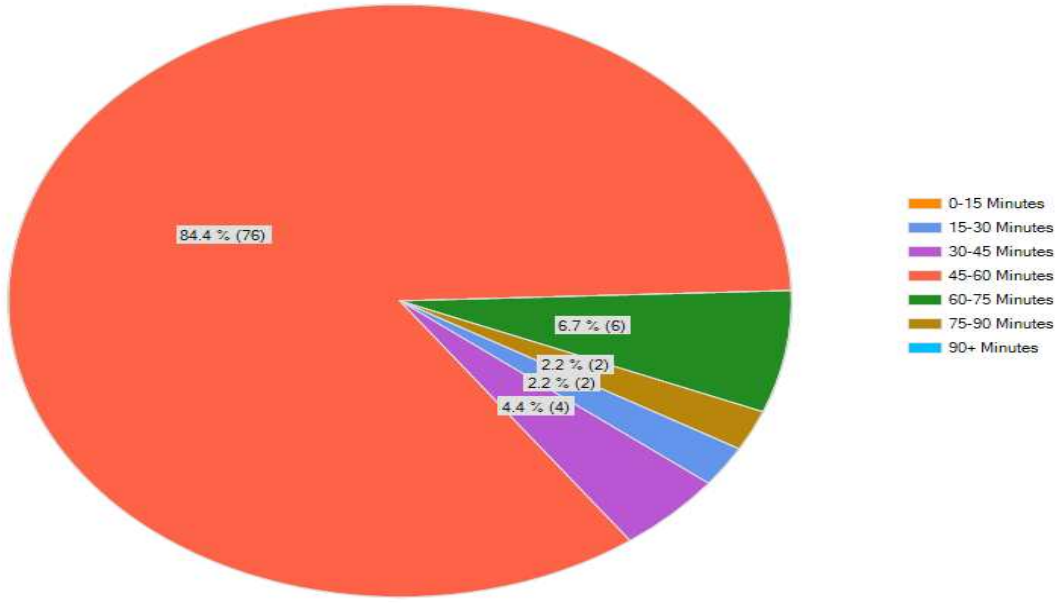


Figure B.16

For clients who have eating disorders, how long are your sessions?

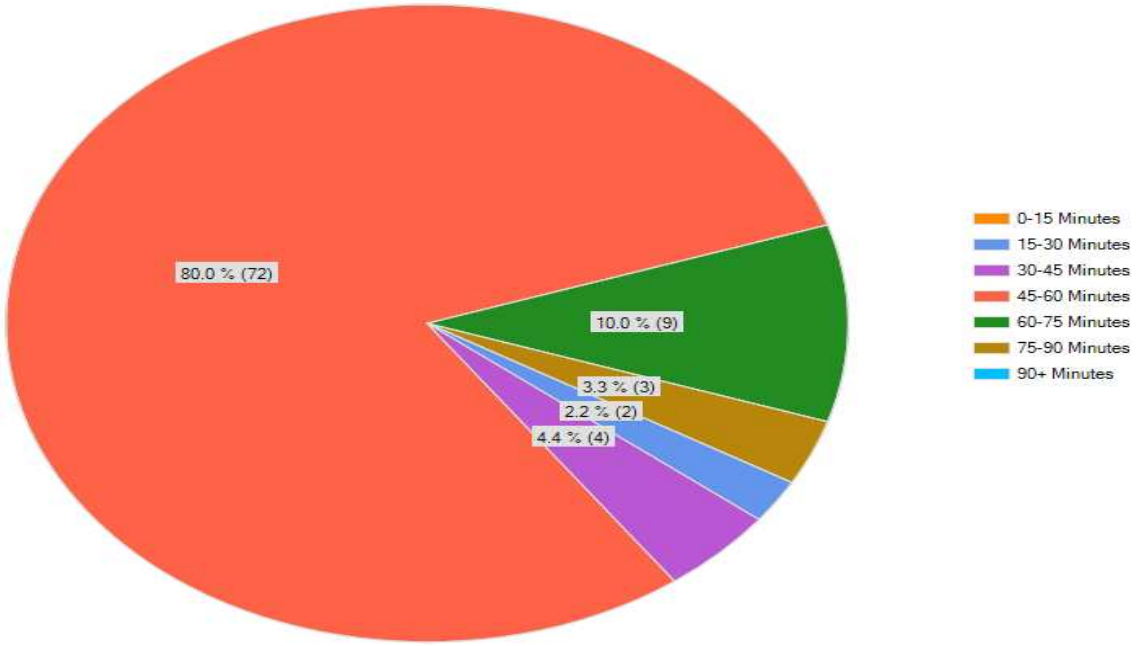


Figure B.17

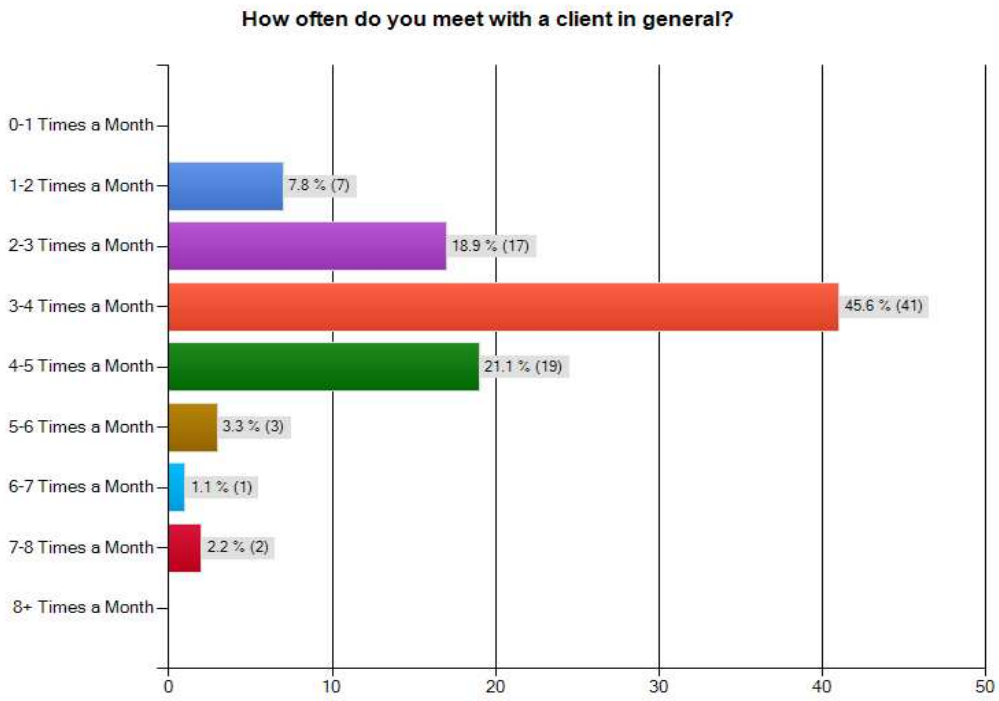


Figure B.18

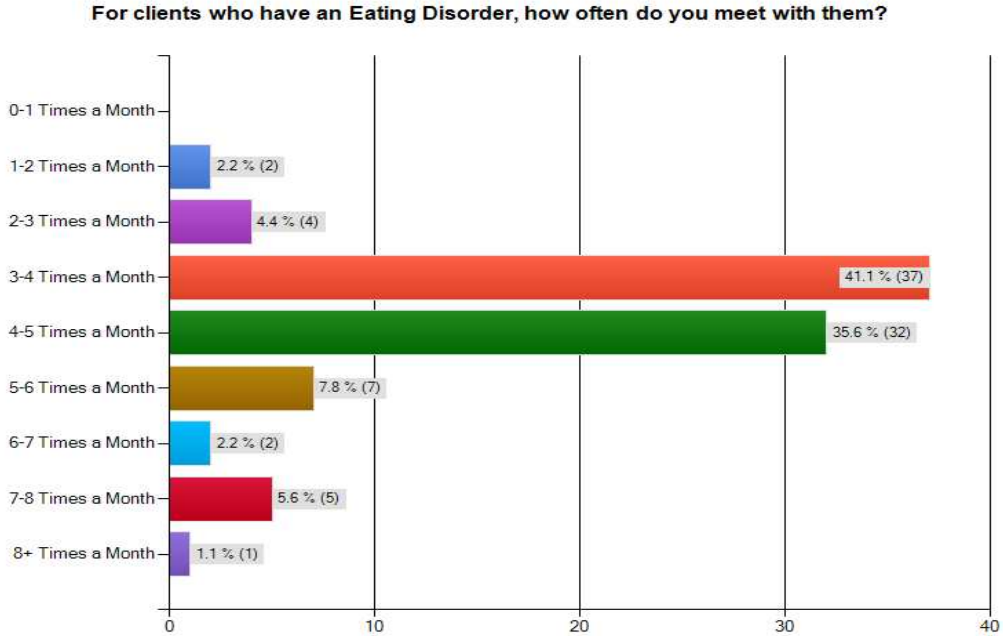


Figure B.19

On average, how long does a client in general remain in treatment?

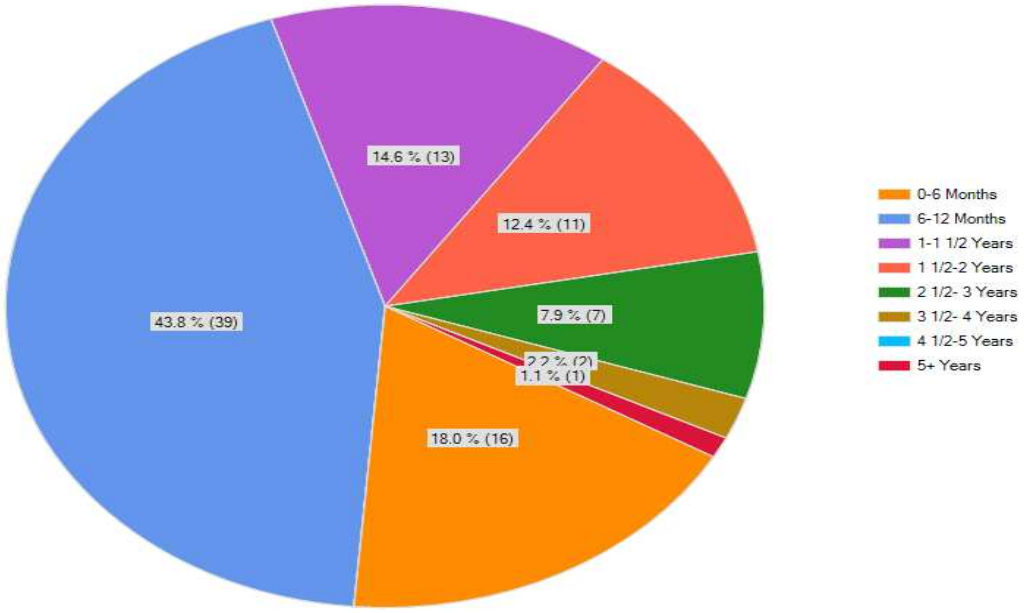


Figure B.20

On average, how long does a client who is suffering from an Eating Disorder remain in treatment?

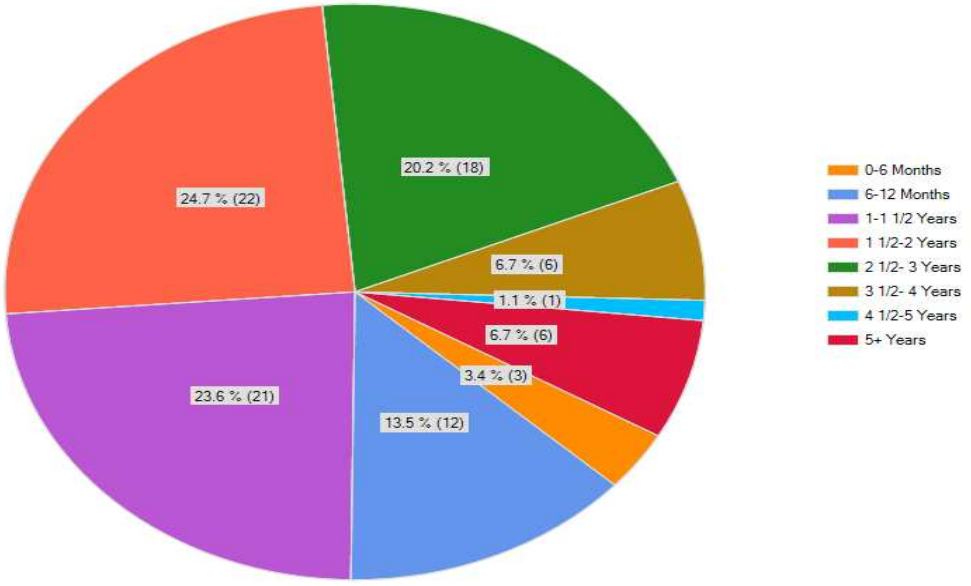


Figure B.21

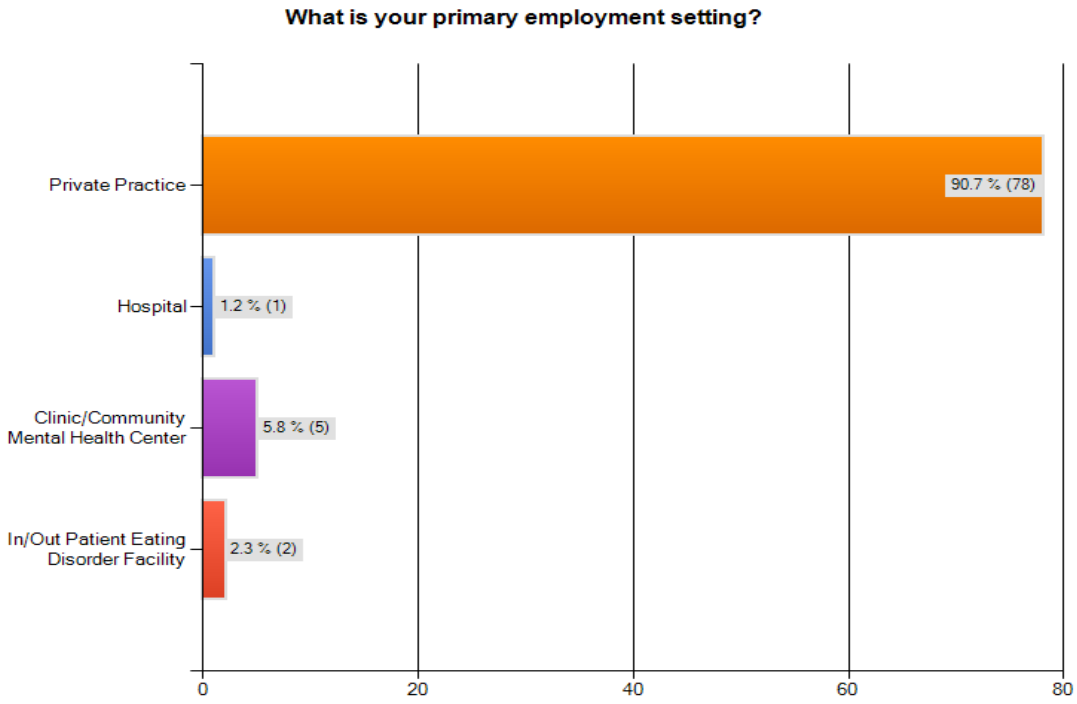


Figure B.22

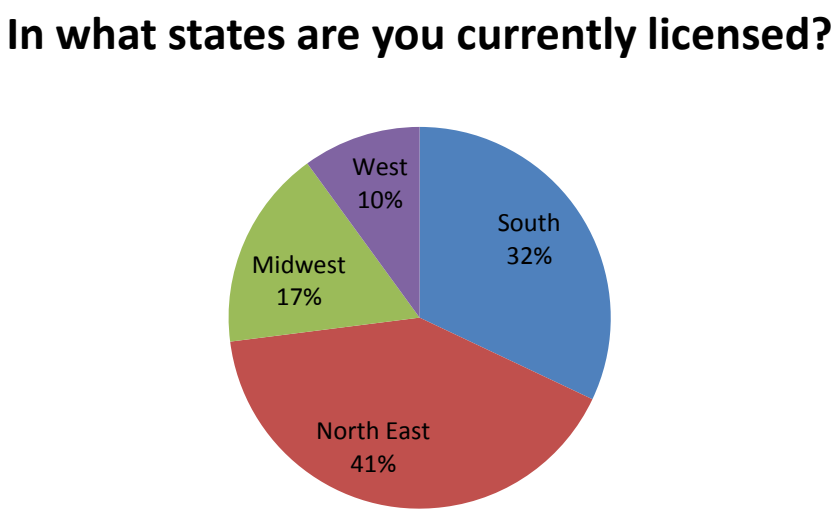


Figure B.23

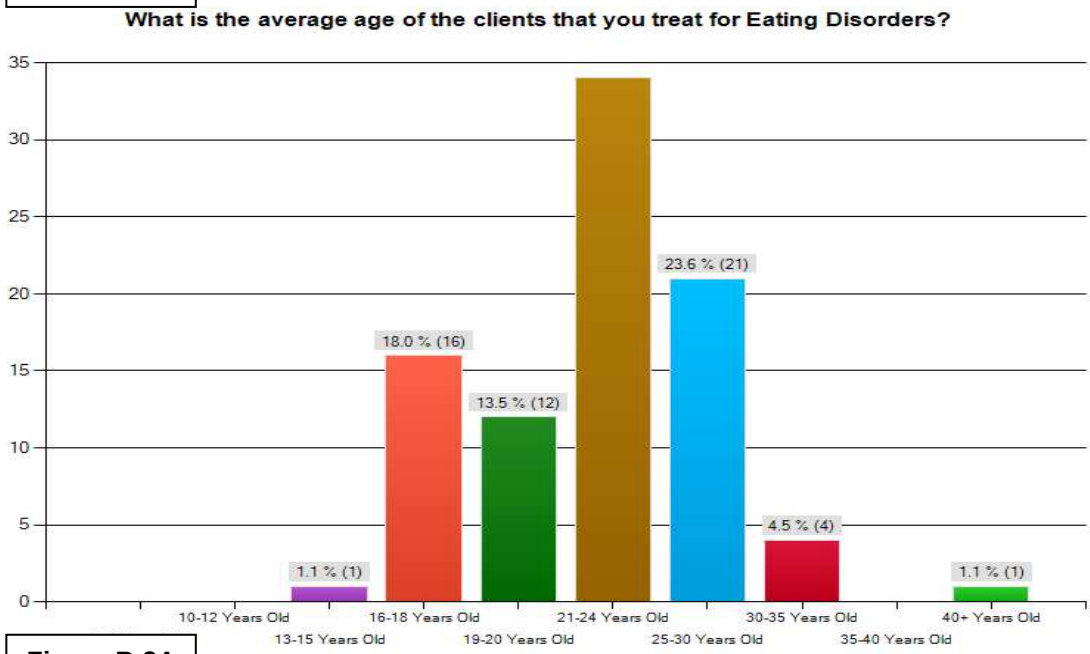


Figure B.24

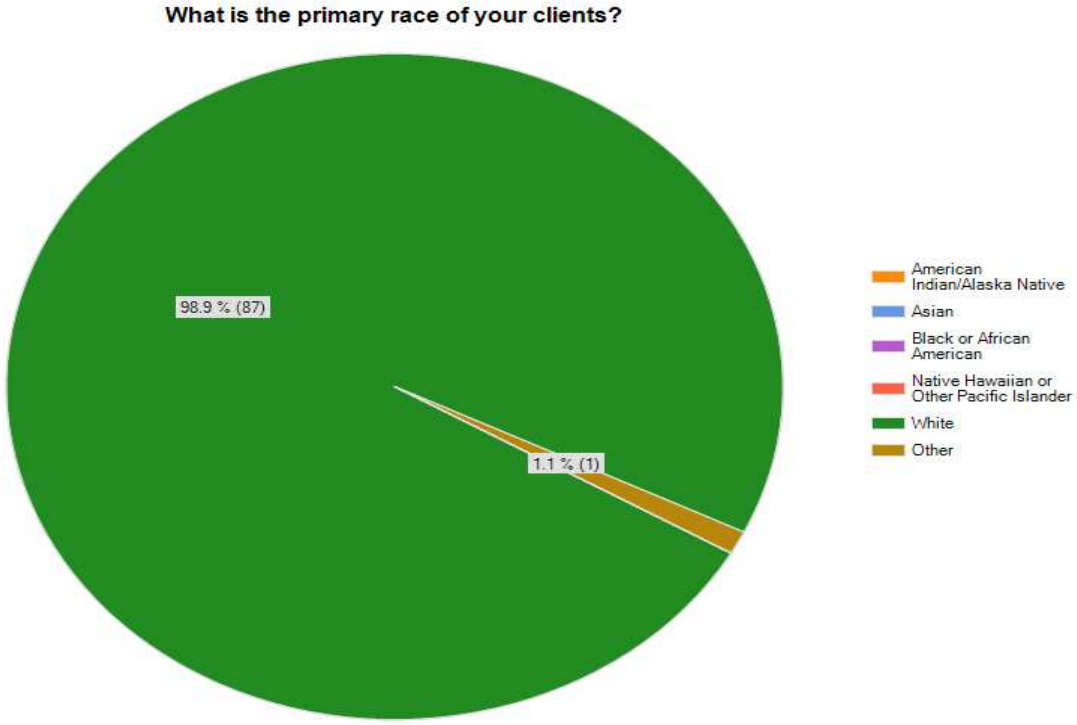


Figure B.25

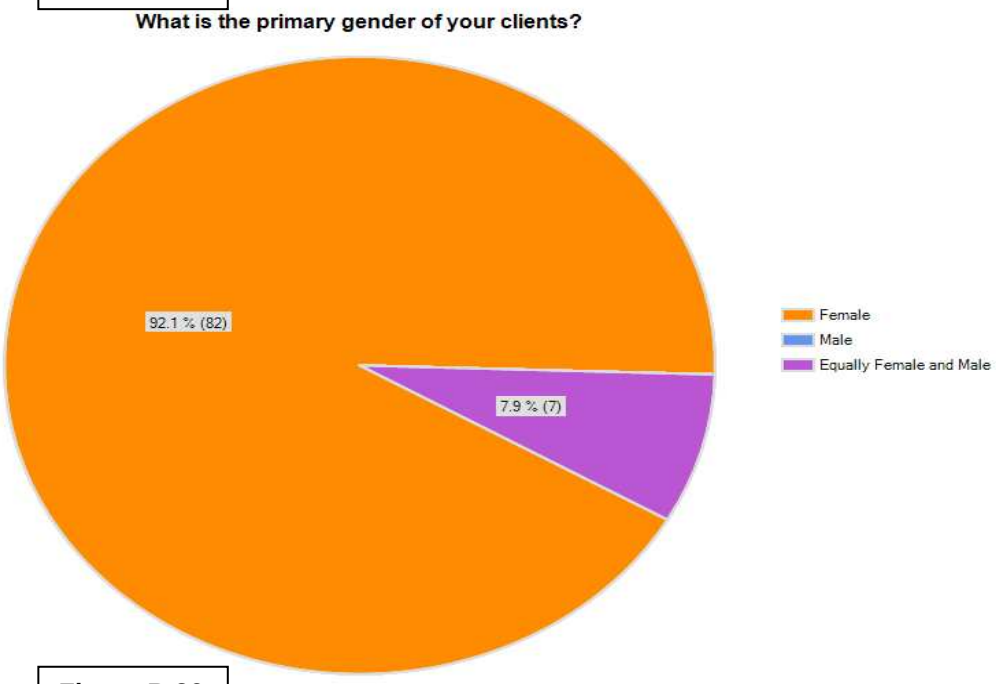


Figure B.26

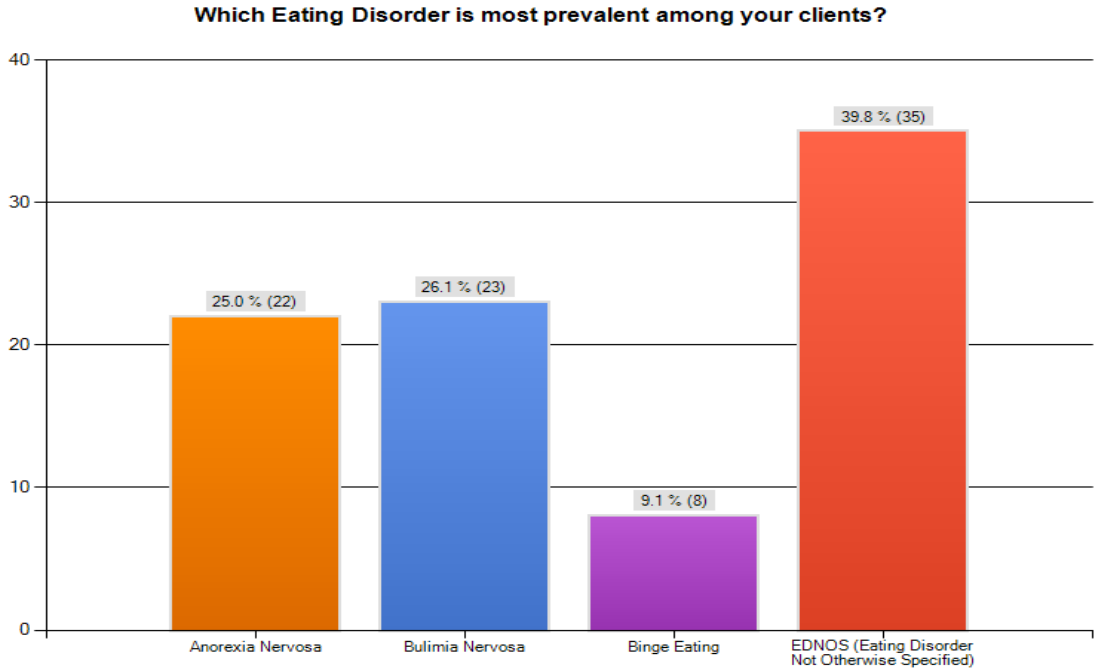


Figure B.27

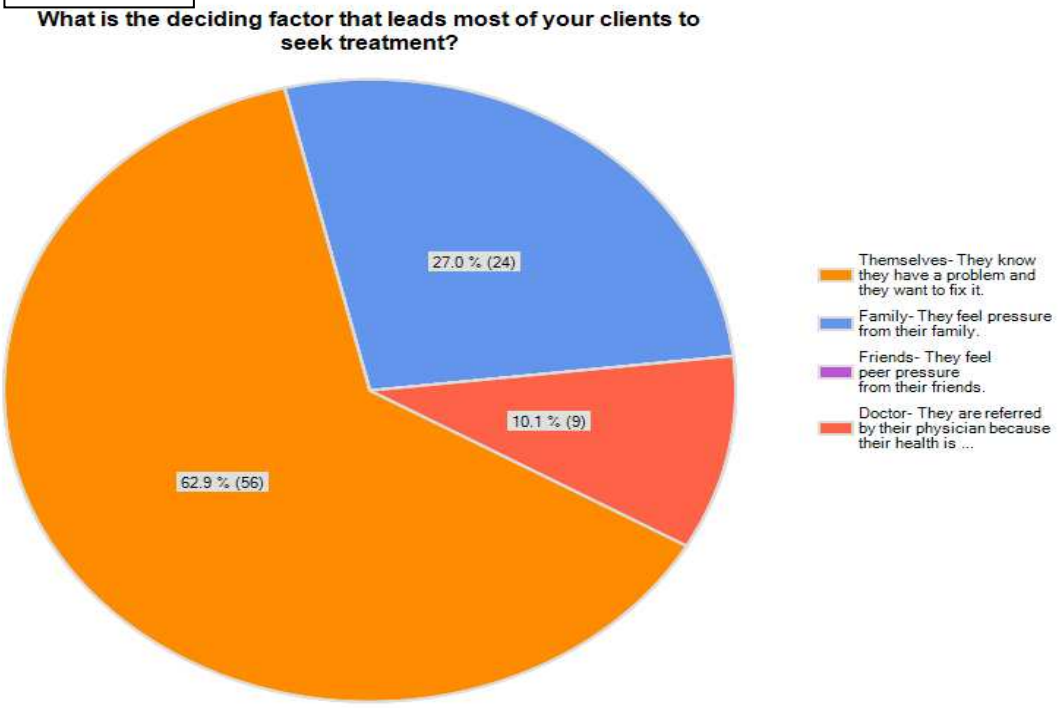


Figure B.28

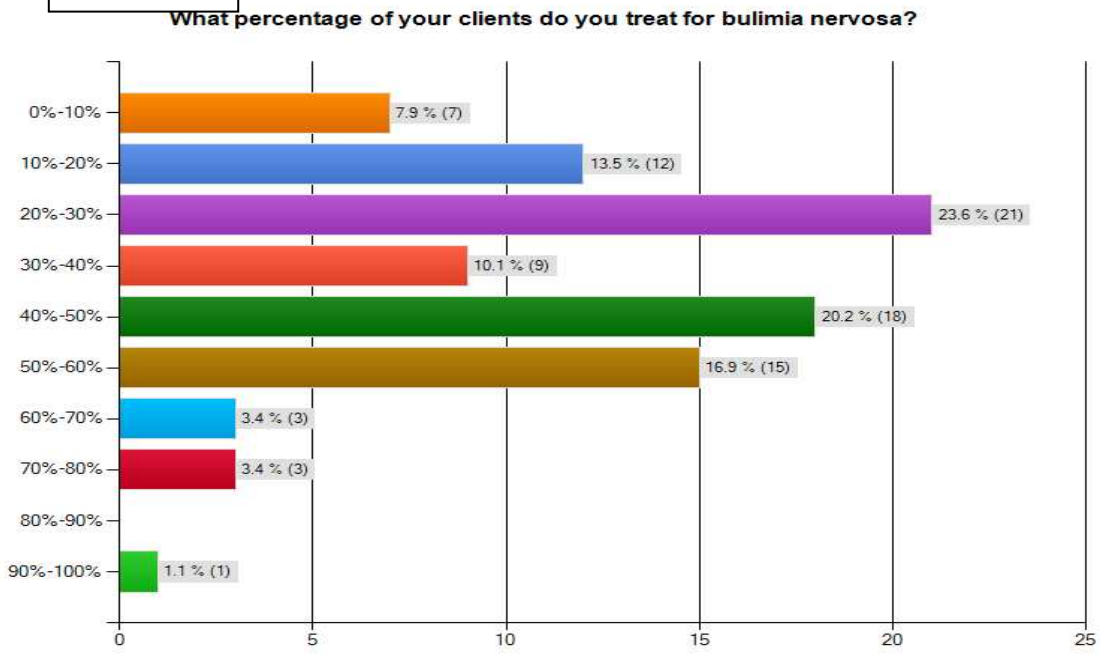


Figure B.29

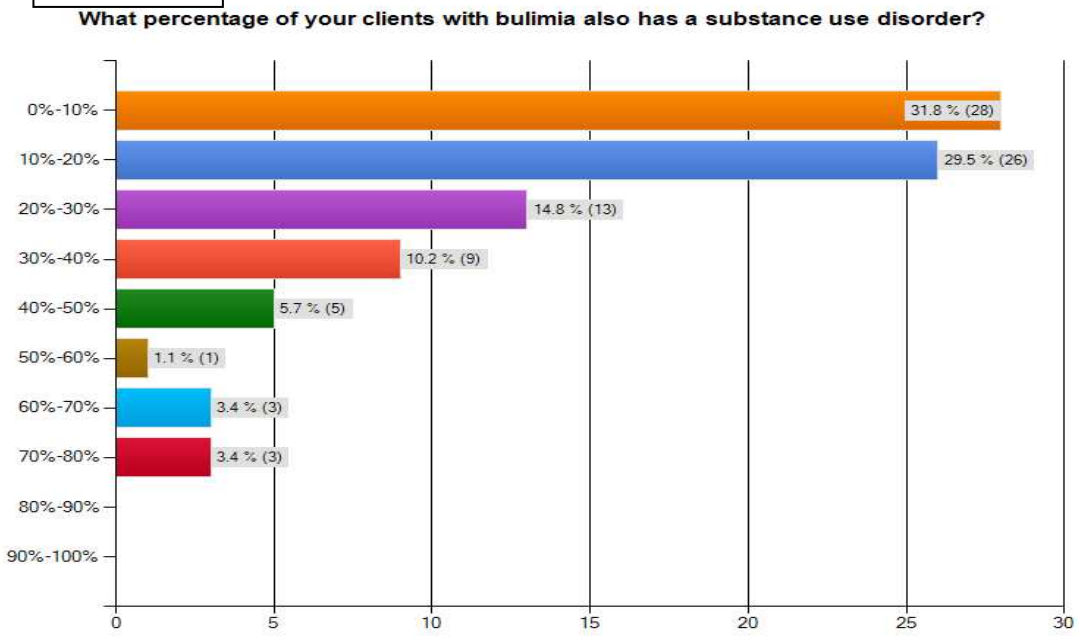


Figure B.30

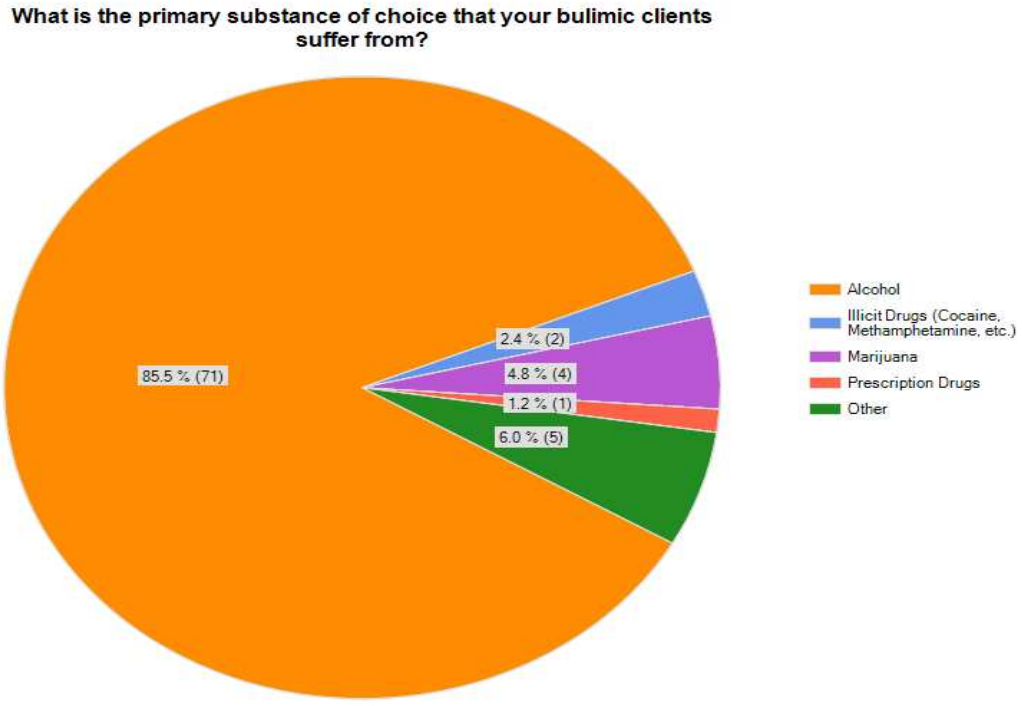


Figure B.31

What are the substances of choice if multiple substances are used? (Please check all that apply)

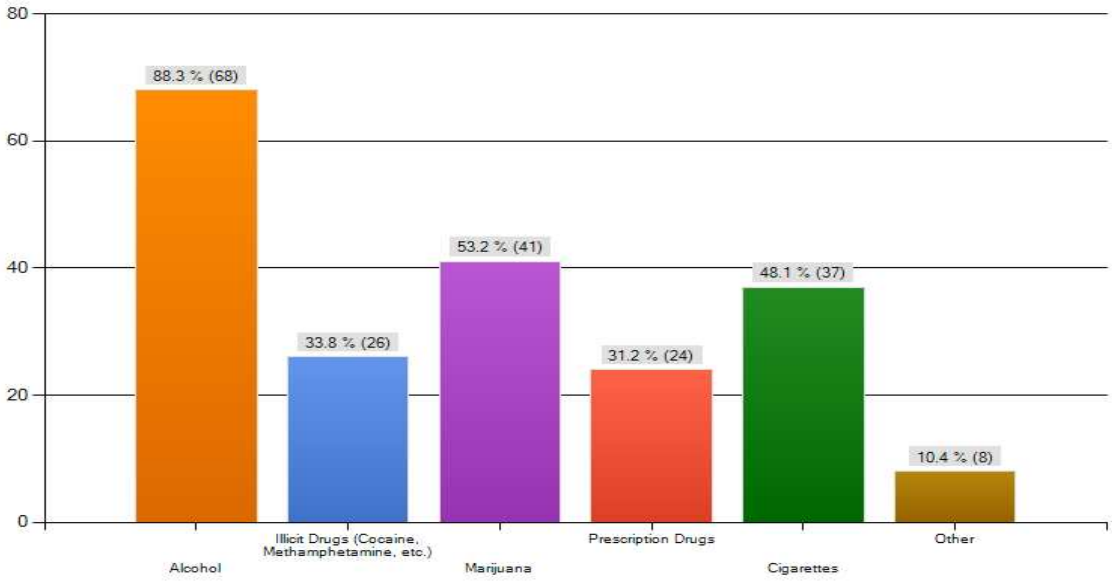


Figure B.32

When treating a client with bulimia nervosa, do you initially screen for Substance Use Disorder?

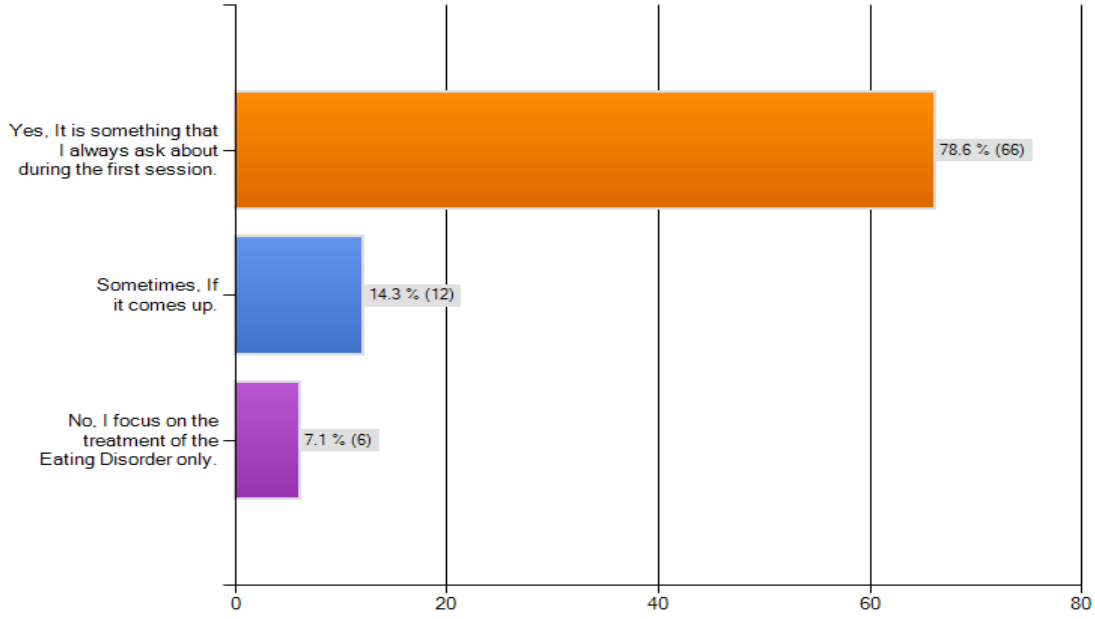


Figure B.33

How skilled are you in diagnosing and treating Substance Use Disorders?

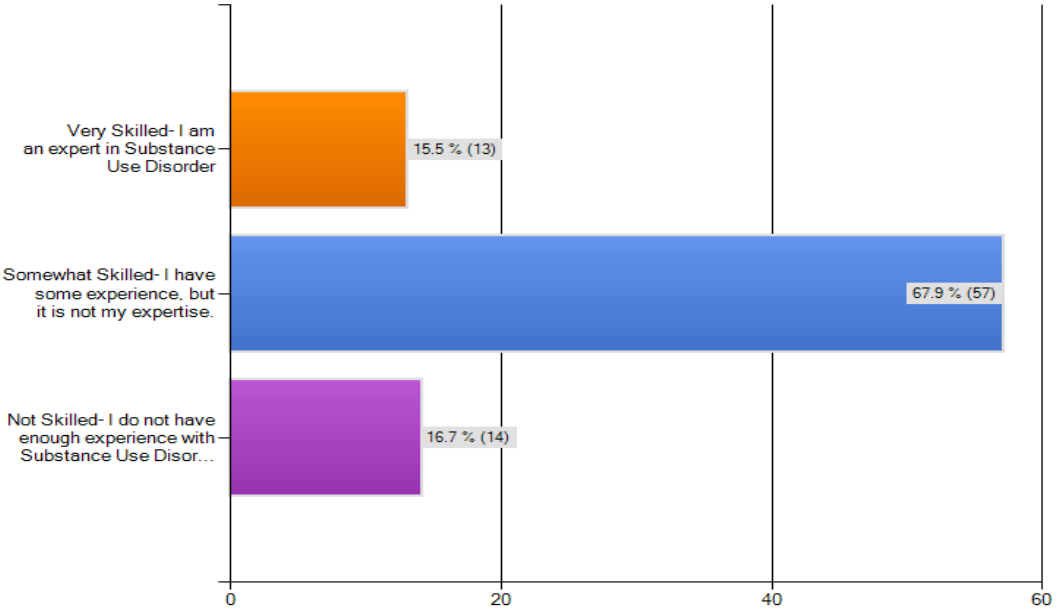


Figure B.34

If your client is suffering from bulimia and Substance Use Disorder, do you treat them for both?

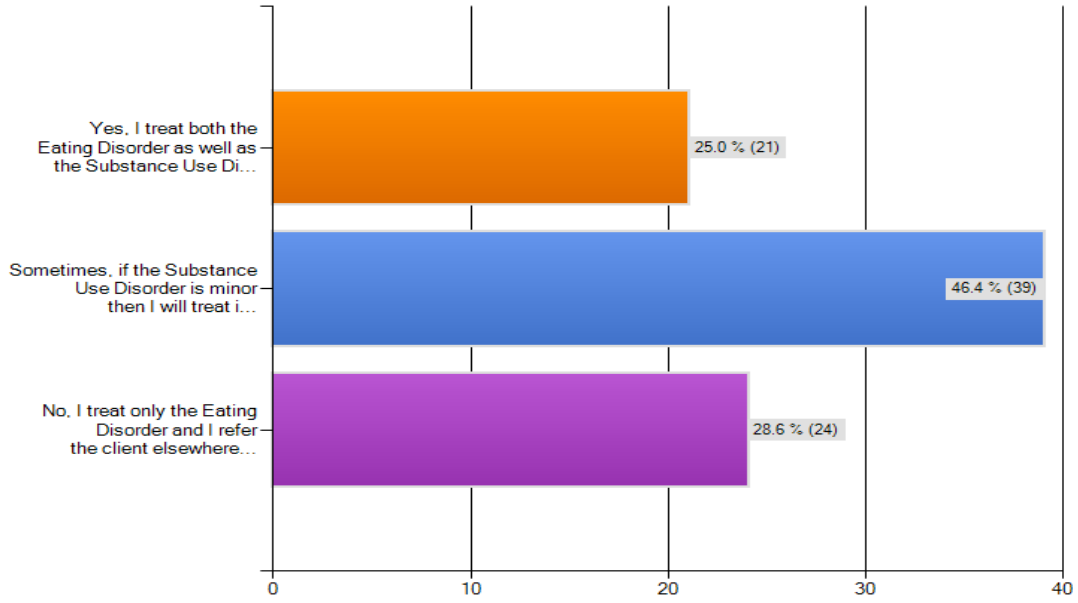


Figure B.35

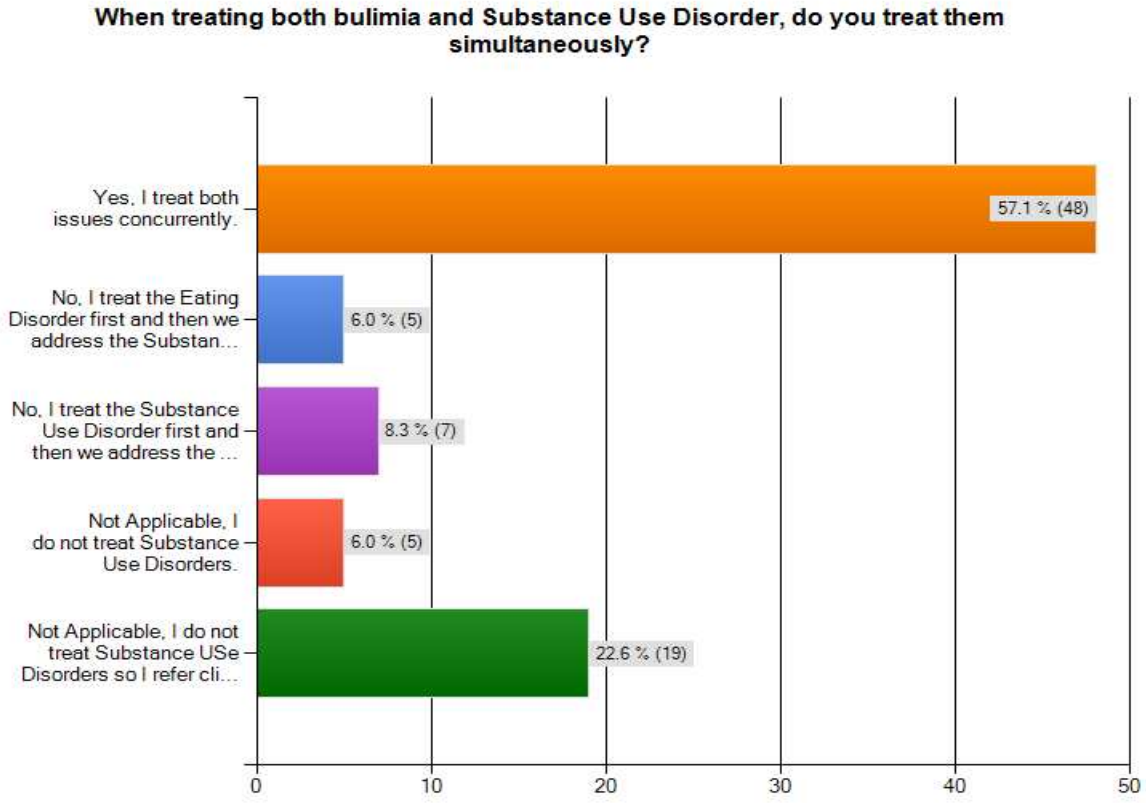


Figure B.36

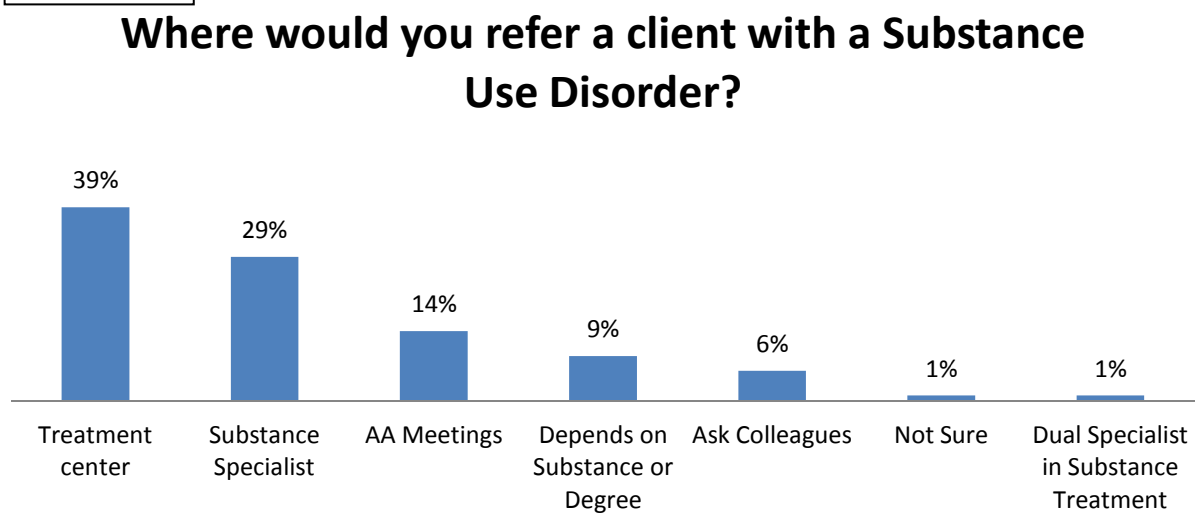


Figure B.37

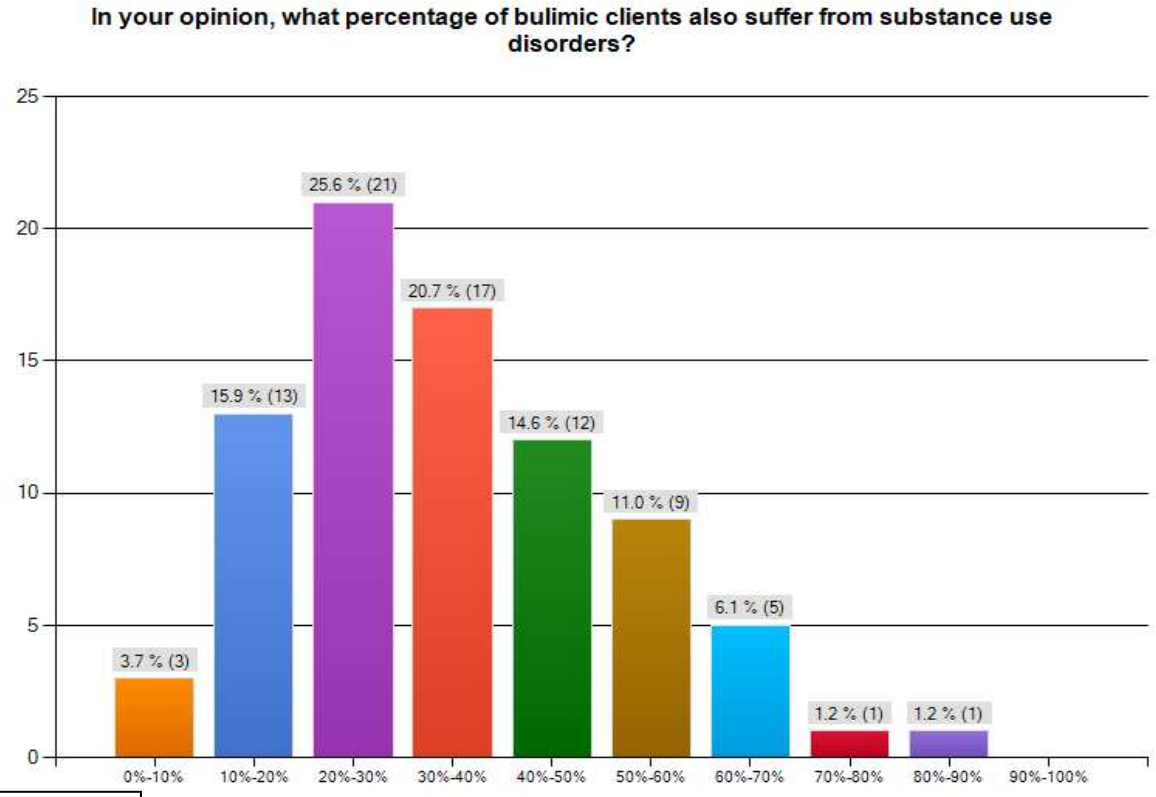


Figure B.38

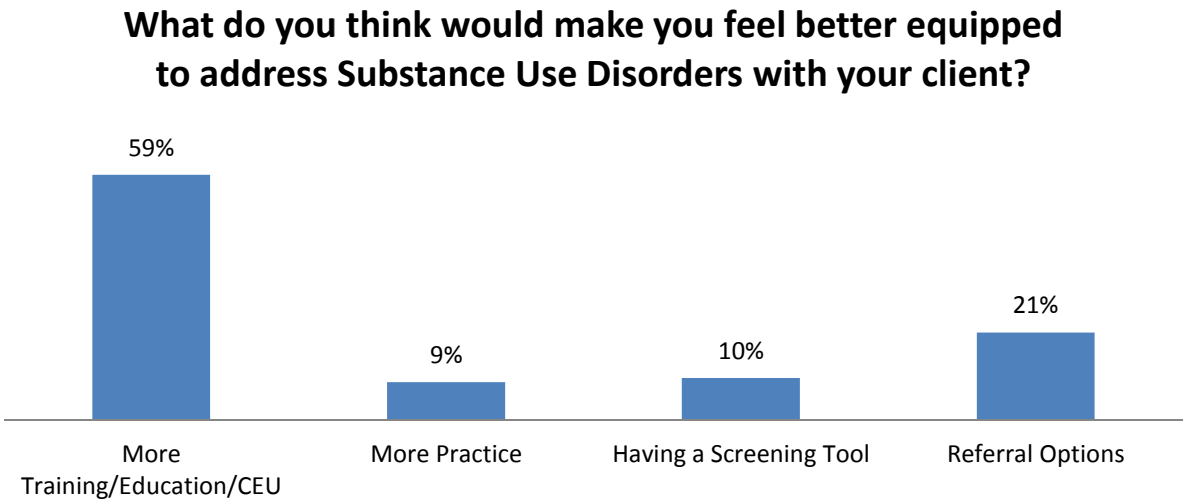


Figure B.39

What growing trends do you see with the treatment of Eating Disorders?

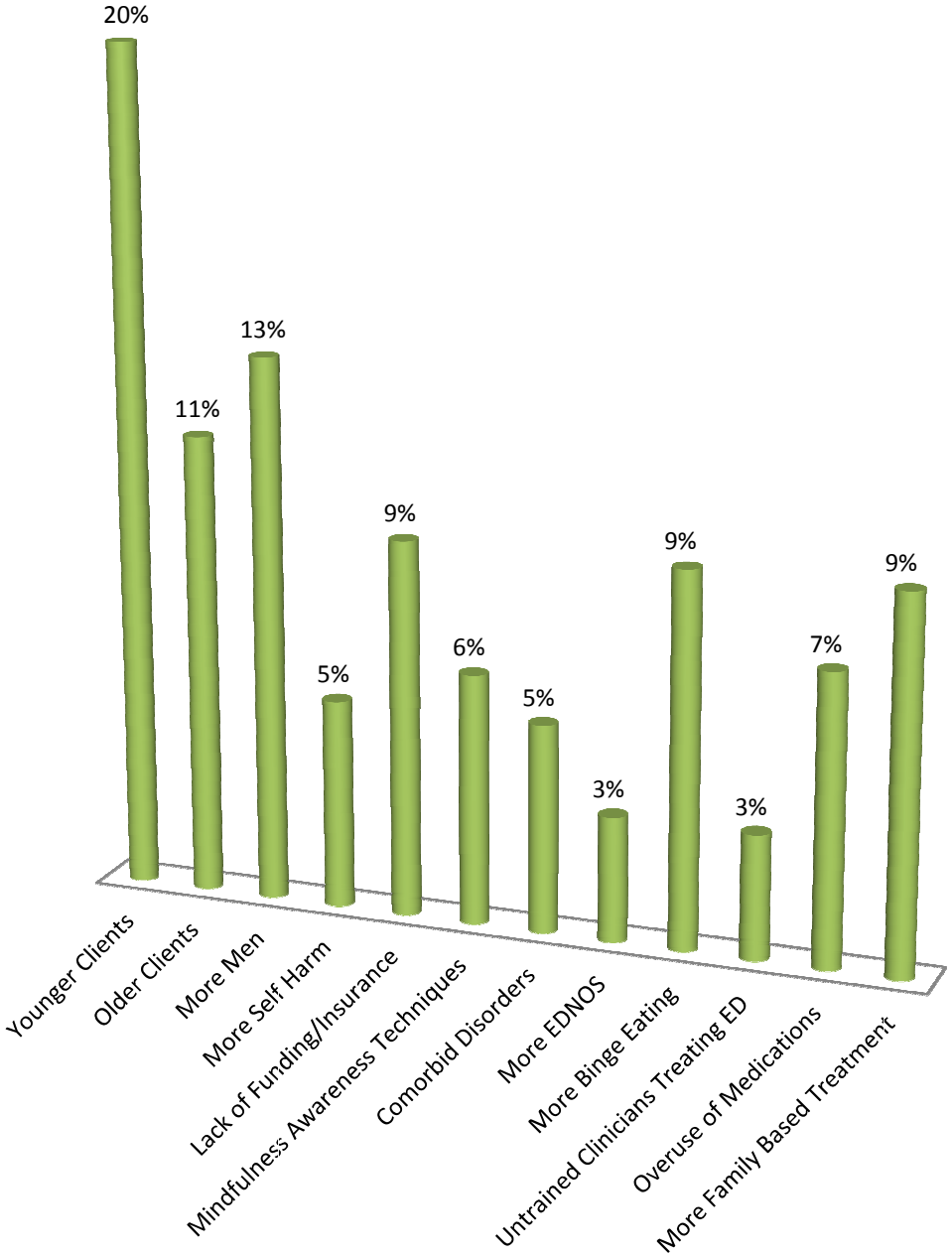
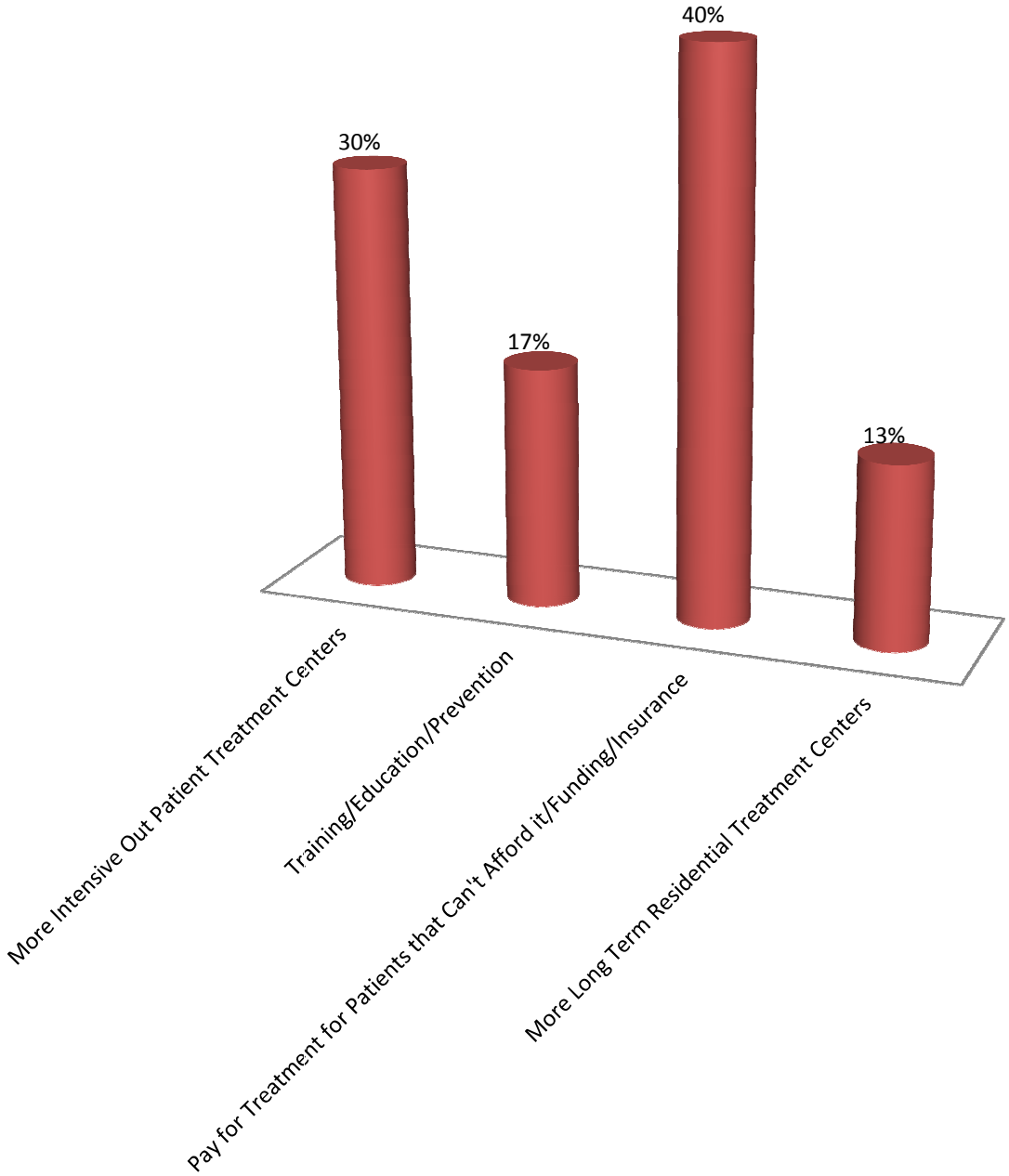


Figure B.40

If you had all of the money in the world to treat Eating Disorders, how would you spend it?



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BIOGRAPHICAL INFORMATION

Kara Cunningham graduated from Texas Christian University in 2005 with a Bachelor's degree in Fashion Merchandising and a General Business minor. Kara decided to go back to school to pursue a Master's degree in Social Work. During her graduate studies, Kara developed a strong desire to specialize in the field of Eating Disorders. Kara will complete her graduate studies in the spring of 2013 from the University of Texas at Arlington.