Identifying Eating Disorders in Patients with Chemical Dependency

Q: Exercise Bulimia? Please elaborate.
A: Well, instead of vomiting, the way they get rid of the calories is by burning it off with exercise. So, it’s kind of a slang term we use in the business; it is simply a way to compensate for the calories.

Q: Explain the Pleasure Principle.
A: That’s an old Sigmund Freud theory or recognition that human beings don’t like pain. So anywhere on the spectrum from complete pain to complete pleasure, you would always be moving away from pain and towards pleasure—towards feeling good. So, the example I used is someone who would binge and purge. If they had a stressful, painful, emotional day and they knew that they could feel better by using this behavior then after a while by repetition, they have programmed this behavior, sometimes even unconsciously. Sometimes people, when they first come into treatment, don’t even know why they are using these behaviors. Then when you start asking these questions they go, “Oh yeah, they make me feel better!” and then they start to get it that they have to stop using these behaviors that they have learned over time that make them feel better, even if it is unconscious.

Most of us, if we have a stressful day, will look towards something to make us feel better; for the people with eating disorders, it’s the eating disorder behavior that does that. So they are moving from a level of discomfort to a level of feeling better. If you look consistently at human behavior, that is the way we all tend to operate.

Q: What’s the difference between chemical dependency and an eating disorder?
A: After about 6 months of treating people with an eating disorder I came to realize that what I had heard over and over again—that the difference between an eating disorder and a drug addiction was that you don’t have to live with your drugs of abuse, but you do have to live with food. As I presented this to my addiction colleagues, I wanted to put it into an explanation that maybe they could realize how challenging it is for people with eating disorders to get out of a structured setting (inpatient treatment) and continue on the road to recovery. So basically, the analogy is taking someone coming out of a 28 day alcohol rehab . . .
A: (continued) . . . and telling them they would have to drink 2 shots of vodka six times a day, but there was no control over it—a gallon of vodka could be sitting right there on the table and they were not supposed to touch it except for the six times a day scheduled. This puts into perspective what the eating disorders person has to face. During inpatient treatment we have a meal plan where the eating disorder patients have to eat 3 meals and 3 snacks a day. When they transition to outpatient they are given a meal plan from their nutritionist. They have to eat what is on their meal plan, no more and no less, and measure it correctly, not under or over measure it, which they learn during their treatment process, to be able to stay on the recovery course. Yet there is always food around.

Q: Is an eating disorder an addiction?

A: That is a good question and I don’t know the answer to that. I think there is a lot of crossover, no doubt about it. Coming from an addiction background into eating disorders, I see many similarities. Again as I said, I believe people become addicted to behaviors because they are so soothing to them; just like the alcoholic who realizes that the drink or two at the end of the workday feels good, before the disease evolution really takes over and it is not necessarily about feeling better. A lot of the people we see are doing the behaviors to feel better.

Q: If a patient has a chemical addiction and an eating disorder, which do you treat first?

A: I was trained that there is no primary and secondary; you have both disorders and they interact with each other, they are bi-directional and one will have an effect on the other. I don’t necessarily believe that one is any more important than the other or primary (sometimes insurance companies will want to list one over the other). The truth is you have 2 diseases and you have to address them both aggressively if you want to get the person healthy. It is no different than if you have heart disease and lung disease; you wouldn’t just treat the heart disease and leave the lung alone since the lung is connected to the heart, it obviously is going to have an impact on heart health—so you treat the whole person and if you do that, it’s ideal.

Q: In your lecture you said that you didn’t know what the body could tolerate until you treated eating disorder patients. Please explain.

A: Well, just what you will see with people living with a heart rate of 35 or 40 which really should not be compatible with being up and around and walking. You see the potassium levels at 2 which I am told is not compatible with life, but the body is trying to keep itself in balance, in homeostasis, and it will adapt to that as best as it can. That’s when someone is really vulnerable to cardiac death, of course. Temperatures of 96 or 97 and still walking, talking, and working — so it’s really what you’ll see in the abnormalities that you use to measure normal in the human being. If these changes happened from one day to the next, the person would be very sick, but since it happens very gradually over days and days, over months and years, the body adapts to it and just keeps itself living. It is amazing.