

Letter to the editor: Best practices in treating substance use and eating disorders

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In the clinical world, mental health professionals must be ready to treat clients with more than one issue. According to research, approximately 40% of adults with substance use disorders also have at least one other mental illness (Hans et al., 2017). A meta-analysis literature review of 43 articles conducted in 2019 by researchers Anees et al. (2019) identified that about one in five individuals with an eating disorder will also develop a substance use disorder during their lifetime. Research conducted by Devoe, Dimitropoulos et al., (2021) identified that 16% of their participants had both substance use and anorexia nervosa. Clients with eating disorders should be regularly screened for substance use disorder for early diagnosis purposes (Anees et al., 2019).

The Diagnostic Statistical Manual (DSM) 5<sup>th</sup> edition classifies a substance use disorder as an individual continually using a substance despite problems associated with its use (Diagnostic Statistical Manual 5<sup>th</sup>, 2013). The DSM 5<sup>th</sup> edition classifies eating disorders as being associated with an inability to regulate self-control and reward when it comes to food intake. It is also noted that the symptoms of eating related disorders, such as anorexia nervosa, bulimia and binge eating disorders, are like the characteristics commonly seen in substance use disorders (DSM 5<sup>th</sup>, 2013). These characteristics include cravings, compulsivity and high anxiety (Butler & Heimberg, 2020). With this comorbidity connection established between substance use disorders and eating disorders in not only the DSM 5<sup>th</sup> edition, but in current published research, clinicians need to be aware of evidence based best practices when it comes to choosing treatment modalities.

When clinicians decide on what treatment modality to utilize with each individual client, they often focus on evidence based best practices. Evidence based best practices are treatment methods that have been found to be statically significant to demonstrate change (Newham & Page, 2010). The tricky part is that evidence based best practices are extremely different when treating eating disorders and substance-use issues. While many substance-use counselors encourage the client to avoid being near the substance of choice, this same counselor must encourage the client to be comfortable around the other substance which is causing stress in their lives...food (Butler & Heimberg, 2020). Clients with eating disorders often have intense fear and anxiety surrounding their relationship with food, this fear comes from a client connecting food to a loss of control or appearing disgusting (Cardi et al, 2019). When it comes to eating disorders, exposure response prevention therapy (ERP) is a commonly used approach.

ERP therapy is gradual exposure to foods which cause a client fear or anxiety (Reilly et al., 2017). This gradual exposure is designed to extinguish the behavior of avoiding the foods and encourage the client to consume them as needed and without fear of negative consequences (Reilly, 2017). First a client creates a food hierarchy with their clinician or dietitian then creates different levels of distress and gradually incorporates those foods back into the client diet (Farrell et al., 2019). ERP desensitizes the response in the brain to food, but also provides variety while challenging food fears and rules (Butler & Heimberg, 2020).

Evidence based best practices for substance abuse treatment are very different from the aforementioned best practices for treating eating disorders. Some of the commonly used evidence based best treatment practices include Cognitive Behavioral Therapy and Solution Focused Therapy Relapse prevention (Lewis, 2023). While these three treatment methods are different in their approaches, they all focus on the client avoiding ingesting the substance (alcohol, heroin, cocaine, marijuana ect) and refraining from engaging with people, places and things that spark their cravings. This is the opposite of eating disorder treatment because, in laymans terms, the client needs to eat food to survive. The counselor must work with the client to directly eat the foods they are fearful of while showing them their fear of negative consequences are not substantiated. With substance abuse, the counselor is going to strongly encourage the client to stay away from their substance of choice all together.

A common challenge in treating a client with eating disorder and substance abuse issues is the difficulty of tracking progress. A counselor is able to track a client's sobriety with urinalysis results. The main method to track a client's eating habits is self-reporting. While self-reporting has its strengths, it also has many disadvantages. These disadvantages include time pressure, consistency of motivation to make self-reports, and potential issues with credibility and accuracy (Paulhus & Vazire, 2007).

Harm reduction and Motivational Interviewing are two evidence based best practices which counselors can use with both types of clients. Research conducted by Doumas et al., (2018) identified addiction counselors view motivational interviewing as a non-judgmental, client-centered and directive clinical approach to exploring a client's ambivalence towards the recovery process. A main component of motivational interviewing is the counselors offering feedback and the clients substance use and potential risks (Doumas et al., 2018). These components are also extremely helpful when working with clients with eating disorders. In a study conducted by Cassin et al., (2008), it was found that a larger number of women with binge-eating disorders abstained from bingeing when motivational interviewing was part of their treatment plan.

Harm reduction is a newer concept that is often met with controversy. Practicing harm reduction means the clinical staff is supportive of their client reducing the negative health, emotional and physical consequences of engaging in substance use without completely abstaining from it (Taylor et al., 2021). Harm reduction approaches are designed for counselors to guide clients in reducing the frequency and intensity of behaviors which are negatively

impacting their lives (Yager, 2021). It offers an alternative to work with a client who may not be ready or able to completely cut the substance use out of their life yet. An example of this is giving clients clean needles for injection. While they are still using a harmful substance, they are cutting down on their chances of contracting a life-threatening blood-borne illness which often happens when sharing needles (Bianchi., et al, 2020). When working with clients seeking help for eating disorders, harm reduction can be a tool used for a client who is struggling with meeting body weight goals or who is having difficulty stopping bingeing and purging behaviors all together (Yager, 2021). Being able to follow harm reduction techniques and offer these clients encouraging words of motivation may help them move towards the goals at their own pace.

When talking about harm reduction with clients, there are ethical concerns which are raised in both substance-use and eating disorder professional fields. In the substance-use clinical field, harm reduction sometimes is seen as ethically challenging as a counselor is allowing a client to continue engaging in dangerous drug or alcohol use behaviors while encouraging harm reduction practices to be used (Bianchi et al., 2020). The same goes for counselors working with clients engaging in eating disorder behaviors. These behaviors of not meeting minimum healthy body weight goals or purging are life threatening to a client. When the counselor uses harm reduction techniques, they are not forcing a client to gain weight or stop purging (Bianchi).

For counselors to be able to properly support a client with a substance-use disorder as well as an eating disorder, they must be properly trained in evidence based best practices designed to support these diagnoses.

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