#  Understanding Eating Pathology in Substance Using Populations

# Supplemental module on body image, dieting, and eating pathology.

# Created for the University of Nevada, Reno, Pacific Southwest Rural Opioid Technical Assistance (ROTA-R) Project – Curriculum Infusion

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**Title:**

- Body Image, Weight Concerns & Dieting: Understanding Eating Pathology in Substance Using Populations

**Purpose:**

- The overarching purpose of this project is to develop an approximately 1-hour academic curriculum on eating pathology in individuals struggling with substance use. This includes information on body image distortion/dissatisfaction, weight concerns, and dieting.

- This course supplement is intended for a general university/college audience that does not have a comprehensive background in psychology or mental health. The goal is for it to be easily incorporated into any general university-level course in which an instructor wants to highlight comorbidity between substance use and eating pathology.

**Course Objectives:**

After completing this module, participants should be able to:

- Identify some of the primary, body-image based diagnosable eating disorders (including anorexia nervosa, bulimia nervosa, binge eating disorder) and substance use disorders.

- Describe comorbid eating pathology and substance use (for example, prevalence data and common clinical presentations).

- Define body image (including its components) and body image disturbance. Explain how it relates to substance use.

- Describe how body image develops from a biopsychosocial model of eating pathology.

- Identify some basic assessment and treatment targets related to comorbid eating pathology and substance use.

**Presentation Outline/Sections**

 Introduction

 Section 1: Eating & Substance Use Disorders

 Symptoms, diagnostic features, overlap, lethality

 Section 2: Body Image & Weight Concerns

 Definition, associated substance use

 Section 3: Development of Eating Pathology

 Biopsychosocial model, promote substance use

 Section 4: Assessment and Treatment

 Primary targets for intervention

 Conclusion

**Materials Created for this Module**

- Course Syllabus

- PowerPoint Slide Deck (\*with comments/suggestions for the presenter to assist with delivery of course material)

- PowerPoint Recording of Dr. Cortney Warren teaching this course

- Guided Class Activity and Discussion Questions

- Sample Quiz/Test Questions

- Reference List

- Recommended Resources

**Suggestions for Use**

The contents of this course can be used as a whole or in parts. Specific content can be easily cut from the presentation by removing the associated slide. For example, if teaching a group of students who already knows basic information on eating disorder diagnoses, those slides can be removed and the remaining content in the module can be taught.

Discussion questions can be added to highlight the most useful and relevant topics for a given student population.

**COURSE SYLLABUS**

\*Note: text in normal font indicates the basic purpose and topic of a given slide. Text provided in italics indicates possible verbiage an instructor can use during instruction.

**Mini-Module/Video 1**

**Introduction to Curriculum**

**- SLIDE 1: Cover page/Introduction**

o Highlight the relationship between nutrition, exercise, and mental health (transition from previous modules in this series, if applicable)

*Suggested Verbiage: Welcome to Body Image, Weight Concerns, & Dieting: Understanding eating pathology in substance using populations. I want to introduce this module by saying that our psychological relationship to our physical body and outward appearance can strongly influence our health. It can affect our mental health, our physical health, and our health-related behaviors and choices. From that basic framework, the overarching goal of this module is to give you a better understanding of how eating pathology (like body shape and weight concerns) can influence and interact with substance use in meaningful ways.*

**- SLIDE 2. Introduction and Disclaimer**

o Dr. Cortney Warren, PhD, ABPP

 ▪ Board Certified Clinical Psychologist

 ▪ Eating disorders, addictions, honesty, multicultural competency

o No conflicts of interest

 ▪ Rural Opioid Technical Assistance (ROTA) Project

o Content can be difficult

 ▪ Call or text 988 (Suicide & Crisis Lifeline)

 ▪ Contact treatment provider

 ▪ Seek support

*Suggested Verbiage: Before we begin, I want to briefly introduce this content. It was created by Dr. Cortney Warren, a board certified clinical psychologist. As a psychologist, she specializes in understanding mental health and illness. Her areas of expertise are eating disorders, addictions, honesty, and multicultural competency in psychology. She had no conflicts of interest to disclose other than I am getting paid from a grant to create this course.*

*I want to tell you up front that the content of this module might be difficult for some of you. We are going to be reviewing some information and seeing some images of people struggling with some serious mental health issues. If you find it triggering to you, please know you can call or text 988, contact a treatment provider, or seek some other type of support.*

**- SLIDE 3. Classroom Activity**

o Start critically thinking about the topic.

*Suggested Verbiage: I want to start our time together by doing a brief experiential activity to get us thinking more deeply about this topic. I want you to picture a person who is really struggling with an eating disorder. What do they look like? What are their symptoms? For example, what are some things that the person might think, feel, or experience in their life because of their eating disorder?*

*Now, I want you to picture a person who is really struggling abusing substances. What do they look like? What are their symptoms? What does this person think, feel or experience because of their struggle with substances?*

*Now, I want you to think about the images you’re picturing. What’s different about your descriptions? How do people with eating disorders look compared to people struggling with substances? What’s similar? Does your image of what someone with an eating disorder looks like mirror your description of what someone with a substance use problem look like?*

*I want you to keep these images and descriptions in in mind as we go through this presentation because it’s going to be helpful as a starting point to explore this content--how eating disorders and substance use overlap.*

\*NOTE: an in-class and writing prompt were also created for this activity. If you want to make it more interactive, see the attached description for a more detailed description.

**- SLIDE 4: Importance of This Topic.**

o Historically conceptualized separately

 ▪ Different populations, development, symptom sets

 ▪ Rarely assessed or treated together

o Increasing evidence of overlap

 ▪ Subclinical symptoms commonplace

 • Eating pathology can motivate drug use

 • Drug use can affect eating and body image

 ▪ Clinical

 • Highly comorbid

 • Higher impairment and mortality risk

o Must understand overlap to prevent, assess, and treat

*Suggested Verbiage: As you think about what someone struggling with substance use and eating pathology might look like, I want to cut to the chase and highlight for you why we are talking about this today. Why is this topic important? Why does this matter?*

*Historically, eating disorders and substance use have been conceptualized largely separately. They were seen by mental health professionals as distinct populations with very different developmental trajectories and symptom sets—which you may have noticed in your answers to our opening activity. For example, eating disorders were generally perceived to influence young, White girls from affluent socioeconomic backgrounds who struggled with weight and shape concerns. Conversely, problematic substance use was thought to be most problematic for people of any age, but mainly adult men, perhaps who were homeless and struggled to maintain relationships, jobs, and family connection. Independent from educational background, they continued to use despite harmful life consequences.*

*As a result, eating pathology and substance use were rarely assessed together. For example, people with eating disorders were not screened for substance use in a comprehensive way; and people in substance use treatment rarely assessed for various forms of eating pathology, like body dissatisfaction or weight concerns. As such, not surprisingly, very few treatment facilities treat both simultaneously. That continues to be true today. Yet, there is increasing evidence of overlap. Recent national estimates suggest very high comorbidity rates! And, when someone struggles with body eating pathology and substance use, they tend to be more impaired and are at increased risk for premature death. So, we must understand the overlap between eating pathology and substance use to prevent, assess, and treat them—which is why this topic is so important. So, we must understand the overlap between eating pathology and substance use to prevent, assess, and treat them—which is why this topic is so important.*

**- SLIDE 5: Course Outline.**

**o Section 1: Eating & Substance Use Disorders**

 ▪ Symptoms, diagnostic features, overlap, lethality

**o Section 2: Body Image & Weight Concerns**

 ▪ Definition, associated substance use

**o Section 3: Development of Eating Pathology**

 ▪ Biopsychosocial model, promote substance use

**o Section 4: Assessment and Treatment**

 ▪ Primary targets for intervention

*Suggested Verbiage: This material is divided into 4 main sections. In section 1, we’re going to delve into eating pathology and substance use. This section really sets the stage for this module by describing these constructs. I’ll describe the symptoms and diagnostic features of eating and substance use disorders. I’ll also describe how they may overlap in their clinical presentation—how people look who are struggling with both—and their lethality.*

*In section 2, we’re going to explore body image and weight concerns. We’ll define these constructs and how and why they’re associated with both eating pathology and substance use.*

*In section 3, we’re going to focus on the development of eating pathology. I’ll review the biopsychosocial model and talk about some of the cultural values and norms that promote eating pathology while fueling substance use.*

*Finally, we’ll focus on assessment and treatment. While only qualified mental health professionals can really address and treat these symptoms, I’ll discuss some general recommendations when working with someone who presents with these symptoms, focusing on the primary targets that are necessary to address in healing.*

**Mini-Module/Video 2**

Section 1: Eating & Substance Use Disorders

**- SLIDE 1: Cover page/Introduction**

o Eating pathology

 ▪ Disorders characterized by disturbance of attitudes and behaviors related to food and eating

 • Weight & shape concerns

 • Body image disturbance

 • Rigid food rules

 • Chronic dieting/restrictive eating

 • Binge eating

 • Forbidden foods

 • Vomiting

 • Excessive exercise

 • Problematic use of weight-loss drugs

*Suggested Verbiage: What do we mean by eating and substance use disorders? The term eating pathology is used to describe disorders characterized by a disturbance of attitudes and behaviors related to food and eating. They include weight and shape concerns, body image disturbance, rigid food rules, chronic dieting, binge eating, purging (e.g., laxatives, vomiting), unhealthy dieting practices (e.g., skipping meals, extreme dietary restriction), and other unhealthy weight control behaviors (e.g., diet pill use, unhealthy/excessive exercise).*

**- SLIDE 2: Eating Disorders (EDs)**

o Subclinical symptoms rampant in USA/Western cultures

 ▪ Women > men

o Feeding and Eating Disorders in DSM-5-TR (APA, 2022)

 ▪ Anorexia nervosa (AN)

 ▪ Bulimia nervosa (BN)

 ▪ Binge eating disorder (BED)

 ▪ Other Specified Feeding and Eating Disorder (OSFED)

 ▪ Avoidant restrictive food intake disorder (ARFID)

 • \*not body image related

*Suggested Verbiage: When we think about eating pathology, it’s important to note that subclinical symptoms of eating disorders are rampant in USA/Western cultures. In fact, most Americans struggle with their weight, their body image, their behavior around eating at some point during their lives. So, as we go through this information today, it’s important not only to be thinking about people with full-blown eating disorder diagnoses but also about how the average person experiences their physical body. These symptoms tend to be more common in women than men—we’ll explore why that is a bit more later.*

*When symptoms become significantly impairing—they negatively affect a persons physical or emotional health, quality of life, daily life function—they may meet diagnosis for an eating disorder. In the DSM-5 TR, which is the manual that mental health professionals use to diagnose mental illness, there are a few eating disorders I want to highlight here.*

*-anorexia nervosa is characterized by 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. People with AN are significantly underweight.*

*-bulimia nervosa is characterized by 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. Self-evaluation is unduly influenced by body shape and weight.*

*-like bulimia, binge eating disorder is characterized by binge eating episodes. However, there is no compensatory behavior to rid oneself of the calories. Individuals with BED tend to be average weight or overweight.*

*-Other Specified Feeding and Eating Disorder (OSFED). This is basically an “other” category. It’s also common for someone to experience characteristics of an eating disorder that cause significant distress or impairment in important areas of life but do not meet the full criteria to be clinically diagnosed (e.g., weight is too high or the frequency and duration of behaviors is too low; night eating; etc.).*

*-Finally, avoidant restrictive food intake disorder (ARFID) is 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 wellbeing. However, body image and weight concerns are not the motivating factor for eating behavior.*

*The lifetime prevalence of eating disorders in the USA is estimated to be between 5-10%. This means that 5-10% of people in the US will meet diagnostic criteria for an eating disorder in their lifetime.*

**- SLIDE 3: Substance Use Disorders (SUDs)**

o Subclinical use rampant worldwide

 ▪ Legal prescription, illicit, OTC

o Substance-Related and Other Addictive Disorders (SRADS; DSM-5-TR)

 ▪ 10 recognized types of drugs

 • Alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, tobacco, and other

 ▪ Core symptoms (11 possible for diagnosis)

 • Hyperfocus on substance (central importance)

o Cycle: use, recovering/withdrawal, planning for next use

 • Effort to control use ineffective/relapse

 *• Impairs major role obligations at work, home, or school*

*Suggested Verbiage: Also in the DSM, are substance use disorders. Like eating pathology, subclinical substance use is rampant worldwide. People use drugs and alcohol regularly. The most recent diagnostic information about substance use in the DSM-5 is now in a category called Substance Related and Other Addictive Disorders (SRADS). There are many drugs of abuse, 10 classes listed in the DSM (alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics and anxiolytics, stimulants, tobacco, and other (or unknown) substances) and 11 core symptoms that are listed to get a diagnosis. Overall, there is a hyperfocus on substance (most important thing in life) that is evident in the cycle of use, which is characterized by using the drug, recovering from use/withdrawal, and planning for next use.*

*Efforts to control use are generally ineffective with high relapse, and the use impairs major role obligations at work, home, school.*

**- SLIDE 4: Comorbid ED & SUD**

o Prevalence

 ▪ Up to 50% of ED patients have problematic substance use (5x national

average) (Bahji et al., 2019)

 ▪ Up to 35% of SUD report eating pathology (11x national average)

(Hudson et al., 2007)

o Common Overlap

 ▪ Tobacco, alcohol, caffeine, stimulants, amphetamines

 ▪ Diet pills, steroids, laxatives, energy drinks, enemas, diuretics

 • \*compensatory behavior\*

*Suggested Verbiage: As I mentioned at the start of this talk, when we look at eating disorders and substance use disorders, they are highly comorbid. Meaning, they are often diagnosed together. For example, it’s estimated that up to 50% of ED patients have problematic substance use. Furthermore, up to 35% of individuals with a SUD report some eating pathology. When looking at people struggling with both, the most common drugs used are tobacco/nicotine, alcohol, caffeine, simulants, amphetamines. In addition, diet pills, steroids, laxatives, energy drinks, enemas, diuretics are commonly used.*

*It’s important to note that some drug use is imbedded in the diagnostic criteria compensatory behavior after a binge (as we would see in BN for example).*

**- SLIDE 5: Clinical Impairment & Lethality**

o Among highest mortality of any mental illness

 ▪ ED’s alone (Hoeken & Hoek, 2020)

 • AN inpatient 5x risk; BN outpatient 2x risk

 ▪ SUDs alone (Pan American Health Organization, WHO)

 • 2019, 47% of global deaths caused by drug use disorders

o Comorbidity has an additive effect on mortality

 ▪ Danish: 20,759 ED, 83,036 matched controls (Melletin et al., 2022)

 • ED with no SUD to controls: adjusted hazard ratio of death = 2.85

 • ED with polysubstance (alcohol, cannabis, hard drug) to control AHR = 22.99

*Suggested Verbiage: Understanding this comorbidity is important because when these symptoms co-occur, people generally report increased clinical impairment and are at risk for premature death. The lethality of these disorders is noteworthy. In general, both eating pathology and substance use are associated with among the highest mortality rates of any mental illness. When looking at samples of people with eating disorders alone, people diagnosed with AN who have been in inpatient treatment are still at 5x greater risk of premature death compared to controls and people with BN in outpatient treatment are at double the risk.*

*When looking at substance abusing populations without eating pathology, in 2019, the Pan American Health Organization and World Health Organization noted that 47% of global deaths were caused by drug use disorders.*

*Even more shockingly, comorbidity between these two diagnoses has an addictive effect on excess mortality. This was a Danish sample of 20,759 people with an ED and matched controls. Patients with an eating disorder with no substance use disorder were 2.85 times more likely to die that non-eating disordered controls. However, if you looked at people with ED with drug problems that number increased dramatically, with the most extreme being the combination of ED with polysubstance use (alcohol, cannabis, and a hard drug) they were almost 23 times more likely to die than controls. (For help interpreting odds ratios: https://sph.unc.edu/wp-content/uploads/sites/112/2015/07/nciph\_ERIC3.pdf)*

**Mini-Module/Video 3**

Section 2: Body Image & Weight Concerns

**- SLIDE 1: Body Image**

o Body image

 ▪ Subjective mental representation of one’s own body and appearance

(APA, 2018)

o Multidimensional construct

 ▪ Affective: emotions and feelings

 ▪ Cognitive: thoughts and beliefs

 ▪ Perceptual: evaluations and observations

 ▪ Behavior: actions to change, check on, alter, conceal o 2 core features: evaluation and investment (Cash, 2011)

*Suggested Verbiage: So, why are eating pathology and substance use so comorbid? Why do they co-occur so often? To really understand the overlap, we must start by talking about body image and weight concerns. Body image is the subjective mental representation or picture of one’s own body and appearance.*

*Body image is a complex, multidimensional construct comprised of 4 main components:*

*1) First, the affective element. This is the emotional feelings people have about their appearance. For example, feeling ashamed or embarrassed about one’s looks.*

*2) Second, there’s a cognitive component. This reflects the thoughts and beliefs someone holds about their body, weight, eating, and appearance in general. For example, thinking things like, “If I lose 5 pounds then I’ll feel better.” Or, “I’m bad if I eat dessert or French fries—I’ve already ruined my diet so I might as well keep eating.”*

*3) Third, there’s a perceptual element, which reflects our evaluations and observations about our appearance. For example, a person may look in the mirror and see themselves as overweight or ugly even when they objectively aren’t.*

*4) Finally, there’s a behavioral component. These are the actions people take to change, check on, alter, conceal or respond to their body. For example, pinching their skin, seeing if that one pair of pants still fits, weighing themselves repeatedly, not eating. Within this multidimensional construct we call body image, there are really two core features that we’re looking for as an indicator of mental health. Evaluation is how positively or negatively someone (satisfied or dissatisfied) someone is with their appearance. Investment is how important physical appearance is to a person’s overall self-evaluation.*

**- SLIDE 2: Body Image Disturbance**

o Negative evaluation + high appearance investment

 ▪ Body dissatisfaction; current-ideal discrepancy

 ▪ Highly distressing

o Core feature of most EDs + subclinical eating pathology

o Associated with:

 ▪ Depression, anxiety, impaired social and occupational functioning, reduced quality of life, low self-esteem, substance use

*Suggested Verbiage: As humans, all of us develop a body image—a sense of ourselves as a physical being. Yet, when that body image is unhealthy, it can be very harmful to our mental and physical health. In general, body image disturbance is most obvious through 1) Negative evaluation, which is often seen as body dissatisfaction. This is generally measured as a discrepancy between the way you currently look and the ideal of how you wished you looked). And 2) high appearance investment—your appearance matters greatly to how you feel about yourself as a person.*

*Body image disturbance is a core feature of most EDs (as we mentioned earlier) and subclinical symptoms. It’s also associated with some severe mental health concerns, including:*

*-symptoms of depression—feeling sad, blue, crying*

*-anxiety—being on edge, preoccupied, worried*

*-Impaired social and occupational functioning—not being comfortable in social settings, getting dressed, eating, working*

*-Reduced quality of life—not enjoying life or participating in a fulfilling way*

*-Low self-esteem*

*-And, not surprisingly, substance use—everything from diet pills to cigarettes to high amounts of caffeine.*

**- SLIDE 3: Body Image Disturbance**

o Rampant in USA

 ▪ 30-90% report some body dissatisfaction

 • 5,868 women: 91% smaller ideal than current (Runfola et al.,2013)

 • Review 126 studies; adolescents 10-19 (San Martini et al., 2023)

o Weight dissatisfaction: 19.2-83.8% girls and 10.8-82.5% in boys

o Motivation for drug use

 ▪ 297 women in SUD treatment (Warren, et al., 2013)

 • 33% started using drugs (in part) to lose weight

 • 71% concerns about weight gain in recovery

 • 45% concerned that weight gain could trigger relapse

*Suggested Verbiage: Body image disturbance also happens to be rampant in the United States and many Western cultures. Depending on how we measure body image disturbance, rates vary greatly. That said, 30-90% of people in Western cultures reports some body dissatisfaction. For example, in a study of almost 6000 adult women, 91% identified that they had a smaller ideal body size. This is a more liberal estimate but highlights the strong desire in women to lose weight. Similarly, in a review of 126 studies done between 1997-2020 on adolescents aged 10-19, San Martini and colleagues found that weight dissatisfaction ranged from 19 to almost 85% in girls and 11 – 83% in boys across studies. This included a range of measurement methods but highlights how prevalent body image disturbance can be.*

*As mentioned, when present, body image disturbance can be a motivation for drug use. In a study my colleagues and I did of 297 women in treatment for SUD (NOT ED), 33% said they started using drugs in part to lose weight, 71% were concerned about weight gain in recovery, and 45% were concerned that weight gain could trigger relapse.*

**- SLIDE 4: Clinical Presentation**

o Diverse population

 ▪ Types of drugs, types of ED

 ▪ Development: ED first, drug use first, simultaneous

 ▪ Other factors (e.g., gender, BMI, ethnicity/race, history)

o Common experiences

 ▪ Use drugs to feel good/not feel bad, elevated mood, increased energy, weight-loss (“positive” side effects)

 ▪ Body image/weight concerns are/become motivator for use

 ▪ Drug use fuels/reinforces body focus

 ▪ Weight gain in treatment triggers relapse

*Suggested Verbiage: When we think about how these two might overlap in the real world, the truth is that it is a very diverse group. There are many types of drugs, types of eating disorders with different features as well as many substances that people use and abuse. The development is also variable-some people develop eating pathology first whereas others develop problematic drug use first, and still other develop them simultaneously.*

*That said, there are some common experiences of people who struggle with both. These revolve around the effects of drugs. Most people start using drugs because it feels good or helps them not feel as bad (alleviate pain), elevated mood (even to the point of feeling euphoric and full of pleasure). Can give increased energy and some drugs have large weight-loss side effects.*

*From that perspective, body dissatisfaction is a strong motivation for drug use in many people.*

*In addition, using drugs fuels or reinforces a focus on the physical body and appearance, which can influence body image. And, for individuals who are focused on being thin, weight gain that often accompanies getting clean can be a trigger for relapse.*

**- SLIDE 5: Clinical Examples**

o Jennifer (AN and SUD)

 ▪ Intervention, Season 16, Episode 1

o Maria (eating pathology and alcoholism)

 ▪ Intervention, Season 22, Episode 20

o Katie (ED and SUD)

 ▪ Intervention, Season 14, Episode 1

o Notice: observations, thoughts, reactions

*Suggested Verbiage: I want to offer you some clinical examples. These are selected from the popular show Intervention and I think are good examples (and readily available to watch). They might be triggering or difficult to watch but offer a glimpse into the lives of some people struggling with both.*

*As you watch, I want you to notice your experience. What are your reactions? Thoughts? Observations?*

**- SLIDES 6: Optional Video**

o Jennifer’s story on A&E: https://www.aetv.com/shows/intervention/season-16/episode-1

o Maria’s story on YouTube: https://www.youtube.com/watch?v=ryllfeQ5MeM

o Katherine’s story on YouTube: https://www.youtube.com/watch?v=cbGk19rnnC0&t=52s

Suggested Verbiage: What are your reactions?

**Mini-Module/Video 4**

Section 3: Development of Eating Pathology

**- SLIDE 1: Eating Pathology**

o Develops over lifetime

 ▪ Adolescence (early puberty age 8-10 through mid 20s; National Academy of Sciences, 2019)

 • Biological changes

 • Identity formation

 • Social relationships and dating

 • Cultural interaction

o Family, friends, peers, media, social structures

*Suggested Verbiage: How does someone develop eating disorder and substance use disorder? How does it get so bad? Body image develops over lifetime. It starts very young. We start learning in early childhood about gender roles, appearance ideals, and acceptable eating behavior. Our body image becomes particularly important during adolescence—which starts at the beginning of puberty around age 8-10 and ends in our mid-20s—for many reasons.*

*-It’s a developmental time characterized by huge biological changes and growth characterized by the ability to procreate and have children.*

*-Psychologically, it’s a time of identity formation—teens are trying to figure out because there are many body changes through puberty.*

*-Social relationships are of primary importance as teens grapple with individuating from their family of origin and it’s the first time in people’s life where they often start dating and understanding themselves to be a sexual being.*

*-It’s also a time when we begin to really interact with our cultural context away from our parents by consuming media, using technology independently, and experiencing our social group away from our family. Messages about our appearance come from family, friends, peers, media, and social structures like schools, sports, and groups.*

**- SLIDE 2: Western Culture**

o “Normative Discontent” (Rodin, Silberstein, Streigel-Moore, 1984)

o Values & ideals

 ▪ Individualism, competition, rational thinking, personal wealth, patriarchal family structure

 • Idealize thinness/fitness

 • Stigmatize obesity/fatness

 • Appearance is central to value and role

 •→ happy, healthy, rich, popular, successful, famous…

*Suggested Verbiage: When we think about cultural interaction, Western cultural values and ideals are implicated in eating disorder development. This would include 1st world cultures like the United States, Western Europe and Australia.*

*-Starting in the mid 1980’s, research on suggested that that body image in Western cultures is characterized by a ”normative discontent.” Meaning, it’s normal to experience body image disturbance—more people are dissatisfied with their appearance than they are satisfied with it. In Western culture, we have some very clear values and ideals that fuel this dissatisfaction. For example, Western cultures value individualism—you are who you choose to be. Competition, rational thinking, personal well, a patriarchal family structure.*

*When it comes to physical appearance, Western cultures tend to idealize thinness (for women) and fitness, stigmatize obesity or fatness, and promote the message that appearance is central to a persons’ value and role in society.*

*If you meet the ideal appearance, good things will happen to you—you’ll be happy, healthy, rich, popular successful, famous.*

**- SLIDE 3: Images in Media of Women**

o Show photos of media depictions of women/girls.

Suggested Verbiage: One way we start learning these cultural messages in through the media, social media, and advertising. For example, what do typical film, advertisements, and social media posts tell us about what makes a valuable woman?

**- SLIDE 4: Images in Media of Men**

o Show photos of media depictions of men/boys.

Suggested Verbiage: And a valuable man?

**- SLIDE 5: Western Cultural Internalization**

o We learn cultural norms and ideals

 ▪ Thin-ideal internalization (muscular-ideal)

 ▪ Pressure

o Personal responsibility to meet expectations

 ▪ Drugs, pills, surgery, anti-aging, weight loss products, makeup

*Suggested Verbiage: As we look around, we learn the cultural norms and ideals of our community. Over time we personally apply those ideals to ourselves and those around us. This is referred to as thin-ideal internalization or muscular-ideal internalization.*

*Moreover, in Western culture, it’s our personal responsibility to achieve appearance expectation. If you fail—which all of us will because the ideals are so extreme, there are lots of things you can try to do that are highly marketed to all of us—things drugs, pills, plastic surgery, anti-aging products, weight loss products, and makeup.*

**- SLIDE 6: Biopsychosocial Model**

o Image of model

*Suggested Verbiage: When we think about the development of eating pathology, we generally conceptualize it from a biopsychosocial model. It’s really a combination and interaction between 3 large influences that predict eating pathology. Biological factors, like genetics, hormones, and body size. That combines with a persons’ psychological experience and way of being in the world. Things like perfectionism, emotion regulation difficulty, and body dissatisfaction. All of that interacts with a social and cultural environment that places high value on physical appearance as a determinant of value. And that holds very rigid ideals of beauty.*

*As a result, growing up and living in cultural group influences body image. For example, feeling pressure to be thin or muscular, see extreme beauty ideals perpetuated in mainstream media with rigid beauty ideals that are strongly esteemed. Seeing how normal it is to diet and teasing when you don’t look ideal. Taken together, these are etiologically tied or causally tied to the development of eating pathology.*

**- SLIDE 7: ED/SUD Shared Etiology**

o Conceptual overlap/shared risk factors

 ▪ Biological/genetic predisposition

 ▪ Psychological

 • Trauma and abuse

 • High comorbidity with other mental health diagnoses

 ▪ Cultural factors

 • Normalization of use/behaviors

 • Pressure

*Suggested Verbiage: There is actually a great deal of conceptual overlap or shared etiology between the two kinds of disorders. Both have some strong biological and genetic predisposition—if you’re genetic relative struggled with an ED or SUD, you’re more at risk for developing one. Both are associated with some psychological characteristics and experiences.*

*For example, experiencing trauma, abuse, or other ACEs or adverse childhood experiences (like exposure to violence, living with a mentally ill or incarcerated family member). They both have high comorbidity with other mental health diagnoses, including depression, anxiety, and PTSD. There also have some cultural factors in common—for example, in the US, there is a normalization of drinking and being on a diet. There is a great deal of pressure to be perfect, take responsibility for your appearance and drinking while at the same time promoting a culture of indulgence in both eating and drinking.*

**- SLIDE 8: Adolescent Body Image**

o Allure Video: Girls 6-18

 ▪ https://www.youtube.com/watch?v=5mP5RveA\_tk

o Reset: Boys body image

 ▪ https://www.youtube.com/watch?v=eFv9qQBov0o

o Notice: observations, thoughts, reactions

*Suggested Verbiage: All of these characteristics of adolescence influence body image. Let’s take a moment to listen to some adolescents talk about their body image. As you watch, I invite you to notice your observations—what do you hear them say? Your thoughts and reactions to the content.*

**- SLIDES 9 & 10: Optional Videos**

Suggested Verbiage: What are your reactions?

**Mini-Module/Video 5**

Section 4: Assessment & Treatment

**- SLIDE 1: Professional Considerations**

o Professionals must assess and integrate BOTH

 ▪ Ongoing, team approach (nutrition, MD, therapist)

 ▪ Baseline and regular follow-ups

o Starts with relationship

 ▪ Trusting and confidential

 ▪ Active listening

 ▪ Non-judgmental commentary

 ▪ Understand relapse is part of journey

 • Harm-reduction versus abstinence

*Suggested Verbiage: So now what? We know there are many people struggling with eating pathology and substance use. How do we help them? What can we do in terms of assessment and treatment? Perhaps the most obvious answer that the field really hasn’t done all that well to date is that we must address both! Need to do an assessment of both and integrate both sets of symptoms into treatment.*

*In addition, the initial assessment helps form a health therapeutic relationship, which is one o the most influential aspects of therapeutic effectiveness. The nature of the relationship with a client is critical to helping them heal over time. So, focus on building the relationship. It should be trusting and confidential. Use active listening skills to communicate to the person that you hear them, that you’re there with them. Use non-judgmental commentary that communicates you see them as a person who is struggling—not as a person who is bad or pathetic. Be honest about what you see and how you see their symptoms. And understand that relapse is a part of the journey for most. This enters into many longer debates about harm reduction versus abstinence models of healing, but I would say that the first goal is connecting with the other person and meeting them where they are. We can’t stop eating—so recovery means learning to have a healthier relationship with eating and body image.*

**- SLIDE 2: Assessment/Treatment Provider**

o Requires self-evaluation

 ▪ Often struggle with same issues

 ▪ Internalized cultural messages

 • Anti-fat attitudes, reinforce unhealthy ideals

o Working with population requires extra self-awareness

 ▪ Note bias and reactions

 • Towards clients and self

 ▪ Change/evolve over time

*Suggested Verbiage: Being a treatment provider or assessor for this population requires self- evaluation. Often, we struggle with the same issues because we may have learned some of the harmful sociocultural messages. So, we may have internalized cultural messages like anti-fat attitudes or reinforce unhealthy beauty ideals. None of us are immune.*

*So, working with this population requires extra self-awareness. Noticing and noting our biases and reactions, both toward clients and towards ourselves after meeting with clients, is essential. Then as we learn, we need to change and evolve anything that may harm ourselves or others over time.*

**- SLIDE 3: Assessment**

o Weight/shape concerns related to substance use

 ▪ Evaluation:

 • Do you have body weight or shape concerns? How much do they affect your desire to use drugs?

 ▪ Importance:

 • How important is your weight or appearance to your value as a person? Will it influence your ability to quit using drugs/stay clean?

o Screeners/formal assessments

 ▪ DAST-10 (NIDA; Skinner 1982)

 ▪ EDE-Q 6.0 (Fairburn & Belgin, 2008)

 ▪ SATAQ-5 (Schafer et al., 2017)

*Suggested Verbiage: At the most basic level, it’s critical to assess whether weight and shape concerns are related to a person’s substance use. I often ask questions in two general areas. The first is aimed at body image evaluation. Do you have body weight or shape concerns? Do they affect your desire to use drugs? The second is aimed at the importance of physical appearance to identity. I would ask questions like, “How important is your weight or appearance to your value as a person? Will it influence your ability to quit using drugs and stay clean”. This will give some idea about how gaining weight in treatment.*

*In terms of assessment tools, there are many screeners for both substance us and body image/eating pathology. The DAST-10 is a quick drug abuse screener. The EDE-Q is really the gold standard questionnaire to get an idea of a global level of body image and eating issues. The SATAQ is looking at internalization of cultural norms and values of appearance.*

**- SLIDE 4: Treatment Targets**

o Interventions (CBT-based)

 ▪ Psychoeducation (about nutrition, healthy eating, developing healthy body image)

 ▪ Focus on health--not weight and appearance

 ▪ Meal planning

 ▪ Coping strategies

 • relaxation, mindfulness, distress tolerance, impulse control

 ▪ Emotion regulation (DBT, see Claudat et al., 2020)

 ▪ Body acceptance (media literacy, positive body-talk)

 ▪ Social support\*

*Suggested Verbiage: As we get a sense of what a person is struggling with, it becomes easier to craft some specific treatment targets. Many of these interventions are based in Cognitive Behavioral Therapy.*

*We often start with psychoeducation about anything relevant, including nutrition, healthy eating, developing healthy body image. As we learn, we add some coping strategies to intervene in tough moments. Things like Focus on health, not weight and appearance. Meal planning can be very helpful. Coping strategies like progressive muscle relaxation training, mindfulness, distress tolerance and impulse control. Emotion regulation is often a challenge for both people with Eds and substance use—DBT skills can be very helpful. Body acceptance (including media literacy, positive body talk). And social support, which gets an asterisk because it may be one of the most important aspects of healing. Feeling a sense of belonging and connectedness to others is highly predictive of both mental and physical health outcomes.*

**Mini-Module/Video 6**

Summary & Concluding Remarks

**- SLIDE 1: Summary**

o EDs and SUDs highly comorbid

 ▪ Increase mortality risk

 ▪ Weight loss strong motivator to use

o Body image key aspect of mental health

 ▪ Correlated with eating pathology and substance use

o Biopsychosocial development of eating pathology

 ▪ Adolescence; biology + psychology + socio-cultural

o Assessment and treatment must address both

 ▪ Team

*Suggested Verbiage: In sum, eating disorders and substance use disorders are highly comorbid—as are subclinical symptoms. When they co-occur, people are at increased risk for premature mortality and likely have more severe life impairment. For many, weight loss is a strong motivator for use. Body image is a key aspect of mental health. It’s a multidimensional construct comprised of feelings, thoughts, evaluations and behavior around one’s physical self. Body image disturbance is correlated with eating pathology and substance use. We conceptualize the development of eating pathology (and many forms of mental illness) from a biopsychosocial perspective. Biological factors, psychological factors, and cultural factors all interact to create the normative discontent people experience in Western contexts. Assessment and treatment must address both using an integrated, team approach.*

**- SLIDE 2: Resources & Information**

o Additional considerations

 ▪ Gender, race, ethnicity, family history, genetics, types of drug/ED

interaction, developmental course, physical consequences

o National Eating Disorder Association

 ▪ https://www.nationaleatingdisorders.org

o Substance Abuse and Mental Health Services Admin

 ▪ https://www.samhsa.gov

o Fact Sheets

*Suggested Verbiage: This is just the tip of the iceberg on this topic. For anyone interested, there are many additional considerations when working with and understanding this population. For example, you may want to do a deeper dive to understand the role of gender, race, family history, genetics, types of drug/ED interaction, developmental course, and physical consequences. And there are many resources--here are a few I would recommend. The National Eating Disorder Association and SAMHSA. We also wrote some fact sheets as part of this module that you can download and use for free.*

**- SLIDE 3: Selected References**

-American Psychological Association (updated 2018). Definition of body image.

- Bahji A, Mazhar MN, Hudson CC, Nadkarni P, MacNeil BA, & Hawken E (2019). Prevalence of substance use disorder comorbidity among individuals with eating disorders: A systematic review and meta-analysis. Psychiatry research, 273, 58–66.

- Brewerton TD & Brady K (2014). The Role of Stress, Trauma, and PTSD in the Etiology and Treatment of Eating Disorders, Addictions, and Substance Use Disorders. In: Brewerton, T., Baker Dennis, A. (Eds.) Eating Disorders, Addictions and Substance Use Disorders. Springer, Berlin, Heidelberg. https://doi.org/10.1007/978-3-642-45378-6\_17

- Bucchianeri MM, Arikian AJ, Hannan PJ, Eisenberg ME, Neumark-Sztainer D (2013). Body dissatisfaction from adolescence to young adulthood: findings from a 10-year longitudinal study. Body Image, 10, 1-7. doi: 10.1016/j.bodyim.2012.09.001.

-Claudat K, Brown TA, Anderson L, Bongiorno G, Berner LA, Reilly E, Luo T, Orloff N, & Kaye WH (2020). Correlates of co-occurring eating disorders and substance use disorders: a case for dialectical behavior therapy. Eat Disorders, 28, 142-156. doi:10.1080/10640266.2020.1740913.

- Eck KM, Quick V, & Byrd-Bredbenner C (2022). Body dissatisfaction, eating styles, weight-related behaviors, and health among young women in the United States. Nutrients, 14, 3876.

- Hudson JI, Hiripi E, Pope HG Jr, & Kessler RC (2007). The prevalence and correlates of eating disorders in the National Comorbidity Survey Replication. Biological Psychiatry, 61, 348–358. https://doi.org/10.1016/j.biopsych.2006.03.040

- Mellentin AI, Mejldal A, Guala MM, Støving RK, Eriksen LS, Stenager E, & Skøt L (2022). The impact of alcohol and other substance use disorders on mortality in patients with eating disorders: A nationwide register-based retrospective cohort study. The American Journal of Psychiatry, 179, 46–57. https://doi.org/10.1176/appi.ajp.2021.21030274

- National Academies of Sciences, Engineering, and Medicine 2019. The Promise of Adolescence: Realizing Opportunity for All Youth. Washington, DC: The National Academies Press. https://doi.org/10.17226/25388.

- Runfola CD, Von Holle A, Trace SE, Brownley KA, Hofmeier SM, Gagne DA, Bulik CM (2013). Body dissatisfaction in women across the lifespan: results of the UNC-SELF and Gender and Body Image (GABI) studies. Eur Eat Disord Rev. 21, 52-59. doi: 10.1002/erv.2201.

- San Martini MCS, Assumpção D, Barros MBA, Mattei J, Barros Filho AA (2023). Prevalence of body weight dissatisfaction among adolescents: a systematic review. Rev Paul Pediatr. 41,e2021204. doi: 10.1590/1984-0462/2023/41/2021204.

- Warren CS, Lindsay AR, White EK, Claudat K, & Velasquez SC (2013). Weight-related concerns related to drug use for women in substance abuse treatment: Prevalence and relationships with eating pathology. Journal of Substance Abuse Treatment, 44, 494-501.

*Suggested Verbiage: These are some of the resources cited in this course. Thank you for your participation in this course!*

Guided Class Activity and Class Discussion Questions

Guided Class Activity (do early in the course):

This exercise can be structured as an individual or a large-group activity, depending on class needs and norms. If you want to preserve anonymity and encourage internal reflection or use the

**WRITING PROMPT. If you want to encourage open conversation and exploration of assumptions and biases in the group, use the DISCUSSION PROMPT.**

1. Start by introducing the activity to the class, as follows: I want us to really explore body image and substance use by doing a brief experiential activity.

a) WRITING PROMPT: Please pull out a pen and paper. You’ll have 3 minutes—write whatever comes to mind and then I’ll stop you to ask you another set of questions. I want you to picture a person who is really struggling with an eating disorder. What do they look like? What are their symptoms? For example, what are some things that the person might think, feel, or experience in their life because of their eating disorder?

After 3 minutes: Thank you. Now I want you to start a new section. You’ll have another 3 minutes. I want you to picture a person who is using substances in a problematic way. What do they look like? What are their symptoms? What does this person think, feel or experience because of their struggle with substances?

b) DISCUSSION PROMPT: We’re going to spend the next 5 or so minutes brainstorming. I want you to picture a person who is really struggling with an eating disorder. What do they look like? What are their symptoms? For example, what are some things that the person might think, feel, or experience in their life because of their eating disorder? During the brainstorm period, the instructor (and perhaps a student assistant, if needed) records every word on a board or screen visible to the class.

After 2-3 minutes: Thank you. Pause. Now I want you to start a new section. You’ll have another 3 minutes. I want you to picture a person who is really struggling abusing substances. What do they look like? What are their symptoms? What does this person think, feel or experience because of their struggle with substances?

2. Now, I want you to look at what you wrote down. What’s different about your descriptions? How do people with eating disorders look compared to people struggling with substances? What would someone look like if they were struggling with both?

Please keep your descriptions in in mind as we go through this next set of slides because it’s going to be really helpful as a starting point to explore this content.

**Additional Discussion Questions – either before or after you review the slide deck**

1. Why is it important to understand body image in people who use substances?

2. Why is it important to understand substance use in people who struggle with body image

issues?

3. What is body image?

4. What are some of the primary components of body image?

5. What are some common ways that people struggling with body image act, look, or think?

6. How common is it to have some body image disturbance in the United States and other Western cultures?

7. How does culture influence body image and eating pathology?

8. What are some diagnosable eating disorders?

9. What percentage of people who struggle with substance use also have eating and body image issues?

10. What percentage of people with an eating disorder abuse substances?

11. Why is it important to assess for body image and eating pathology when treating individuals who use and abuse substances, like drugs and alcohol?

12. What are some useful interventions to use with people struggling with body image who may be using substances?