

Comorbidity of alcohol abuse disorders and bulimia



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Co-Morbidity of Bulimia Nervosa (Bulimia) and Alcohol Use Disorders (AUD)

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Substance abuse and eating disorders have the highest mortality risks of all

mental disorders and half of all clients with eating disorders abuse alcohol or

illicit drugs” (Carbaugh & Sias, 2010, p. 125). Clients with Eating Disorders

are already at an increased risk for mortality, so alcohol or drug abuse places

additional dangers onto this group. A study by Suzuki, Takeda, and Yoshino

(2011) into mortality rates of patients with eating disorders, found the

mortality of eating disorder patients with alcoholism were significantly higher

than those without.

Eating Disorders (ED) are psychological disorders, characterized by and

resulting in severe disturbances in eating behaviors, and can subdivided into

Anorexia Nervosa (AN), Bulimia Nervosa (Bulimia), Binge-Eating Disorder

(BED), and Eating disorder not otherwise specified (Palme, 2008). Alcohol

Use Disorder (AUD) is a substance abuse disorder, where the individual’s

consumption of alcohol is great enough to damage or adversely affect their

daily functioning and/or becomes a prerequisite for normal functioning

(Gordon, 2008). AUD are subdivided into alcohol abuse and alcohol

dependence disorders (Gordon, 2008).

Research into the co-morbidity of AUD and ED suggests AUD occurs more frequently with Bulimia than Anorexia (Kane. 1999). The National Institute on Drug Abuse (2011) defines “ co-morbidity, as two or more mental disorders occurring in the same person at the same time, or one after the other.

Bulimia, is where an individual consumes huge quantities of food in a short period (binging) and then to prevent weight gain partakes in either purging (vomiting or taking laxatives) or non-purging (extreme exercising or periods of starvation) behaviors (Eating Disorders and Substance Abuse, 2010).

This purpose of this paper is to examine the prevalence of co-morbidity between Bulimia and AUD, the possible reasons for this co-morbidity, and the recommended treatment options available to clients. 2. Frequency of Co-Morbidity between Bulimia and AUD Beary, Lacey, and Merry’s (1986) study into Alcoholism and eating disorders in woman found, “ Fifty per cent of the bulimics either abused (40%) alcohol or used it to excess (10%)”, (p. 685). Dansky and Brewerton’s 2000 study into Bulimia and AUD co-morbidity, found 31% of bulimic woman suffered from AUD, compared to 9% in the general population.

Baker, Mitchell and Neale’s (2010) study into ED and substance use disorders found 24% of the 118 bulimic women interviewed suffered from AUD. Berry’s et al (1986) also suggests AUD may occur many years after the onset of Bulimia, for example, this study reported, “ Alcohol abuse increased with age to 50% by the age of 35 and may be even higher by 40” (p. 685).

The above research suggests a high level of co-morbidity between Bulimia and AUD, and suggests clients with bulimia are at a higher risk than the

general population for developing AUD's. 3. Reasons for the Possible Co-Morbidity of Bulimia and AUD

There are a number of different hypotheses explaining the reasons for the co-morbidity between Bulimia and AUD. Wolfe and Maisto (as cited in Carbaugh & Sias, 2010) categorised these hypotheses into (1) Shared etiologies, and (2) Causal etiologies. Etiologies refer to the underlying factors and causes, which may account for how these two disorders are connected (Carbaugh & Sias, 2010). 1. Shared Etiologies Shared etiology hypotheses view co-morbidity as resulting from a common predisposition or shared risk factors (Carbaugh & Sias, 2010). 1. Personality traits:

Sysko & Hildebrandt (2009) suggest women with Bulimia and AUD share similar personality traits, such as high anxiety levels, mood instability, and lack of control, and impulsivity, which predisposes them to developing both disorders. Kaye and Wisniewski (as cited in Kane, A, 1999) believe mood instability and anxiety, results in clients using food and alcohol to relieve anxiety and regulate moods. A study by Kane, Loxton & Dawe (2004) into the link between impulsivity, binge eating and alcohol use, suggests impulsivity and a lack of control contributes to the development of both disorders.

Kane, A. (1999) suggests clients with co-morbid Bulimia and AUD, have an underlying addictive personality trait, predisposing them to food (Bulimia) and alcohol (AUD) addiction. As food and alcohol are functional equivalents, clients addicted to food (Bulimia) are also at risk for developing an addiction of alcohol (Kane, A. , 1999). 2. Family History Goldbloom, Naranjo and

Bremner's (1992) study into ED and AUD in woman, suggested genetic factors might predispose clients to developing both disorders. Another study by Bulik and Sullivan (1993) found 76. % of 17 bulimic women with AUD, have a relative with AUD. However, a later study conducted by Kendler, Walters, and Neale (as cited in Grilo et al, 2002) found genetic factors associated with vulnerability to AUD did not increase the risk for developing Bulimia. These results show the inconsistencies between different research studies into this particular area of psychology. Bulik and Sullivan (1993) suggest similar paternal and maternal characteristic in the families of woman, suffering from Bulimia and AUD, might contribute to the development of both disorders.

Paternal characteristics included inappropriate seductive boundaries and attempts to inhibit independence and maturity; maternal characteristics also included attempts to inhibit independence as well as placing excessive attention to weight and appearance (Bulik & Sullivan, 1993). Barlow (as cited in Carbaugh & Sias, 2010) believed an invalidating family environment might contribute to the development of both disorders. An invalidating environment is one where the client's emotions and needs are negated, punished, and/or responded to inappropriately by the family (Barlow, as cited in Carbaugh & Sias, 2010).

This type of environment could result in client developing bulimia and AUD, as a way of coping with unmet needs and suppressed emotions (Carbaugh & Sias, 2010) 3. Biological Vulnerability Research into addictions conducted by Mercer and Holder (cited in Grilo et al, 2002) suggests atypical endogenous opioid peptides activity (EOP) within the brain chemistry of Bulimics and <https://assignbuster.com/comorbidity-of-alcohol-abuse-disorders-and-bulimia/>

Alcoholics, might play a role in the development of both disorders. EOP's are neuromodulators, which modulate the actions of neurotransmitters in the brain to influence emotions, such as euphoria (Froehlich, 1999).

For example, Froehlich (1999) suggests, "Enhanced sensitivity of opioid peptide systems to alcohol may contribute to a predisposition for the development of alcoholism in certain people" (p. 135).

2. Casual Etiology Group Casual hypotheses suggest bulimia and AUD are causal factors for each, so having one disorder puts the client at risk for developing the other (Carbaugh & Sias, 2010).

1. Self Medication According to Carbaugh & Sias (2010), Bulimic clients may be self-medicating with alcohol to manage: (1) anxiety and guilt around bingeing and purging, (2) underlying depression, or (3) family dysfunction.

. Food Deprivation A study by Krahn, Kurth and Demitrack (as cited in Grilo et al, 2002), into the relationship between dieting, bulimic behaviors and substance abuse, found food deprivation led to increased alcohol consumption within the sample population. However, another study by Bulik & Brinded (1993) on the effect of food deprivation on alcohol consumption in bulimics, suggests food deprivation does not necessarily lead to increased alcohol consumption.

These two studies are evidence of how there is yet no conclusive explanation for the relationship between Bulimia and AUD.

3. Bulimic Behaviours A study into the vulnerability to substance abuse in ED undertaken by Kaye, Lilenfeld and Plotnicov (1996) suggests bulimics use alcohol to numb hunger and cravings for food. Another study by Franko, Dorer, Keel, Jackson, Manzo, and Herzog (2005), into the influence of ED on alcohol use, found the influence of bulimia on AUD was greater than the reverse.

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Both Baker et al (2010) and Berry et al (1996) suggest woman diagnosed with co-morbid Bulimia and AUD, tend to develop the eating disorder first. Baker et al (2010) suggests this might be because, as women get treatment for Bulimia, they start replacing bingeing and purging with excessive drinking.

4. Treatment for Bulimia and AUD 1. Treatment Approach Carbaugh & Sias 2010, Gordon 2008, Grilo et al (2002), and Sysko & Hildebrandt 2009 recommend treating both disorders concurrently, in an integrated manner. There are number advantages of concurrent treatment.

Advantages for concurrent treatment include; (1) allows for the identification of common themes, life patterns and etiologies underlying both disorders (Carbaugh & Sias , 2010); (2) permits collaboration of treatment goals to alleviate these underlying factors (Carbaugh & Sias, 2010); (3) avoids inconsistencies between different treatment approaches (Sysko & Hildebrandt, 2009); and (4) most clients prefer concurrent treatment as they believe the two disorders are related (Sysko & Hildebrandt, 2009). 2. Specific Treatment Plan

The basis of any specific treatment plan is a though, in-depth evaluation and assessment of the client's situation and needs (Grilo et al, 2002). Carbaugh & Sias (2010) and Grilo et al (2002) recommend using a combination of Cognitive Behavior Therapies (CBT), Dialectical Behavioral Therapies (DBT), and pharmaceutical treatments in addressing both disorders. CBT, focuses on modifying clients thoughts around weight, food, bingeing, purging and drinking (alcohol) to bring about desired emotional and behavioral change (Corey, 2008).

CBT is viewed by many professionals as an effective method for treating substance abuse disorders and ED, especially bulimia (Carbaugh & Sias, 2010). Coping Skills training forms an important part of CBT when addressing these two disorders (Carbaugh & Sias, 2010). If a client is abusing alcohol, bingeing and purging to alleviate anxiety and suppress negative emotions, learning new skills to cope and manage their anxiety, negative emotions, and impulsivity, can assist in reducing bingeing, purging and drinking episodes (Grilo et al, 2002).

In DBT, the emphasizes is on teaching the client to become mindful and accepting of their negative behaviors, whilst learning to cope with and regulate negative emotions, so as to bring about positive behavior changes (Carbaugh & Sias, 2010). Skills DBT, teaches clients include mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness skills (Shepphird, 2008). According to Shepphird (2008), clinical trials have reported 82-90% rates of abstinence from binge eating at the end of a DBT therapy program.

Depending on the clients needs pharmacological treatments may also form part of the treatment plan (Carbaugh & Sias, 2010). Antidepressant medications, such as Naltrexone and fluoxetine seem to be effective in treating alcohol dependence and in reducing bingeing and purging behaviors (Gordon, 2008 and Sysko & Hildebrandt, 2009). Nutritional Counselling assists the client with meal planning, understanding their body's nutritional requirements, changing unhealthy eating behaviors and identifying potential triggers that precipitate a binge (Eating Disorders and Substance Abuse,

2010). 5. Conclusion

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The research findings presented in this paper indicates a high level of co-morbidity between Bulimia and AUD. Many of the women seeking treatment for Bulimia have or will develop an AUD within their lifetime (Beary et al, 1986). Although there is no conclusive evidence as to why this co-morbidity exists, there are various hypotheses, which can be categorised into either shared etiologies, or causal etiologies (Wolfe and Maisto as cited in Carbaugh & Sias, 2010). Shared etiologies include personality traits, family history, and biological vulnerability, whilst casual etiologies include self-medication, food deprivation, and bulimic behaviors.

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