SAMHSA ADVISORY
Substance Abuse and Mental Health Services Administration

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EVIDENCE-BASED CARE FOR CLIENTS WITH CO-OCCURRING SUBSTANCE USE DISORDERS AND EATING DISORDERS

Eating disorders (EDs) are serious mental disorders with grave physical health consequences and can be fatal. These disorders can affect anyone.[1] EDs also have numerous psychosocial consequences, such as problems with family, friends, school, or work and lower perceived happiness.

EDs may co-occur with substance use disorders (SUDs)—a 2019 meta-analysis suggests that more than one in four people with an ED will also meet criteria for an SUD at some point.[2] Treating a person's ED and SUD is essential to achieving the best outcomes.[3,4] Clients treated for only one of the co-occurring disorders have a high risk of switching between problematic behaviors.[2] For example, they may rely on substance use to cope with feelings or situations that trigger their ED behaviors.

Although treatment services for SUDs and EDs may be available in a single facility or program, there are no available data on whether these programs offer comprehensive, integrated care for co-occurring SUDs and EDs. In a qualitative study, staff members and women receiving treatment at a facility in Canada were interviewed about their priorities for integrated ED and SUD care.[5] Both staff and program participants said the care should include concurrent therapeutic programming, nutritional support, and medical monitoring. The availability of such integrated care and the best protocols for providing that care are both areas that need further study.[6]

This *Advisory* aligns with President Trump's *Make America Healthy Again (MAHA)* initiative and its commitment to addressing the chronic disease epidemic impacting Americans. Recognizing that co-occurring SUDs and EDs are complex, chronic conditions that require integrated and sustained care, this *Advisory* emphasizes evidence-based, whole-person approaches to behavioral health treatment.

By promoting the integration of specialized care for individuals with both SUDs and EDs, this *Advisory* reflects MAHA's priority to improve health outcomes through comprehensive, patient-centered care that transcends institutional silos. These recommendations prioritize timely access to coordinated services—grounded in current science and clinical best practices—that effectively address the medical, psychological, and nutritional needs of individuals affected by these co-occurring disorders.

Further, this *Advisory* embodies MAHA's directive to promote transparency and reduce conflicts of interest in healthcare delivery. The practices outlined herein are informed by rigorous research demonstrating improved treatment retention, reduced relapse rates, and enhanced quality of life. By encouraging collaborative care models that remove barriers to integrated treatment, this *Advisory* supports MAHA's goal of restoring fundamental health principles centered on healing and recovery. Additionally, it advances MAHA's vision of a healthier, more resilient America, one where individuals with co-occurring disorders receive dignified, effective, and compassionate care.

This *Advisory* can inform those who provide SUD and ED treatment services and other health care in a variety of settings on basic information about EDs, ED treatments, and the relationship between SUDs and EDs so care providers can:

- Identify clients with possible co-occurring SUDs and EDs.
- Create a recovery-friendly, supportive environment that encourages clients to engage in healthy behaviors, regardless of their weight and body size.[7]
- Make appropriate referrals for evidence-based ED treatment services.
- Help clients with co-occurring EDs and SUDs attain and maintain recovery by understanding the effects of EDs on SUDs and vice versa.

The content of this *Advisory* and most of the available evidence applies primarily to adults. Although evidence on treating adolescents is limited, some content is included in this resource.

In addition to educating providers about EDs, this *Advisory* discusses the relationship between EDs and SUDs and issues related to co-occurrence. It also includes an overview of screening approaches and evidence-based treatments. Although the *Advisory* does not provide comprehensive information about treating clients with co-occurring SUDs and EDs, it offers targeted information about effective treatments and directs readers to additional resources.

Key Messages

- EDs that co-occur with SUDs most often are anorexia nervosa, bulimia nervosa, and binge eating disorder.
- EDs and SUDs must both be treated for clients to have the best outcomes, although the initial treatment should address the most serious immediate threats to the client's health and safety.
- EDs and SUDs have shared etiological factors, including genetics, neurological response patterns, and a history of trauma or adverse childhood events.
- Some effective treatments for EDs, particularly psychosocial therapies, are also effective for SUDs.
- SUD treatment providers should screen clients for EDs and be alert for red flags that signal a possible ED.
- SUD treatment providers should develop referral relationships with ED treatment providers.
- Many ED treatment programs also offer SUD treatment, although availability varies by location.

Types of EDs

Most EDs begin in childhood, adolescence, or early adulthood and are characterized by disturbed eating patterns and behaviors and by dysfunctional attitudes toward food, eating, and body shape, all of which impair physical health and psychosocial functioning.[8]

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) identifies three EDs that often co-occur with SUDs: anorexia nervosa, bulimia nervosa, and binge eating disorder.[9,10] Although some diagnostic criteria for these three disorders overlap, the DSM-5-TR frameworks for diagnosing them are mutually exclusive because these EDs have different clinical courses and outcomes and require different treatment approaches.

Anorexia Nervosa

The three primary DSM-5-TR criteria for an anorexia nervosa diagnosis are an extreme fear of gaining weight, a disturbed perception of body weight or body shape, and not consuming enough calories to meet the body's energy requirements, resulting in a significantly lower than healthy body weight for the person's age, sex, and developmental trajectory.[10] Low body weight alone is not enough to diagnose anorexia nervosa. People with significant weight loss may still meet the criteria for anorexia nervosa, even if they are not "underweight."[10,11] (See Exhibit 1 for more information about using the body mass index [BMI] in the diagnosis of EDs.) In addition, people with SUDs who have low body weight because of poor nutrition or substance use that suppresses appetite, such as cocaine or stimulant use, would not meet the criteria for co-occurring anorexia nervosa unless they also show fear of gaining weight and disturbed perceptions of body weight or shape.[10]

Exhibit 1. Uses and Limitations of the BMI

Despite increasing recognition that the presence or absence of an ED has very little to do with a person's actual weight or appearance, assessments of weight continue to play a key role in the diagnosis of these disorders. For example, BMI, which calculates degrees of over- or underweight based on a person's weight and height (kg/m^2),[11,13] is used by healthcare providers in diagnosing EDs. A "healthy" BMI is at least 18.5 and less than 25, according to current standards used by the Centers for Disease Control and Prevention.[14] The DSM-5-TR specifies a BMI of less than 17 as one criterion for diagnosing anorexia nervosa.[10] Insurers also often use BMI as a factor in making decisions on coverage for ED treatment.

Researchers have indicated that BMI is a poor predictor for EDs and has the potential to delay diagnoses and impede referral, treatment, and recovery for people with these disorders.[15] Healthcare providers who rely on BMI or focus on signs of starvation may not appropriately diagnose people with these disorders who present with BMIs in the normal or higher ranges. The result is delayed care and potentially poorer longer term health outcomes, which are key concerns given that early identification of ED is the primary predictor of a full recovery.[15]

Because of these concerns, alternative methods for diagnosing EDs are being explored. For example, empirically derived levels of shape and weight overvaluation have demonstrated potential in accurately evaluating ED severity.[16,17] Shape and weight overvaluation occurs when people believe their self-worth is closely tied to their body shape or weight. Studies indicate that people with clinically significant shape and weight overvaluation have significantly more ED symptoms, depression, stress, and disabilities and significantly lower quality of life than people with anorexia nervosa without shape and weight overvaluation.[18] Another related method being explored is the use of structural equation model trees to empirically determine specific BMI and shape and weight overvaluation levels that differentiate anorexia nervosa severity.[17]

As knowledge and research on EDs continue to grow, SUD treatment providers should be aware of the complexity of these disorders as well as the emerging research on methods for diagnosing and assessing them.

According to the DSM-5-TR, anorexia nervosa has two subtypes: restricting and binge eating/purging.[10] Both subtypes involve manipulating body weight by restricting food intake. The restricting subtype may also include excessive exercise. The binge eating/purging subtype always includes purging (i.e., self-induced vomiting or use of laxatives, diuretics, or enemas after eating), and it may also include episodes of binge eating (i.e., uncontrolled eating to the point of discomfort or pain). A person may experience each subtype at different times. Both subtypes have serious medical consequences, including delayed puberty or slowed growth, bone mass reduction, nutritional deficiencies, electrolyte disturbances, serious cardiac problems, severe anemia, and more. People with anorexia nervosa may experience amenorrhea or menstrual disruptions.

Anorexia nervosa has the highest mortality of all the EDs, from medical complications of the disorder or from suicide,[10] although mortality estimates vary among studies.[12] Suicide risk among people with anorexia nervosa is as much as 18 times greater than the risk among people of the same age and sex who do not have the disorder.[12] However, the course of the disorder varies widely. Some people recover fully after experiencing the disorder for a short period (e.g., 3 months), and most people experience remission within 5 years of presentation.[10]

Bulimia Nervosa

The DSM-5-TR has three criteria for a bulimia nervosa diagnosis.[10] The first is binge eating. The second is that some type of inappropriate compensatory behavior occurs after the binge eating. The compensatory behavior might be self-induced vomiting, diuretic or laxative use, weight loss supplements or medications, fasting, or excessive exercise. The third is self-evaluation that overly focuses on weight and body shape.

Binge eating and the compensatory behavior must occur at least once per week for 3 months to meet DSM-5-TR diagnostic criteria for bulimia nervosa.[10] The disorder includes severity categories dependent on the frequency of compensatory behavior. The disorder typically develops during adolescence or young adulthood and can begin during periods of dieting or stress.

Medical consequences of bulimia nervosa include dangerous fluid and electrolyte imbalances, nutritional deficiencies, menstrual irregularity, and other reproductive system problems.[10] Rare but potentially fatal complications include esophageal tears and gastric rupture from self-induced vomiting, as well as cardiac arrhythmias. Erosion of tooth enamel (from stomach acid) is common. People with bulimia nervosa who purge are more likely to experience severe medical problems than those who do not purge.

Binge Eating Disorder

The DSM-5-TM criteria for a binge eating disorder diagnosis require recurring episodes of binge eating at least once per week for 3 months.[10] The binge eating must involve:

- Eating a larger amount of food in a short time than most people would eat in similar circumstances. Many people eat large amounts of food in a short time at holiday gatherings, but that behavior would have to occur regularly to meet the criteria for a binge eating disorder diagnosis.
- Feeling a lack of control during a binge eating episode.

The episodes must also include three or more of the following behaviors[10]:

- Eating much faster than normal.
- Eating until uncomfortably full.
- Eating large amounts in the absence of physical hunger.
- Eating alone or hiding eating due to shame.
- Feeling disgusted, depressed, or guilty about binge eating.

The frequency of episodes determines the disorder's severity categories.[10] The categories range from mild (1–3 episodes per week) to extreme (14 or more episodes per week). Binge eating disorder is distinct from anorexia nervosa and bulimia nervosa because it does not include purging or other compensatory behaviors. The disorder typically develops during childhood, adolescence, or young adulthood, although it may develop later.

The development of binge eating disorder is not well-understood, but the disorder has been associated with several gene variants and seems to run in families.[19] People with binge eating disorder are more likely to experience remission than people with anorexia nervosa or bulimia nervosa.[10]

People with binge eating disorder have an increased risk for type 2 diabetes, heart disease, joint problems, metabolic syndromes, and other medical consequences.[20]

Other Eating and Feeding Disorders

The DSM-5-TR describes other eating and feeding disorders that involve problematic eating patterns but do not meet the full criteria for anorexia nervosa, bulimia nervosa, or binge eating disorder.[10] In this diagnostic category, two of these designations—bulimia nervosa and binge eating disorder—allow providers to indicate why the person doesn't meet full criteria for a specified eating disorder (i.e., behaviors occur at a low frequency [less than once a week] or for a limited duration [for less than 3 months]). People with atypical anorexia nervosa exhibit all the symptoms of anorexia nervosa except low body weight. Purging disorder is defined as recurring purging episodes without binge eating, and night eating syndrome involves excessive eating at night that impairs daily functioning.

Prevalence of EDs

The literature reports more evidence of EDs among women; however, men are increasingly being diagnosed with EDs. A review of published research spanning 2000 to 2023 estimated the lifetime prevalence of anorexia nervosa at 1.4 percent for women and 0.2 percent for men.[21] The lifetime prevalence of bulimia nervosa was 1.9 percent for women and 0.6 percent for men. For binge eating disorder, the lifetime prevalence was 2.8 percent for women and 1 percent for men. Despite the increase in the number of men diagnosed with EDs, these rates may be low given that this population is less likely to be diagnosed or seek treatment.[22]

Men and women exhibit the same physical and behavioral signs and symptoms of EDs, although men may focus more on muscularity and low body weight/lean mass,[23] which may result in underdiagnosis of EDs.[24,25]

EDs tend to appear early in life. A study of survey data from U.S. adults showed that the median age of onset was about 17 years for anorexia nervosa, 16 years for bulimia nervosa, and 21 years for binge eating disorder.[8]

Relationship Between EDs and SUDs

EDs and SUDs have similar primary characteristics, including compulsive behavior, craving, loss of control, use of food and/or substances as maladaptive coping mechanisms, and continuation of the problematic behavior(s) despite negative consequences.[10,26] EDs and SUDs often stem from similar genetic, neurochemical, and psychological causes,[27,28] with social experiences—such as adverse childhood experiences, trauma, and family and cultural influences (particularly those that normalize problematic eating and substance use behaviors)—also playing a role.[2] For example, people with binge eating disorder may use stimulants to prevent an eating binge or to control weight.[29]

Common Co-Occurring Disorders

Both EDs and SUDs commonly co-occur with other mental disorders.[10] According to the DSM-5-TR:

- Anorexia nervosa frequently co-occurs with bipolar, depressive, and anxiety disorders and occasionally co-occurs with obsessive-compulsive disorder. People with the binge eating/purging subtype of anorexia nervosa are more likely than those with the restricting subtype to have co-occurring alcohol use disorder (AUD) or other SUDs. One meta-analysis revealed co-occurring SUD in 18 percent of people with the binge-purge type of anorexia nervosa, whereas co-occurrence was only about 7 percent in people with the restrictive type.[30]
- Bulimia nervosa often co-occurs with other mental disorders, including depressive, bipolar, anxiety, and borderline personality disorders.[10] Many people with bulimia nervosa have multiple co-occurring mental disorders.[31] More than 30 percent of people with bulimia nervosa will have an SUD in their lifetime, often AUD or stimulant use disorder.[10]
- Binge eating disorder also commonly co-occurs with other mental disorders, especially major depressive disorder and AUD. An analysis of data from a U.S. survey reported that 94 percent of people with binge eating disorder had symptoms of mental illness in their lifetime.[8] Up to 23 percent had attempted suicide, 70 percent reported mood disorders, and 68 percent reported SUDs. Binge eating can be a symptom of borderline personality disorder, although a diagnosis of the two disorders together is made only when all the criteria for both have been met.[10]

Shared Etiology of EDs and SUDs

The underlying causes of EDs are complex and not fully understood, although a person's genes, gut microbes, immune system, and personality may contribute.[19] Possible risk factors for ED include in utero exposure to unusually high levels of hormones or cortisol, experience of trauma, childhood and early adolescent exposure to familial pressures surrounding food and idealized body images (particularly having a parent with an ED), and other mental issues.[19]

Biological and Genetic Factors

Research on how genes and other biological factors influence the connection between EDs and SUDs is still in the early stages. An extensive analysis of data from multiple genome-wide association studies has shown that anorexia nervosa and AUD share genetic factors (although researchers noted that both disorders are also associated with genes linked to major depressive disorder).[28] Additional research is needed to evaluate genome data in the context of environmental factors (e.g., trauma) that increase the risk for co-occurring EDs and SUDs.

Further, several studies have identified common neurological, metabolic, and genetic bases for SUDs and EDs.[28] For example, many genes associated with both problematic alcohol use and binge eating disorder have been linked to activity in neural circuitry that regulates reward, stress, and executive control.[27]

The Role of Trauma and Adverse Childhood Experiences

Trauma and adverse childhood experiences are well-known risk factors for developing EDs and SUDs, as they can cause long-term neurological disruptions and have been associated with an increased risk for these conditions.[32] One large meta-analysis found statistically significant associations between exposure to emotional, physical, or sexual abuse and the occurrence of all types of EDs.[33] People with EDs who reported childhood trauma were significantly more likely than those who did not report childhood trauma to have co-occurring psychiatric disorders, suicidality, younger ED onset, more severe forms of ED, and more frequent bingeing and purging.[33]

Considerations for Treating Adolescents

EDs often emerge during adolescence, a critical period for intervention. Although EDs are more common among girls, they also affect boys, who are less likely to be diagnosed and receive proper treatment.[34] Boys may exhibit distinct symptoms, such as a preoccupation with muscularity, which can go unrecognized until they become severe.[34]

Complications of Co-Occurring Conditions

Adolescents with EDs who have co-occurring conditions, such as depression, anxiety, and SUDs, may face significant challenges in their treatment and recovery. These co-occurring conditions can worsen ED symptoms, making them more complex and more difficult to manage and treat.[35,36] EDs also heighten the risk for suicidal thoughts and behaviors.[35,36]

Barriers to Treatment for Adolescent Males

Adolescent males face significant barriers when seeking help or accessing ED treatment. These barriers include stigma and societal perceptions that EDs are a "female issue."[37] As a result, adolescent males may be less likely to seek treatment or disclose their symptoms than their female counterparts, leading to delayed diagnosis and intervention. Furthermore, the lack of tailored treatment approaches and limited provider experience in treating male ED clients can exacerbate these challenges.

Health Coverage and Access to Care

Health coverage may also play a significant role in limiting access to ED treatment for adolescents. Research has shown that clients with public insurance are less likely to receive evidence-based treatment, with only one-third receiving recommended care compared with those who have private insurance.[38] Geographic location and provider shortages can further hinder access to care, particularly in rural or underserved areas. Left untreated, EDs can have severe and potentially life-threatening consequences, including serious medical complications and a heightened risk of death.[39]

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Addressing Disparities and Improving Treatment Outcomes

To improve treatment outcomes for adolescents with EDs, addressing the gaps and barriers that exist in accessing care is essential. This includes increasing awareness about EDs in adolescent males, providing tailored treatment approaches, and expanding insurance coverage to ensure access to evidence-based treatment. Additionally, healthcare providers must be aware of the sociocultural factors that influence treatment seeking and access.[37] By recognizing and addressing these challenges, healthcare providers can better support adolescents with EDs and work toward improving treatment outcomes, ultimately reducing the significant burden of these disorders on people, families, and communities.

The Role of Pediatricians in ED Care

Pediatricians, as primary care providers, are frequently the initial point of contact for families seeking assistance, thereby positioning them to facilitate timely and effective treatment for clients.[40] Screening for EDs should include a comprehensive assessment with a thorough medical, nutritional, and psychiatric history. Pediatricians should also be aware of key signs and symptoms of EDs, such as low body temperature, dry skin (particularly on the palms and soles), thinning hair, brittle nails, and abrasions on the knuckles, which may be a sign of self-induced vomiting. Additionally, screening for specific vitamin and mineral deficiencies, such as vitamin B_{12}, vitamin D, iron, and zinc, may be indicated based on a person's nutritional history. To address the unique needs of youth with EDs, pediatricians may suggest that clients work collaboratively with multidisciplinary teams, such as family physicians, internists, nurse practitioners, and psychiatrists.[40,41] Comprehensive treatment planning with a multidisciplinary team of healthcare providers can minimize delays in care that prolong the recovery process.[36,40]

Screening and Referral to ED Treatment Services

Retention in ED and SUD treatment is low among people with one disorder and even lower among those with co-occurring EDs and SUDs.[2] Given the interplay between these disorders and the increased risk for serious medical consequences (including death) when they co-occur, they should be screened for, identified, and treated concurrently.

Clinical Warning Signs of EDs

Identifying potential EDs among clients with SUDs can be challenging. Some signs and symptoms of EDs, SUDs, and other mental disorders overlap. For example, weight loss, lethargy, changes in eating habits, and depressed mood can indicate an SUD, an affective disorder, or an ED.[10] People with EDs often go to great lengths to disguise and hide their problematic behaviors related to eating.

Clients with SUDs may exhibit problematic eating behaviors even without meeting all criteria for an ED diagnosis as specified in the DSM-5-TR.[10,42] These problematic eating behaviors may signal the risk of developing an ED and should be noted, monitored, and addressed. Patterns, behaviors, and attitudes that have the potential to become problematic include frequent dieting; significantly fluctuating weight; feelings of guilt, anxiety, and shame about eating; rigid routines related to food and exercise; compulsive eating habits or a loss of control around food; and preoccupation with food, weight, and body image.

Providers should be aware of behaviors that commonly occur among people with EDs. The following red flags (some associated with specific EDs) could indicate an active or developing ED:

- Shows preoccupation with weight, food, calories, dieting, and body size, image, or shape.
- Shows significant weight loss or gain.
- Complains of fatigue, low energy, or dizziness.
- Makes excuses to avoid situations involving food.
- Develops food rituals (e.g., eating foods in certain orders, excessive chewing, rearranging food on a plate).
- Engages in restrictive or fad dieting (e.g., paleo, vegan, keto) or fasting.
- Frequently checks reflection in mirrors for perceived flaws in appearance.
- Has stomach cramps or other gastrointestinal complaints (e.g., constipation, acid reflux).
- Maintains an excessive, rigid exercise regime.
- Dresses in layers to hide weight loss or stay warm (anorexia nervosa).
- Drinks excessive amounts of water or noncaloric beverages or uses excessive amounts of mouthwash, mints, or gum (bulimia nervosa).
- Has cuts and calluses across the tops of finger joints, which may be caused by frequently inducing vomiting (bulimia nervosa).
- Has dental problems like erosion of enamel, bleeding gums, or periodontal disease (bulimia nervosa).
- Steals food or hoards food in strange places (binge eating disorder).
- Has disrupted eating behaviors such as eating throughout the day with no planned mealtimes, skipping meals, or taking small portions of food at regular meals (binge eating disorder).

SUD treatment providers who screen all clients for EDs will likely identify clients who need further assessment and treatment services. Providers can incorporate ED screening into SUD assessments in the following ways:

- As part of the substance use assessment, ask clients about their use of over-the-counter and prescription laxatives, diuretics, and diet pills.
- As part of recording the medical history, ask clients about past hospitalizations and behavioral health history, including any history of EDs.
- As part of assessing daily activities, ask clients how often and how long they exercise and if they frequently think about their food intake and dieting.
- Use a screening questionnaire (see Exhibit 2).
- Ask clients, “Other than those we’ve discussed so far, are there any health issues that concern you?”

Exhibit 2. Screening Tools

SUD providers can use several tools to screen clients for EDs.

The SCOFF questionnaire was originally developed in 1999 in the United Kingdom and is simple, widely used, and standardized. It works especially well for identifying anorexia nervosa and bulimia nervosa in young women.[43] It is not a diagnostic tool, and it cannot predict a client's risk of developing an ED.[44] It is less accurate for identifying EDs in men, for identifying binge eating disorder, and for use in diverse populations.[45] The SCOFF questionnaire includes the following questions:

1. Do you make yourself **Sick** (induce vomiting) because you feel uncomfortably full?
2. Do you worry you have lost **Control** over how much you eat?
3. Have you recently lost more than **One** stone* in a 3-month period?
4. Do you believe yourself to be **Fat** when others say you are too thin?
5. Would you say that **Food** dominates your life?

Two or more "yes" responses indicate that ED is likely.

Source: Morgan, J. F., Reid, F., & Lacey, J. H. (1999). The SCOFF Questionnaire: Assessment of a New Screening Tool for Eating Disorders. British Medical Journal, *319(7223), 1467–1468.* https://pubmed.ncbi.nlm.nih.gov/10582927

At least two electronic tools are based on the SCOFF questionnaire:

- Screening, Brief Intervention, and Referral to Treatment for Eating Disorders (SBIRT-ED) is a free tool from the National Center of Excellence for Eating Disorders. It works across multiple devices and enables providers to quickly screen clients and offer appropriate referrals.
- The American Psychiatric Association offers a free online tool for ED screening, assessment, and treatment recommendations. The tool begins with the SCOFF questionnaire and has an additional question specifically about binge eating. Additional steps are recommended based on the client's responses. It also includes excerpts from the DSM-5-TR and other information sources, and providers can save client responses.

Two other widely used screening tools are the Eating Attitudes Test (EAT26),[46] first published in 1982, and the Eating Disorder Examination–Questionnaire, first published in 1994 as an interviewing tool for clinicians and later adapted as a questionnaire for clients.[47] The Muscularity-Oriented Eating Test was published in 2019 and may be useful for screening male clients or any client who is preoccupied with muscle tone and fitness.[48]

Screening tools developed based on one population may not apply equally well to other populations. For example, ED screening questions that focus on "thinness" may miss EDs among those whose ideal body images are based on other criteria. Research among Black women has shown that their ideal body images may be either curvy and feminine or toned and muscular.[49] To be fully alert to the possibility of EDs in their clients, SUD providers must be familiar with attitudes toward food and body image in the populations they serve.

**14 pounds (Some U.S.-based versions of the questionnaire use 15 pounds.)*

Providers should ask clients for their permission to talk about body image. People with disordered eating or EDs may have deep distress over their body image, regardless of their size.[50] (See the text box **A Note on Language** for more information and resources on language sensitivity.) Clients receiving SUD treatment may be confused or defensive when asked questions about their eating behaviors and body image. To prepare clients for these questions, providers can:

- Explain that having a clear picture of their overall health status is important.
- Explain that EDs commonly co-occur with SUDs.
- Ask clients for permission to pursue ED screening (e.g., "May I ask you some questions about your eating habits?").

Online self-screening tools are available and may be helpful for screening clients who are uncomfortable discussing their eating behavior with an SUD treatment provider.

Screening does not end after the initial evaluation. Providers should remain alert for signs of EDs, including changes in weight that may develop during the course of treatment or when a client is in recovery.

A Note on Language

One important element of behavioral health screening is being sensitive when using language that describes people, conditions, and symptoms. In the context of ED treatment, that sensitivity is particularly important for language about weight, body size, and food consumption. Weight stigma is an issue for people in larger bodies, but possibly even more so for people with EDs.[50] Insensitive language can trigger or intensify that dread. Negative experiences may make clients avoid the topic entirely, hampering the provider's ability to help or offer referrals. Person-first language is preferable when discussing eating disorders (e.g., "a person with bulimia" instead of "a bulimic"). Neutral terms like "a person at a higher weight" are preferred over stigmatizing terms like "obese."[51,52]

Referring Clients for Further Assessment and Treatment Services

Ideally, a person with an ED and an SUD would receive integrated treatment services through one program, although such integrated treatment is not widely available.[3] Many facilities offer treatment programs for EDs and SUDs at the same location, although the availability of these programs varies by location, and not all programs accept all types of insurance.[3,53] If an SUD treatment program does not have a dual-diagnosis program for clients with EDs, SUD treatment providers should refer clients with EDs to specialized ED treatment providers. However, an SUD that poses an immediate health or safety threat to a client should be treated first to stabilize the client for further treatment services.[4]

Clients with health insurance may have some coverage for ED treatment services, but coverage and eligibility criteria vary widely.[54]

The best approach for treating people who have EDs and co-occurring disorders such as SUDs is not clear.[4,6,55] Decisions about treatment require a multidisciplinary team approach that includes the client and their family, an SUD treatment provider, a physician, and an ED specialist. To enhance the referral process and facilitate ongoing treatment for clients with both disorders, SUD treatment providers should develop formal referral relationships with local resources that offer evidence-based ED treatment.

Regardless of whether an SUD treatment program provides treatment for clients who have co-occurring EDs and SUDs, discharge planning should ensure that clients have appointments or referrals to initiate or continue their ED-specific care. Clients should also receive information on available community resources.

ED treatment services can involve specialized programs and practitioners, dentists, and nutritionists or dietitians. (See the **Resources** section for more information.) The following resources may provide information that can help SUD treatment providers with referrals to ED treatment services:

- SAMHSA's Eating Disorders webpage.
- SAMHSA's FindTreatment.gov.
- National Institute of Mental Health's Eating Disorders: What You Need to Know.
- Families Empowered and Supporting Treatment of Eating Disorders' (F.E.A.S.T.) support groups for parents and families of people with ED.
- Community centers that offer behavioral health services.
- Behavioral health specialists.
- Hospital psychiatry departments and outpatient clinics.
- Universities and medical schools.
- Employee assistance programs.
- Local medical and psychiatric societies.

ED Treatments

Evidence-based treatment for EDs generally includes medical stabilization, nutritional rehabilitation, pharmacotherapy, and psychosocial support services. The American Psychiatric Association recommends the following psychosocial therapies and pharmacotherapies for EDs[56,57]:

- **Anorexia nervosa/atypical anorexia:** People with this ED should have individualized goals for weekly weight restoration and receive psychotherapy focused on EDs.[57] The therapy should focus on normalizing eating and weight control and restoring a healthy weight, and it should address body image disturbance, fears about weight gain, and other psychological aspects. Adolescents and young adults who have an involved caregiver should receive family-based treatments.

- **Bulimia nervosa:** Adults with this ED should receive ED-focused cognitive behavioral therapy and early consideration of pharmacotherapy, such as a selective serotonin reuptake inhibitor (SSRI).[57] The SSRI can be prescribed at the beginning of treatment or when psychotherapy alone results in minimal or no response after 6 weeks of treatment. Adolescents who have an involved caregiver should receive family-based treatments.
- **Binge eating disorder:** People with binge eating disorder should receive individual or group ED-focused cognitive behavioral therapy or interpersonal therapy.[57] For adults with binge eating disorder, pharmacotherapy may be indicated, particularly for those who have not responded to therapy alone.

Medical Stabilization

People with EDs may need immediate medical attention if they are severely malnourished or dehydrated, have electrolyte imbalances or abnormal vital signs, or have fainted or lost consciousness. Inpatient medical care for other physical consequences also may be necessary.

Nutritional Rehabilitation

Nutritional rehabilitation is a critical aspect of ED treatment. For some people with EDs, nutritional rehabilitation may begin with a process of refeeding. If malnutrition is severe, inpatient treatment may be required. This process is slow and must be closely supervised to avoid refeeding syndrome and side effects.[58] In less severe cases, refeeding may be handled on an outpatient basis.

Nutritional rehabilitation for EDs also includes evaluation of nutritional status, weight monitoring, education about nutrition and the risks of EDs, and techniques for relearning healthy eating patterns. A registered dietitian is best equipped to provide these services.[59,60]

To optimize treatment, recovery, and long-term remission, nutritional deficiencies and malnutrition must be addressed either before engaging in psychological, cognitive, and pharmacological therapies or concurrently, depending on the severity of the nutritional issues. Nutritional restoration and optimization are necessary to improve the client's cognitive functions, mood, energy, and general health so they can engage successfully in therapy.[4]

Psychosocial Treatments

Psychosocial treatments for EDs can also be effective treatments for SUDs, and providers should address both issues during therapy. A meta-analysis showed that certain treatments were associated with a greater likelihood of recovery from EDs, including cognitive behavioral therapy, family-based therapy, and dialectical behavior therapy, although the researchers noted that many of the effective treatments were multidisciplinary and not limited to a single intervention.[61]

Trauma-Informed Care

Trauma-informed care offers clients a safe way to process their experiences and should begin with screening.[62] If a client has a history of trauma, the treatment should first ensure that ED and SUD symptoms are stabilized or improving and the client is not in immediate danger. To begin addressing the trauma itself, clients must be willing and emotionally and cognitively ready, which includes tolerating feelings of distress and processing information about how the trauma may be connected to their symptoms.[63]

Cognitive Behavioral Therapy

Cognitive behavioral therapy approaches, used widely in SUD treatment, have been tailored for treating EDs by addressing the distorted thought processes related to body shape and image that drive ED behaviors.[64] Approaches focus on altering food restriction, compulsive overeating, binge eating, and purging behaviors.

Dialectical Behavior Therapy

Developed originally as a treatment for borderline personality disorder—particularly suicidal and self-harming behavior—dialectical behavior therapy has been shown to have some efficacy as a treatment for binge eating disorder.[65] EDs and SUDs both involve poor impulse control and emotional dysregulation. This therapy may be a good choice for treating co-occurring EDs and SUDs,[26] as it focuses on developing specific skills to increase mindfulness, improve interpersonal relationships, regulate emotions, and tolerate distress.

Family-Based Treatment

Because eating and attitudes toward food and body image are often deeply integrated into family life, ED treatment often involves the family, particularly for adolescents.[61] As discussed earlier, EDs often develop during adolescence and may coincide with the development of SUDs.

Treating adolescents successfully often involves treating their families, as well.[66] Family-based treatment assumes that parents and caregivers have the most influence over their child's recovery and are in the best position to help disrupt the behavior patterns underlying the ED.[40] The seminal family-based treatment is the Maudsley approach, which was developed in the United Kingdom.[67] In this approach, family members play an active role in changing the eating patterns of a person with ED. The approach has demonstrated effectiveness as a treatment for anorexia nervosa and bulimia nervosa.[66]

Interpersonal Psychotherapy/Psychodynamic Psychotherapy

Interpersonal psychotherapy, which focuses on interpersonal problems rather than the client's thoughts and emotions, has been found to be effective in treating bulimia nervosa and binge eating disorder.[65] The premise is that negative interactions lead to negative emotions, which lead to ED behaviors. In this approach, clients with bulimia nervosa or binge eating disorder focus on methods of coping with the tension and frustration that result from negative interpersonal interactions. They also learn to improve their relationship skills. A related approach, also effective, is psychodynamic psychotherapy, which emphasizes how past unresolved conflicts shape behavior and personality.[65,68]

Digital Tools

Smartphone applications and other digital outlets have created options for self-help when clients lack access or willingness to engage in other types of therapy. Some of these approaches have been effective in clinical trials. A randomized clinical trial of a digital cognitive behavioral therapy intervention showed a reduction in eating-related negative thoughts and a reduced frequency of binge eating among female students at 27 universities, when they were compared with a control group that received usual care.[69] A meta-analysis of research on digital ED therapy tools showed reduced symptoms and reduced co-occurring depression and anxiety, especially among users with bulimia nervosa and binge eating disorder.[70] In this analysis, a greater diversity of multimedia content was associated with greater improvement.

Pharmacotherapy

People with bulimia or binge eating disorder often receive treatment with medication. The U.S. Food and Drug Administration (FDA) has not approved any medications for the treatment of anorexia nervosa. Antidepressant and antianxiety medications are sometimes used to help clients cope with the anxiety and depression that often accompany EDs, and some evidence shows that the antipsychotic olanzapine may help people gain weight.[71] The FDA approved fluoxetine, an SSRI, for the treatment of bulimia nervosa, and the drug is commonly used as a treatment for binge eating disorder. Topiramate, a medication for treating seizures, has shown some effectiveness when used off-label as a treatment for binge eating disorder (as well as for the treatment of cocaine use disorder and AUD).[72]

Peer Support Services

Peer support services are nonclinical recovery support services provided by people with lived experience of a particular mental issue or substance use. Peer support services can enhance clinical ED treatment by offering people in ED recovery an opportunity to connect with others in recovery and to share their feelings and experiences.

Resources

SAMHSA

- Eating Disorders webpage.
- 988 Suicide & Crisis Lifeline: a 24/7 national hotline offering one-on-one support for mental health, suicide, and substance use-related problems.

Web Resources

- Academy for Eating Disorders | AED Publications
- American Psychological Association | Eating Disorders
- Medline Plus | Eating Disorders
- National Eating Disorders Association
- National Institute of Mental Health | Eating Disorders
- Office on Women's Health | Eating Disorders

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SAMHSA ADVISORY

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