

INSTITUTE FOR CLINICAL SOCIAL WORK

THE RELATIONSHIP BETWEEN CHEMICAL DEPENDENCY  
AND EATING DISORDERS

A DISSERTATION SUBMITTED AS PARTIAL FULFILLMENT OF  
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## PREFACE

Chemical dependency and eating disorders are complex and serious conditions which alter the physical and psychological state of an individual. They are chronic and often fatal illnesses based on the compulsive use of mood-altering chemical substances or food. In recent years, chemical dependency and eating disorders have become increasingly prevalent in the United States. These disorders affect every culture, age group, ethnic group, socioeconomic class and both men and women.

This research project sought to examine the possible relationship between chemical dependency and eating disorders. The focus was on exploring if eating disorder behaviors can be found in an inpatient chemical-dependency sample and if these behaviors could be documented by two separate observers. It was found that eating disorders coexist with chemical dependency and, in fact, eating disorders predate chemical dependency. This finding supports the substantive hypothesis that eating disorders and chemical dependency coexist. Chemical dependency and eating disorders are not distinct, but related and represent an addictive disorder. This knowledge has significance for clinical practice and theory, clinical social work, health care benefit plans, health care policy and research.

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## CHAPTER I

### PURPOSE OF PROJECT AND RESEARCH QUESTION

#### Introduction

Chemical dependence and eating disorders are complex and serious conditions. They are chronic, progressive and often fatal illnesses based on the impulsive and compulsive use of mood-altering chemical substances or food. These disorders alter the physical and psychological state of the individual and affect family and interpersonal functioning. The self-help support groups Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Overeaters Anonymous (OA) view the process as pathological when they describe alcoholism, drug addiction and compulsive eating as a "mental, physical and spiritual disease" (Alcoholic Anonymous, 1954; Narcotics Anonymous, 1982; Overeaters Anonymous, 1981). In recent years, chemical dependence and eating disorders have become increasingly prevalent in the United States (American Hospital Association, 1990).

The National Institute on Drug Abuse (NIDA), the nation's clearinghouse of information on alcohol and drugs, estimates that one out of every ten Americans is a substance abuser. NIDA studies indicate that there are approximately

18 million persons in the United States who suffer from alcoholism and 23 million people currently addicted to drugs. NIDA statistical reports indicate there are 1.1 million people who use opioids, 1.9 million people who use sedative hypnotics, 6.5 million people who use cocaine, 22 million people who abuse alcohol and 25.8 million people who use marijuana (U.S. National Institute on Drug Abuse, National Survey on Drug Abuse, 1988). Studies indicate that over 10 million employees of the American work force are using alcohol or drugs and this contributes \$175 billion annually in losses to the American economy. Additional studies also suggest that alcohol and drug abuse contribute to over \$163.6 billion in health care costs, lost productivity and crime. Estimates of medical hospital beds occupied by patients whose physical condition is complicated by alcohol and drug problems range from 25-50 percent and there are 45,136 hospital beds designated for chemical dependency in the United States according to the American Hospital Association (1991). Over 20,000 treatment facilities ranging from inpatient hospitalization to residential treatment centers to outpatient programs are devoted to providing care to chemical-dependent individuals in the United States. In 1988, there were 598,079 Americans in treatment and in 1989, there were 745,175 Americans in treatment (National Institute on Drug Abuse, National Drug and Alcoholism Treatment Survey, 1990).

The National Association of Anorexia Nervosa and Associated Disorders (ANAD), the national nonprofit educational and self-help organization for eating disorders, estimates that 8 million people in America suffer from an eating disorder. No longer perceived as the "middle class women's" disorder, eating disorders are found in men and cross all cultural, ethnic and socioeconomic classes and age groups. Out of the 8 million people affected, 1 million are men and male cases are being reported with increased frequency. Twelve percent of high school students and 24 percent of college students exhibit behaviors that suggest a serious eating disorder. Eating disorders can lead to death and 15 percent of people with eating disorders die from complications of starving, bingeing and purging (ANAD, 1990). Over 2,000 hospitals provide care to patients with eating disorders according to the American Hospital Association (1991).

Chemical dependence is the physical and psychological dependence on a chemical substance. The chemical substances abused usually are alcohol, cocaine, marijuana, opioids, amphetamines or sedative hypnotics. Early in the field, there was a distinct division between alcohol dependence and drug dependence (Levin, 1987). Presently, there is the accepted concept of cross addiction or poly addiction of one or more chemical substances. This has resulted in the usage of the term chemical dependency.

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Eating disorders consist of the physiological and psychological dependence on food. Obesity is not an eating disorder per se; it is a physical state of being as the result of overeating. The eating disorders, anorexia, bulimia and compulsive overeating involve what one does and how one feels about oneself in relationship to food. During the late 1970s and the early 1980s, eating disorders were clearly distinguished as either anorexia, bulimia or compulsive overeating. Anorexia is a syndrome characterized by extreme and excessive weight loss and severe dietary restriction. Bulimia is expressed by episodes of binge eating followed by some form of purging and severe dietary restraint. Compulsive overeating is characterized by excessive weight gain, continuous eating and binge eating. Clinically, anorexia, bulimia and compulsive overeating exist on a continuum from the food restrictor anorexic at one extreme to the normal or overweight binge eater at the other. From this viewpoint, eating disorders are not separate diseases; they are syndromes or clusters of symptoms varying in cause and function (Ceaser, 1988). Currently, there has been a much greater recognition that anorexia, bulimia and compulsive overeating share many common features and the variability within each group is probably greater than the variance between the groups (Andersen, 1983). Anorexia, bulimia and compulsive overeating are all conditions that may be seen as facets of

an umbrella category of eating disorders. Whether bingeing, vomiting or starving, an eating disorder from the researcher's clinical experience is characterized by gross disturbances in body image, preoccupation with dieting, food, weight and body size and a psychological dependence on food.

Multiple biological, psychological and sociocultural factors seem to interrelate to produce the clinical picture of chemical dependency and eating disorders. Genetic givens such as temperament, body regulation and activity level contribute to the physiological predisposition. Difficulties in the child's earliest relationship with the primary caretaker may create psychological vulnerability. Social factors especially the culture's acceptance of alcohol and recreational chemical use and the overemphasis on body image and the "slenderness" culture contribute to the psychosocial vulnerability. These factors may intertwine leaving an individual predisposed or vulnerable to chemical dependency or eating disorders.

There are numerous treatment programs that treat chemical dependency just as there are programs that treat eating disorders. However, the treatment of these disorders has been mutually exclusive. Separate programs exist on both an inpatient and outpatient basis, yet rarely are these disorders treated together except in a general inpatient psychiatric unit. The treatment programs are remarkable

similar in approach and in clinical orientation. Most treatment programs in an inpatient or residential setting are highly structured and milieu focused. The treatment components usually employ medical intervention; pharmacotherapy; nutritional assessments and counseling; educational seminars; self-help meetings; and individual, family, group and couple treatment. Outpatient programs tend to be intensive day or evening programs which provide a psychoeducational milieu of therapy, seminars, occupational intervention and self-help meetings. The treatment programs' clinical philosophy is either the disease model of chemical dependency or eating disorders, employing a self-help approach or the traditional psychiatric model which often ignores the symptom management or "disease" component of these disorders.

Research in the field of chemical dependency and eating disorders is fairly recent and limited. Substance abuse disorders were not included as a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders until the 1960s and eating disorders were not included until 1980. An ongoing and major effort in the behavioral sciences throughout the 1980s has been the study of chemical dependency and eating disorders. Research has tended to focus on either studying chemical dependency and eating disorders as exclusive disorders (i.e., Clifford et al., 1989; Garner, 1985), linking these disorders to affective

disorders (i.e., Hatsukami et al., 1986) or associations between these two disorders (i.e., Jonas et al., 1987). In spite of ample effort on the part of researchers and clinicians, the etiology and relationship of chemical dependency and eating disorders remain elusive. Little exploration has focused on the overlap between chemical dependency and eating disorders as coexisting conditions or examining this coexisting phenomena from a developmental or psychological perspective.

Through the researcher's clinical work with chemical-dependent and eating-disordered patients on an inpatient and outpatient basis, the researcher has found compelling similarities of these conditions both in the progressive nature and the behavioral consequences of chronic compulsive use. The behaviors directed at chemicals or food are remarkably alike and are distinguished by obsessive rituals, compulsivity, ruminating thoughts, clandestine behavior, hoarding and withdrawal symptoms. The notion to "binge" either on chemicals or food to alleviate psychological stresses is common to both chemically-dependent and eating-disordered patients. The behavior pattern for both chemical and food abuse is episodic, chronic and progressive and patients experience feeling out of control, preoccupied and isolated. Patients also disclose similar feeling states of depression, guilt, insecurity, loneliness, inadequacy and helplessness after the excessive usage of chemicals or food.

Many patients report tandem difficulties regulating both chemicals and food and disclose concerns about their abusive patterns. Patients abuse opioids and amphetamines to maintain or lose weight; binge on high caloric food after intake or injection of chemical substances; experience significant weight gain during an inpatient treatment stay; rely on food or chemicals to reduce labile affective states and interrupt their drug use only to become dysfunctional due to compulsive eating-disorder behavior. The researcher has also observed the abuse of food on an inpatient chemical-dependence unit where patients hoard food, eat rapidly large quantities of high caloric food such as potato chips or cookies and report uncontrollable and obsessive thoughts about food following the cessation of chemical substances.

The treatment of chemical-dependent and eating-disordered patients from the researcher's perspective also reveal similar dynamic histories and overwhelming affective states of rage, depression, shame, guilt and anxiety. Patients are extraordinarily alexithymic, and unable to read or monitor their affective states. From the researcher's clinical experience the clinical picture is one of massive ego regression; infantile wishes and fantasies; fragmentation; splitting; repression; impulsivity and primitive transferences. The similarity of the clinical picture and the behavioral consequences by chronic

compulsive use of chemical-dependent and eating-disordered patients has led the researcher to speculate about the possible relationship between chemical dependency and eating disorders.

The speculation is that chemical dependency and eating disorders are linked and might be coexisting disorders which represent severe psychological disturbances. These addictive disorders appear to be symptoms of underlying developmental arrests and psychological disturbances which erupt or become apparent in latency, adolescence and adulthood. There appears to be a relationship between the presence of eating disorders during latency or early adolescence and the onset of chemical dependency during late adolescence or early adulthood.

The clinical significance of this research project is to expand the knowledge about the possible relationship between chemical dependency and eating disorders. Such knowledge has significance for treatment in making more specific the clinical interventions to be employed in treatment and to extent that there may be underlying developmental arrests. Chemical dependency and eating disorders have a high recidivism or relapse rate and it may be because only one disorder is dealt with in treatment when both disorders may really exist. If chemical dependency and eating disorders are coexisting disorders then treatment interventions and practice should address both disorders for

a successful treatment outcome. This knowledge has significance for prevention and education strategies, treatment diagnosis, planning interventions and clinical treatment programs. Also, clinical experience with patients showing symptoms of chemical and food abuse suggest that this behavior is an attempt to compensate for psychological and developmental deficits. The use of chemicals or food may serve as a defense against oral regression, a response to poor ego functioning or as a self-regulatory function for self-care. The implications for treatment necessitate responding both to the chemical and food addiction and to the underlying psychological issues.

The purpose of this study is to test the contention that chemical dependence and eating disorders coexist in adult chemical dependency. The aims of this research are: (1) to find the prevalence of eating disorders in a sample of inpatient chemical-dependent patients; (2) to determine their age of onset of problems with food and chemicals and to determine if eating problems predate chemical-dependence problems; and (3) to demonstrate that eating-disorder behavioral symptoms occur on an inpatient chemical-dependency unit by documenting raters observations of these symptoms.

#### Substantive Hypothesis

The substantive hypothesis for this study is: Eating disorders and chemical dependency coexist.

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