



Eating Disorders

Family Feud Game: Comorbid Eating Disorder and Substance Use Disorders *Facilitator's Guide*

Contributors

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Overview

The risk of comorbid substance misuse and dependence is of increasing concern among individuals with eating disorders. Prevalence rates estimate that a high number of patients with eating disorders will misuse substances (up to 50%), and eating disorders are also seen at higher rates among those with substance use disorders (up to 35%). The additional medical and psychiatric risks that are associated with having these comorbid conditions warrants increased awareness and recognition to ensure timely and adequate treatment.

Learning Objectives

By the end of this module, participants will be able to:

- 1) Identify the most commonly misused substances among individuals with an eating disorder
 - 2) Explore predisposing and precipitating factors for comorbid ED/SUD
 - 3) Recognize potential complications of comorbid ED/SUD
 - 4) Be familiar with evidence-based treatments for comorbid ED/SUD, as well as screening tools
- Explore specific challenges of alcohol use disorder after gastric bypass

Structure of the Session

This session involves dividing learners into 2 equal size groups and utilizes a “Family Feud” style game to review relevant topics of comorbid eating disorders (ED) and substance use disorders (SUD). There are 6 rounds of questions that are played by the teams, plus 1 Fast Money round that involves an individual from each team competing against each other. After each round, trainees will review an educational slide that provides additional information on the specific topic covered.

The session should last approximately 50-60 minutes with the following suggested time allotments: 5 minutes of introduction and dividing group into teams, 40-45 minutes on Rounds 1-6 (including informational slides), 5-10 minutes on Fast Money Round (including final informational slide).

Resources Required

- 1) A faculty moderator
- 2) Laptop with internet access and projector
- 3) Facilitator guide/Answer key (to effectively run PowerPoint)
- 4) **Optional:** Co-facilitator (as noted below, a co-facilitator will be useful for aspects of this module)



Introduction/Divide into Teams

Begin with introduction of the topic, and clearly state learning objectives related to comorbid eating disorders and substance use disorders. Then divide the learners into 2 equal sized groups. Small to medium sized groups (3-5 members) are ideal, but larger groups can also be accommodated.

General Game Format for Rounds 1 to 5

One team will go at a time, trading off every other question (i.e. Team A starts with Round 1 question, Team B starts with Round 2 question). One person from each team guesses an answer to the question *without asking his/her teammates*. If the person correctly guesses one of the answers, play moves on to the next team player. If the person guesses incorrectly, facilitator clicks the “X” on the bottom right corner. Once a team has 3 X’s, the other team has a chance to steal. In this case, the entire team works together to come up with *one answer guess*. If their answer is correct, that team gets the points instead of the original team. For example: Team A is doing Round 1, has 70 points, but gets 3 X’s. Team B has a chance to steal and comes up with correct 10 point answer. Team A gets 0 points, Team B gets 80 points. If Team B guesses and did not get a correct answer, Team A gets 70 points and Team B gets 0 points.

NOTE: the PowerPoint does not keep track of score (despite their being a score marker at the top of each slide). This has to be tracked by the facilitator in the space provided below; it may be helpful to have a co-facilitator who can help to track the score throughout the game.

For each Round, play starts with hitting the “Show Question” button on bottom left. This will then pop up over the game show template, and you have to subsequently hit “Hide Question” button in order to hide it. At this point, the answer options are now visible. As teams guess their answer, the facilitator must select the correct answer based on the answer key for each round (see below). The facilitator has the final say on what counts as a correct answer; and he/she can also ask for more clarification/a more specific answer when appropriate. For example, in Round 2 facilitator may accept “Trauma history” as an acceptable guess for Answer 2. In Round 4, team may guess “therapy” as an evidence-based treatment, and the facilitator could ask for a more specific answer, looking for specific modalities of DBT or CBT.

NOTE: There is no double or triple rounds in this version of Family Feud (different from game show)

After each Round, there are 1-2 information slides reviewing the key points to gain from the previous Round of questions. Additional information is provided in the facilitator guide beyond what is in the slides, as well as references. It is important to not spend too much time on the information slides, as this may lead to running out of time to complete all Rounds (including Fast Money).

Round 5 is an optional question that the facilitator can choose to complete or skip. This will largely be based on timing, particularly as you want to leave around 5 minutes for the Fast Money round.

Completing Round 5 will mean that one team gets an extra time of being the first guesser for the questions, which may be reflected in the team scores.



Round 1: Common Substances Abused in ED (105 points)

Question: Which substances are the most commonly misused among individuals with an eating disorder?

Answer 1: LAXATIVES	Answer 5: ALCOHOL
Answer 2: TOBACCO	Answer 6: CAFFEINE
Answer 3: CANNABIS	Answer 7: STIMULANTS (I.E. COCAINE, PRESCRIPTION STIMULANTS LIKE METHYLPHENIDATE, CRYSTAL METH)
Answer 4: DIET PILLS/DIURETICS	Answer 8: OPIATES

Information Slides

- 17 to 46% of patients with eating disorder (ED) will abuse alcohol or illicit substances (compared to 9% of the general population)
- 35% of those with substance use disorder (SUD) have an ED (compared to 3% of general population)

Laxatives

- Laxatives are used in up to 75% of ED population, although this is not necessarily all misuse
- Laxatives often prescribed due to changes in bowel function in ED
- Can be used as a means of losing weight, although it is often not effective
- ED patients who misuse laxatives have higher co-morbid psychopathology and more severe clinical presentations. Found to have higher perfectionism and avoidant personality traits and more comorbid psychiatric diagnosis. Also, can lead to medical complications, such as chronic diarrhea, electrolyte disturbances and acid-base imbalances, reflex peripheral edema, constipation, impairment in colon functioning and nephrolithiasis

Tobacco

- 2010 study reported prevalence of smoking cigarettes: 52% in AN and 45% in BN. However, this difference was not statistically significant, and another study showed no difference among subtypes. Prevalence of smoking is greater among ED patients compared to healthy controls.
- Used as weight loss aid, as it can suppress appetite and help distract from thoughts about food

Cannabis

- From a 2008 European study, lifetime prevalence of cannabis use was 40.7% in ED group (compared to 38.9% of control group, not statistically significant). Multiple other studies have demonstrated cannabis use among ED patients is greater than controls
- Rates among AN & BN subtypes comparable
- Postulated as the one of most frequently used substance, likely reflecting population norms
- May be used to treat other comorbid symptoms, or to cancel out restlessness caused by stimulant use



Diet pills/Diuretics

- Prevalence estimates are up to 50%, and more recent studies suggest ~32% lifetime use
- More commonly seen with binge/purging behaviors (rather than restricting), and often associated with laxative use or other forms of purging. In 2008 study, only 2.5% reporting using diet pills alone as form of purging. The use of multiple methods of purging associated with increased eating disorder severity
- Also associated with comorbid anxiety disorders, borderline personality disorder, alcohol use disorder and increased novelty seeking. It was notably not associated with major depressive disorder and narcissistic personality disorder

Alcohol

- Prevalence of lifetime alcohol use disorder among ED patients = 27%, based on 2005 study. However, a 2008 study showed no difference in lifetime prevalence of alcohol use disorder between group of ED patients and healthy control group. Generally accepted that there are higher rates of alcohol misuse among ED patients. Some studies indicate alcohol use is risk factor for development of ED, while others indicate the reverse
- Alcohol use disorder more commonly found in ED with bulimic features, which includes bulimia nervosa, binge eating disorder, and anorexia binge/purging type. Binge drinking seems to be more highly associated with bulimic features, than frequency of alcohol use

Caffeine

- A 2010 study showed prevalence of caffeine use disorder: 26% in AN, 23% in BN
- Used as an appetite suppressant and to provide energy, as low energy is a common symptom in patients with ED

Stimulants

- Based on a 2008 prevalence study, 17.2% of patients with ED reported lifetime use of stimulants compared to 6.2% of controls
- Can be used as an appetite suppressant. Overall, 30.3% of ED group reported using legal drugs to influence appetite-weight (compared to 4.5% of control group), which could include caffeine, tobacco and appropriately prescribed medications that could suppress appetite (i.e. stimulants, bupropion, topiramate). However, 9.1% of ED group reports illegal drug use to influence appetite-weight (compared to 1.5% of control group), which includes all stimulants including crack, cocaine, and other amphetamines.
- Rates appear to be higher in restricting and purging behaviors compared to bingeing behaviors

Opiates

- Lifetime prevalence of opioid use was found to be 20.1% in ED group (compared to 5.7% of control group). Multiple studies indicate rates of opioid use are higher among ED patients compared to controls

References

- Gregorowski C, Seedat S, Jordaan GP. A clinical approach to the assessment and management of comorbid eating disorders and substance use disorders. *BMC Psychiatry* 2013, 13:289.
- Krug I, et al. Present and lifetime comorbidity of tobacco, alcohol and drug use in eating disorders: a European multicenter study. *Drug Alcohol Depend*. 2008 Sep 1;97(1-2):169-79.
- Reba-Harrelson L, et al. Features associated with diet pill use in individuals with eating disorders. *Eat Behav*. 2008 Jan;9(1):73-81.



Round 2: Factors Contributing to Comorbid ED/SUD (105 points)

Question: What are predisposing and perpetuating factors to the development of comorbid ED and SUD?

Answer 1: GENETIC FACTORS	Answer 5: NEUROTRANSMITTER DYSFUNCTION
Answer 2: CHILDHOOD TRAUMA	Answer 6: PRESENCE OF ADHD
Answer 3: PARENTAL FACTORS	Answer 7: PRESENCE OF DEPRESSION
Answer 4: PERSONALITY SUB-TYPES	

Information Slide

The etiological risk factors to comorbid substance use and eating disorders are best understood through the biopsychosocial model

Biological Model:

- Common disturbances in neurotransmitter dysfunction: Dopamine, serotonin, gamma aminobutyric acid, and endogenous opiate systems
 - Evidence for this model includes the similarities in physical symptoms
- Genetic predisposition
 - Independent genetic heritabilities for each disorder
 - Insufficient evidence from twin and familial studies for a shared genetic link
 - Kendler et al (1995): researched genetic risk factors in psychiatric illness including BN and ETOH use. Concluded vulnerability was influenced by separate genetic factors
 - Wade et al (2004): twin study that found that novelty seeking was associated with psychoactive substance use and may be a genetic predisposition in men to BN and novelty seeking, which then may influence psychoactive substance use
 - Slane et al (2012): found significant correlation in genetic factors of bulimic behaviors and comorbid alcohol use

Personality sub-types:

- Personality features:
 - Novelty seeking
 - Cluster B traits: impulsivity and affective instability
- Broad personality sub-types: high functioning, emotionally dysregulated, avoidance/insecure, constricted/obsessional, behaviorally dysregulated
 - Findings are mixed regarding role of personality and behavioral dysregulation
 - Although there is evidence that some ED patients (particularly those exhibiting binge/purging behavior) experience their ED as an addiction, evidence for shared addictive personality characteristics is inconsistent -> overall there appears to be insufficient empirical evidence in support of the addictions model

Presence of ADHD:

- Comorbid ED and ADHD increases the risk of SUD with strongest association with binge behaviors



Presence of Depression:

- Lifetime history of depression is a common underlying factor for ED and SUD
- Measelle et al (2006): Sample of adolescent females found that depressive symptoms predicted higher future level of both ED and SUD

Environmental Factors:

- Cumulative childhood trauma
 - Baker et al (2007) identified an association between childhood sexual abuse and co-morbid BN and a SUD
 - Leads to increase in impulsivity
 - Relationship is varied and complex
- Parental factors: lower parental educational levels, closer maternal relationships, parental modeling of substance abuse or eating disordered behaviors, and maternal emphasis on weight and appearance predicted higher rates of SUD's and ED.

References

- Kendler KS, Walters EE, Neale MC, Kessler RC, Heath AC, Eaves LJ: The structure of the genetic and environmental risk factors for six major psychiatric disorders in women. Phobia, generalized anxiety disorder, panic disorder, bulimia, major depression, and alcoholism. *Arch Gen Psychiatry* 1995, 52:374–383.
- Wade TD, Bulik CM, Prescott CA, Kendler KS: Sex influences on shared risk factors for bulimia nervosa and other psychiatric disorders. *Arch Gen Psychiatry* 2004, 61:252–256.
- Slane JD, Burt SA, Klump KL: Bulimic behaviours and alcohol use: shared genetic influences. *Behav Genet* 2012, 42:603–613.
- Kollins SH: A qualitative review of issues arising in the use of psychostimulants in patients with ADHD and co-morbid substance use disorders. *Curr Med Res Opin* 2008, 24:1345–1357.
- Measelle JR, Stice E, Hogansen JM: Developmental trajectories of co-occurring depressive, eating, antisocial, and substance abuse problems in female adolescents. *J Abnorm Psychol* 2006, 3:524–538.
- Baker JH, Mazzeo SE, Kendler KS: Association between broadly defined bulimia nervosa and drug use disorders: common genetic and environmental influences. *International Journal of Eating Disorders* 2007, 40:673–678.



Round 3: Medical and Psychiatric Complications of Comorbid ED/SUD (90 points)

Question: What are potential ramifications of comorbid eating disorder and substance use disorder?

Answer 1: MEDICAL COMPLICATIONS	Answer 5: MORE FREQUENT AND/OR SEVERE PSYCHIATRIC COMORBIDITIES
Answer 2: HIGHER MORTALITY RATES	Answer 6: HIGHER RATES OF SUICIDE/SUICIDE ATTEMPTS
Answer 3: LONGER RECOVERY TIMES FROM ED AND/OR SUD	
Answer 4: POORER FUNCTIONAL OUTCOMES	

Information Slides

- More severe medical complications
 - Additive effects of comorbid diagnoses increased risk of medical complications seen in eating disorders:
 - GI complications = esophageal/gastric/colonic dysmotility, Mallory-Weiss tears, esophageal dilation/rupture, ileus, pancreatitis, hepatitis
 - Electrolyte abnormalities = dehydration, hypokalemia/magnesemia
 - Cardiovascular issues = myocardial atrophy, bradycardia/tachycardia, arrhythmia, hypotension, edema
 - Endocrine changes = osteoporosis/skeletal fractures, hypoglycemia, neurogenic diabetes insipidus
 - Respiratory difficulties = respiratory failure, spontaneous pneumothorax/pneumomediastinum
 - Hematologic deficiencies = anemia, leukopenia, thrombocytopenia
 - Higher rates of medical hospitalization in those with comorbid ED/SUD than those with SUD alone → 2011 study showed 5 fold increase in hospitalizations for those with BN and stimulant use disorder compared to those with stimulant use disorder only
 - Case reports of more severe complications (i.e. rhabdomyolysis)
 - No specific data of reproductive complications, although likely additive risk of both substance use and eating disorder behaviors based on above
- Longer recovery time from ED and/or SUD
 - ED symptoms associated with leaving SUD treatment earlier and against medical advice (2015 study)
 - Pattern of one disorder being treated, the other disorder gets worse → Often related to coping with stress from not using certain behaviors, by using other behaviors (for example, increased stress from not purging leads to increased use of alcohol to cope)
- Poorer functional outcomes
 - Decline observed across various domains: psychiatric symptoms, family function, employment (2011 study: self-reported outcomes among those with comorbid ED and stimulant use disorder)



- More frequent and/or severe psychiatric comorbidity
 - Higher rates of depression, PTSD (2010 survey of those with comorbid ED and SUD)
- Higher rates of suicide/suicide attempts
 - Substance use disorders associated with increased suicidality
 - Lifetime BN diagnosis associated with increased lifetime risk of suicidality (even after controlling for comorbid diagnosis, including depression and substance use disorder)
- Higher mortality rates
 - Comorbid substance use disorder associated with increased risk of fatal outcome in patients with ED. The severity of the alcohol or substance use also found to be predictive of increased mortality

References

Bodell LP, Joiner TE, Keel PK. Comorbidity-independent risk for suicidality increases with bulimia nervosa but not with anorexia nervosa. *J Psychiatr Res.* 2013 May;47(5):617-21.

Elmqvist J, Shorey RC, Anderson S, Stuart GL. Eating Disorder Symptoms and Length of Stay in Residential Treatment for Substance Use: A Brief Report. *J Dual Diagn.* 2015;11(3-4):233-7.

García-Go´mez M, Gonza´lez JO, del Barrio AG, Garcí´a NA: Rhabdomyolysis and drug abuse in a patient with bulimia nervosa. *International Journal of Eating Disorders* 2009, 42:93–95.

Round 4: Treatment of Comorbid ED/SUD (90 points)

Question: What specific treatments (i.e. medication class, therapy modality) have evidence to support their use in individuals with comorbid eating disorder and substance use disorder?

Answer 1: SSRIS	Answer 5: DBT
Answer 2: OPIOID ANTAGONISTS	Answer 6: 12 STEP PROGRAMS
Answer 3: CBT	
Answer 4: MOTIVATIONAL INTERVIEWING/MET	

Information Slides

- One of the most important questions is: Do we treat these disorders concurrently? [Elicit audience participation on thoughts]
 - Many studies in ED exclude patients with substance use. Overall, the literature suggests to treat concurrently
- Additionally, there are challenges in treatment:
 - Sequential treatment of ED/SUD may lead to increase/relapse of untreated dx
 - Symptoms of untreated dx may interfere with treatment of other dx
 - Inadequate management of either dx may lead to relapse/worsening of one or both
- Evaluate if medical hospitalization is appropriate
 - Detox if appropriate
 - Weight restoration often important due to effects of starvation on affect and cognition



- Also have to evaluate for and treat laxative abuse, given medical complications
- Pharmacotherapy
 - Evidence for SSRI's and opioid antagonists for alcohol use disorder
- Therapy:
 - Common features across interventions include psycho-education regarding the etiological commonalities, risks and sequelae of concurrent ED behaviors and substance abuse, dietary education and planning, cognitive challenging of eating disordered attitudes and beliefs, building of skills and coping mechanisms, addressing obstacles to improvement and relapse prevention
 - CBT: Most evidence, including self-help and often recommend “stepped-care approach”
 - Motivational interviewing/motivational enhancement therapy: can also help to improve insight/build commitment to change prior to initiation of CBT
 - DBT: helps with emotional regulation (even when not focusing on eating behavior specifically); associated with improved retention rates, reduced ED behaviors and substance use
 - 12 step programs: when recovery has been achieved, especially for alcohol use disorders

References

Grilo CM, Masheb RM, Wilson GT: Efficacy of cognitive behavioral therapy and fluoxetine for the treatment of binge eating disorder: A randomized double-blind placebo-controlled comparison. *Biol Psychiatry* 2005, 57(3):301–309.

Dunn EC, Neighbors C, Larimer ME: Motivational enhancement therapy and self-help treatment for binge eaters. *Psychol Addict Behav* 2006, 20(1):44–52.

Round 5: Alcohol Use Disorder and Gastric Bypass (120 points) - OPTIONAL

Question: What factors increase the risk of developing alcohol use disorder after gastric bypass surgery?

Answer 1: ALTERED PHARMACOKINETICS OF ALCOHOL POST-SURGERY	Answer 5: SMOKING
Answer 2: PRE-SURGICAL ALCOHOL CONSUMPTION	Answer 6: PRESENCE OF ILICIT SUBSTANCE USE
Answer 3: MALE GENDER	Answer 7: LOW SOCIAL SUPPORTS
Answer 4: YOUNGER AGE	Answer 8: ROUX-EN-Y GASTRIC BYPASS

Information Slides

- Does bariatric surgery increase the risk of alcohol use? [Elicit audience participation]
- Anecdotal reports suggest that bariatric surgery may increase the risk for alcohol use disorder
 - Three studies have examined AUD pre- and post- bariatric surgery



- Limitations of studies: low participation rate, small sample size, retrospective assessments of AUD, and different time frames, and assessment methods for pre- and postoperative periods -> it remains unclear whether bariatric surgery influences risk of AUD.
- Study by King et al (2012): Found a significantly higher prevalence of AUD in the second postoperative year, overall, and specifically post-RYGB, compared to the years immediately before and following surgery
- Some bariatric procedures alter alcohol pharmacokinetics: RYGB and sleeve gastrectomy
 - Reach a higher peak alcohol level compared to case controls and this occurs more quickly with more time to return to a sober state
 - Patient surveys have revealed similar changes in alcohol sensitivity following RYGB (feeling intoxicated more rapidly, after drinking less, for longer)
- Demographic characteristics:
 - Male gender
 - Younger age
 - Low social supports
- Pre-surgical alcohol use:
 - Current AUD is a contraindication for bariatric surgery
 - Some evidence that prevalence of lifetime AUD is higher among bariatric surgery candidates (e.g., 31%) compared to the general U.S. population (30%)
- Comorbid substance use:
 - Illicit substances
 - Smoking
- King et al (2012): Did NOT find a significant association between preoperative depressive symptoms, binge eating, mental health, or past-year treatment for psychiatric or emotional problems, and postoperative AUD.

References:

King WC, Chen JY, Mitchell JE, et al. Prevalence of alcohol use disorders before and after bariatric surgery. *JAMA*. 2012;307(23):2516-25.

Klockhoff H, Naslund I, Jones AW. Faster absorption of ethanol and higher peak concentration in women after gastric bypass surgery. *Br J Clin Pharmacol*. 2002;54(6):587-591.

Holt PR. Changes in alcohol metabolism after gastric bypass surgery. *Lancet*. 2011;378(9793):767-768.



FAST MONEY:

Directions: The fast money section is 10 questions with very definitive answers (True or False or other definitive answer). Each team nominates 1 team player to play fast money. To begin, have the individual nominated from Team B step outside the room where they cannot hear the questions/answers. The individual nominated from Team A has 1 minute to answer as many questions correctly as he/she can. The time starts when the facilitator click on the “1:00” in the top right hand corner. Each question is then revealed when you sequentially click on each question. *Of note, the questions displayed on the powerpoint are short hand version of questions only. The complete questions are written below. Therefore, it may be helpful to have someone else (either a participant or a co-facilitator) click on each question as the main facilitator reads the question.*

The facilitator needs to tally how many questions the player gets correct. This can be done directly in the PowerPoint by clicking the green + if the player gets it correct, or the red x if the player gets it incorrect. *Of note, the correct answer is never revealed on these slides. The answers can be reviewed after the second player has his/her turn with the final slide of the PowerPoint.*

Each correct question is worth a point value, but this value can be determined by the facilitator based on the totals of the teams coming into fast money. If within 100 points, we recommend making each question worth 10 points. For larger differences, facilitator may want to use 20 or 50 points to give the losing team a chance to get closer to a higher score. This fast money score is added to each team’s total score in the scoring sheet below.

Example 1: Entering fast money, Team A has 180 and Team B has 165. Fast Money questions are worth 10 points each. Team A gets 3 questions correct, 6 questions wrong, and ran out of time before he/she could answer the 10th question. Player from Team B gets 6 questions correct, 4 questions wrong. Team A gets $180 + 30 = 210$ points and Team B gets $165 + 60 = 225$ points.

Example 2: Entering fast money (due to steal), Team A has 255 and Team B has 90. Fast Money questions are worth 25 points so that final difference between teams has a chance of being closer. Team A gets 3 questions correct, 6 questions wrong, and ran out of time before he/she could answer the 10th question. Player from Team B gets 6 questions correct, 4 questions wrong. Team A gets $255 + 75 = 330$ points and Team B gets $90 + 150 = 240$ points.

After the player from Team A is complete, advance the PowerPoint to the next slide (Fast Money slide that is identical to the one used for Team B). Bring in the player from Team B and repeat the process as above.

After Fast Money is complete, advance the slide to show the correct answers to the 10 questions. For questions regarding the answer to each question, the facilitator can reference the content guide in the previous sections.



Fast Money Questions to be read by Facilitator

We recommend reading as quickly as possible due to 1 minute timing to get through all questions.

How many “steps” are in Alcoholic/Narcotics Anonymous?

What is the term for someone who has comorbid psychiatric illness and chemical dependency?

True/False: Providers need not wait for weight restoration/nutritional stabilization before aggressively treating comorbid ED/SUD with therapeutic interventions

True/False: Sequential treatment of ED/SUD may lead to increase/relapse of untreated diagnosis

Which eating disorder behavior is most associated with substance use disorder?

Patients with diabetes may reduce or manipulate what medicine to help change his or her weight?

True/False: There is a higher prevalence of alcohol use disorders in patients with a history of gastric bypass surgery

True/False: Bulimia nervosa has a stronger association with substance use disorders compared to anorexia nervosa

True/False: Patients with eating disorders do not misuse cannabis as this substance may increase appetite

True/False: Females develop alcoholic liver injury more rapidly and have a lower alcohol toxic threshold than men.

Answers (to be viewed on final slide)

How many “steps” are in Alcoholic/Narcotics Anonymous? **(12)**

What is the term for someone who has comorbid psychiatric illness and chemical dependency? **(Dual diagnosis)**

True/False: Providers need not wait for weight restoration/nutritional stabilization before aggressively treating comorbid ED/SUD with therapeutic interventions **(False)**

True/False: Sequential treatment of ED/SUD may lead to increase/relapse of untreated diagnosis **(True)**

Which eating disorder behavior is most associated with substance use disorder? **(Purging)**

Patients with diabetes may reduce or manipulate what medicine to help change his or her weight? **(Insulin)**

True/False: There is a higher prevalence of alcohol use disorders in patients with a history of gastric bypass surgery **(True)**

True/False: Bulimia nervosa has the strongest association with a substance use disorder in comparison to anorexia nervosa **(False)**

True/False: Patients with eating disorders do not misuse cannabis as this substance increases appetite **(False)**

Females develop alcoholic liver injury more rapidly and have a lower alcohol toxic threshold than men **(True)**



Point Scoring Sheet

	TEAM A	TEAM B
Round 1		
Round 2		
Round 3		
Round 4		
Round 5 (Optional)		
Subtotal		
Fast Money		
Total		