Eating Disorder Training for Community Providers

Working with Eating Disorders and Co-occurring Trauma: The Importance of Doing Your Own Work

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Take Care of Yourself

Learning Objectives

1	2	3	4
Gain a deeper understanding of how to connect with eating disorder clients who have experienced trauma.	Understand more about the intersection of eating disorders and trauma.	Feel more confidence in working with trauma survivors who are struggling with an eating disorder.	Come to a deeper understanding of your own work that needs to be done to best engage with eating disorder clients.

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Why Talk About Trauma?

Trauma and Eating Disorders

- There's a powerful link between eating disorders and trauma-related concerns such as posttraumatic stress disorder (PTSD). The National Comorbidity Survey-Replication Study found that approximately 80% of people who struggled with behaviors such as restricting their food intake or bingeing and purging, also reported exposure to trauma (1).

- In a study of more than 100 adult female patients who have anorexia nervosa or bulimia nervosa, 95% of the respondents reported experiencing at least one traumatic event at some point in their life (2).

1. Breland, J. Y.; Donalson, R.; Dinh, J. V.; and Maguen, S. (2018). Trauma exposure and disordered eating: A qualitative study. Women & Health, 58(2), 160–174. https://doi.org/10.1080/03630242.2017.1282398.
2. Tagay, S.; Schlottbohm, E.; Reyes-Rodriguez, M. L.; Repic, N.; and Senf, W. (2014). Eating disorders, trauma, PTSD, and psychosocial resources. Eating Disorders, 22(1), 33–49. https://doi.org/10.1080/10640266.2014.857517.

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Co-Occurring PTSD with Eating Disorders

- Approximately 26% of those with Binge Eating Disorder (BED) have co-occurring PTSD.
- Approximately 13.7% of those with anorexia nervosa meet criteria for PTSD.
- Approximately 37 to 40% of those with bulimia nervosa experience co-occurring PTSD.
- Rates of PTSD are higher in individuals with purging behaviors than any other eating disorder behaviors. Some researchers theorize that the neurological response to purging leads to feelings of euphoria which allows disconnection from trauma memories/responses, explaining this dynamic.

• Co-occurring PTSD and Eating Disorders https://www.eatingdisorderhope.com/treatment-for-eating-disorders/co-occurring-dual-diagnosis/trauma-ptsd

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Trauma

- The *DSM-5* definition of trauma requires "actual or threatened death, serious injury, or sexual violence."

- OHA Trauma Policy (2015): *Trauma is the unique individual experience of an event or enduring conditions in which a person's ability to integrate his/her emotional experience is overwhelmed. The person experiences, either objectively or subjectively, a threat to his or her psychological safety, bodily integrity, life or the safety of a caregiver or family member.*

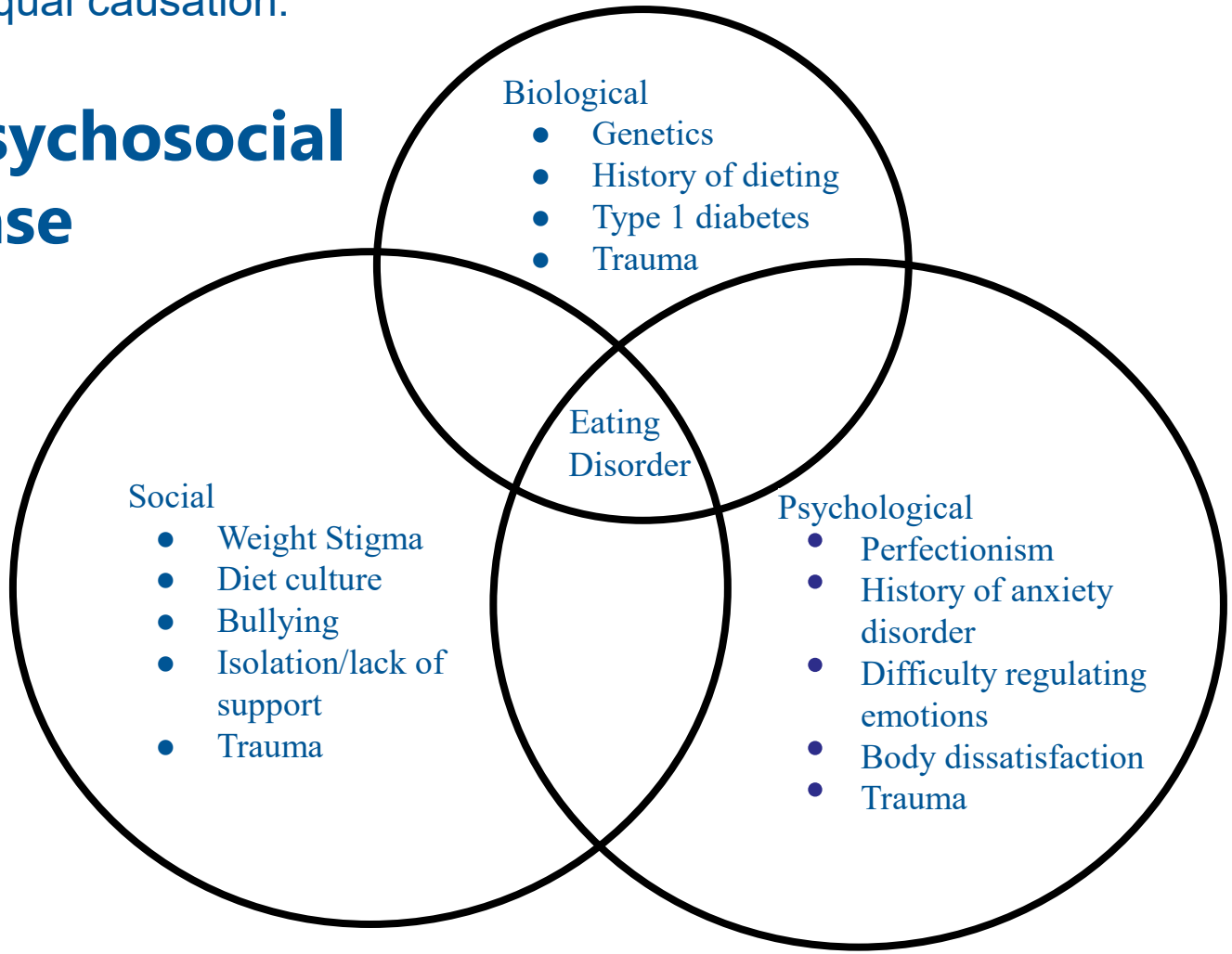
- Three types of trauma
  - Acute - Resulting from a single incident
  - Chronic - Trauma that is repeated or prolonged
  - Complex - Multiple traumatic events

- Shared Characteristics of Trauma and Eating Disorders
  - High rates of dissociation
  - Low self esteem
  - Self Blame
  - Emotional dysregulation

Does trauma cause eating disorders?

Trauma is often co-morbid with eating disorders, but correlation does not equal causation.

Biopsychosocial Disease



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Stages of Brain Response to Trauma

1.The brain continuously scans for threats. Both real and perceived. These threats are processed via the **limbic system.**

2. A detected threat activates the **amygdala,** which stimulates the hypothalamus to release stress hormones, including adrenalin and cortisol.

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Stages of Brain Response to Trauma

3. Reactions to **“fight, flight, freeze, flopping or fawning”** include agitation, fear and frustration which impact mental function and result in unrelated decisions and actions.

4. Prior trauma magnifies the brain-body response. The **parasympathetic nervous system** is automatically activated causing numbing or dissociation.

Stress, Trauma and Eating Disorders

- Trauma and chronic stress elevate adrenaline and cortisol and reduce oxytocin.
- Normally, once a stress is removed, adrenalin and cortisol are removed from the system.
- With chronic stress, these hormones are not removed increasing risk for anxiety, depression, heart disease, sleep disruption, weight instability, and poor memory/concentration.

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Stress, Trauma and Eating Disorders

1. **Nervous system.** The heart may beat faster, and blood pressure rises to ready the body to fight the perceived threat.
2. **Musculoskeletal system.** Muscles tense and can trigger tension headaches.
3. **Respiratory system.** Breathing quickens.
4. **Cardiovascular system.** Heart rate increases.
5. **Endocrine system.** Signals sent from glands to the body cause a release of cortisol into the body to fight the perceived threat.
6. **Gastrointestinal system.** Eating habits may change, and the feeling of "butterflies" in your stomach may occur.

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Stress, Trauma and Eating Disorders

- Oxytocin acts to help us deal with stress. It elevates our moods. Trauma and chronic stress decrease the levels of oxytocin.

- People with certain genetic predispositions may experience less stress with restriction of food intake.

- Other people might experience less stress with bingeing and the temporary reward that it brings.

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Genetics and Intergenerational Trauma

- Not everyone who experiences a traumatic event will go on to develop PTSD. Why?

- The scientific evidence is limited at this time, but it does suggest that DNA methylation associated with severe trauma (living in war zones, witnessing genocide) is passed on to offspring, making them more liable to PTSD.

- Children of parents who had experienced extreme trauma have DNA methylation modifications seen in trauma and PTSD.

The Effects of Trauma, with or without PTSD, on the Transgenerational DNA Methylation Alterations in Human Offspring. Brain Sci. 2018, 8.(5) 83; doi.org/10.3390/brainsci8050083

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Nutrition Status and Stress

- Chronic stress can affect eating patterns. Abnormal eating patterns can affect blood glucose.
- People might feel less motivation to prepare food or pay attention to eating.
- Cortisol tends to promote cravings for highly palatable foods.
- Cortisol promotes central adiposity, which is associated with insulin resistance, increased risk of type 2 diabetes, cardiovascular disease and certain breast cancers.
- Cortisol lowers levels of the hormone leptin (that promotes satiety) while increasing the hormone ghrelin (that increases appetite). This all makes sense from an adaptive standpoint.

Guiding Principles of Trauma Informed Care

SAMHSA's Concept of Trauma and guidance for a Trauma-Informed Approach, 2014 http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Safety

Throughout the organization, staff and the people they serve feel physically and psychologically safe.

Trustworthiness and transparency

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

Peer support and mutual self-help

These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

Collaboration and mutuality

There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.

Empowerment, voice, and choice

Organization aims to strengthen the staff, client, and family members's experience of choice and recognizes that every person's experience is unique and requires an individualized approach. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

Cultural, historical, and gender issues

The organization actively moves past cultural stereotypes and biases , offers culturally responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

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FIRST THINGS FIRST

Treating the trauma is essential but doing so will not make the eating disorder go away. The eating disorder must be stabilized first.

This includes:

- Gather a treatment team: Therapist, Dietitian, Medical provider, family or other support people.
- Medical stabilization.
- Weight restoration.
- Stop Eating Disorder behaviors.
- Recognize other potential co-occurring issues.

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BODY SHAME: Where Eating Disorders and Trauma Meet

- Did you lose weight? you look great!
- You have such a pretty face for your size.
- Aren't you a little old for that outfit?
- Do you really need all that food?
- If you get any fatter no man will want you.
- I wouldn't have to touch you if you didn't look so hot.
- I could tell you wanted it because of the way your body responded.

Body shaming is the act of making negative or inappropriate comments about someone's body, weight or size. This can include things like racialized or sexualized comments or comments about a disability.

Shame is a key emotional after effect of trauma, and an emerging literature argues that we may "have failed to see the obvious" by neglecting to acknowledge the influence of shame on post-trauma disorders (Taylor, 2015) (1)

1.Dolezal, L., Gibson, M. Beyond a trauma-informed approach and towards shame-sensitive practice. *Humanit Soc Sci Commun* **9**, 214 (2022). https://doi.org/10.1057/s41599-022-01227-z

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Making Ourselves Ready to do the Work

How do we connect? And is it important?

A client with an eating disorder and trauma often has a difficult time walking in and asking for help. How we greet them, talk with them and the relationship we form can have a huge affect on their recovery.

“Anyone who dispassionately looks at effect sizes can now say that the therapeutic relationship is as powerful, if not more powerful, than the particular treatment method a therapist is using.” (1)

1.”Better relationships with patients lead to better outcomes” retrieved from https://www.apa.org/monitor/2019/11/ce-corner-relationships

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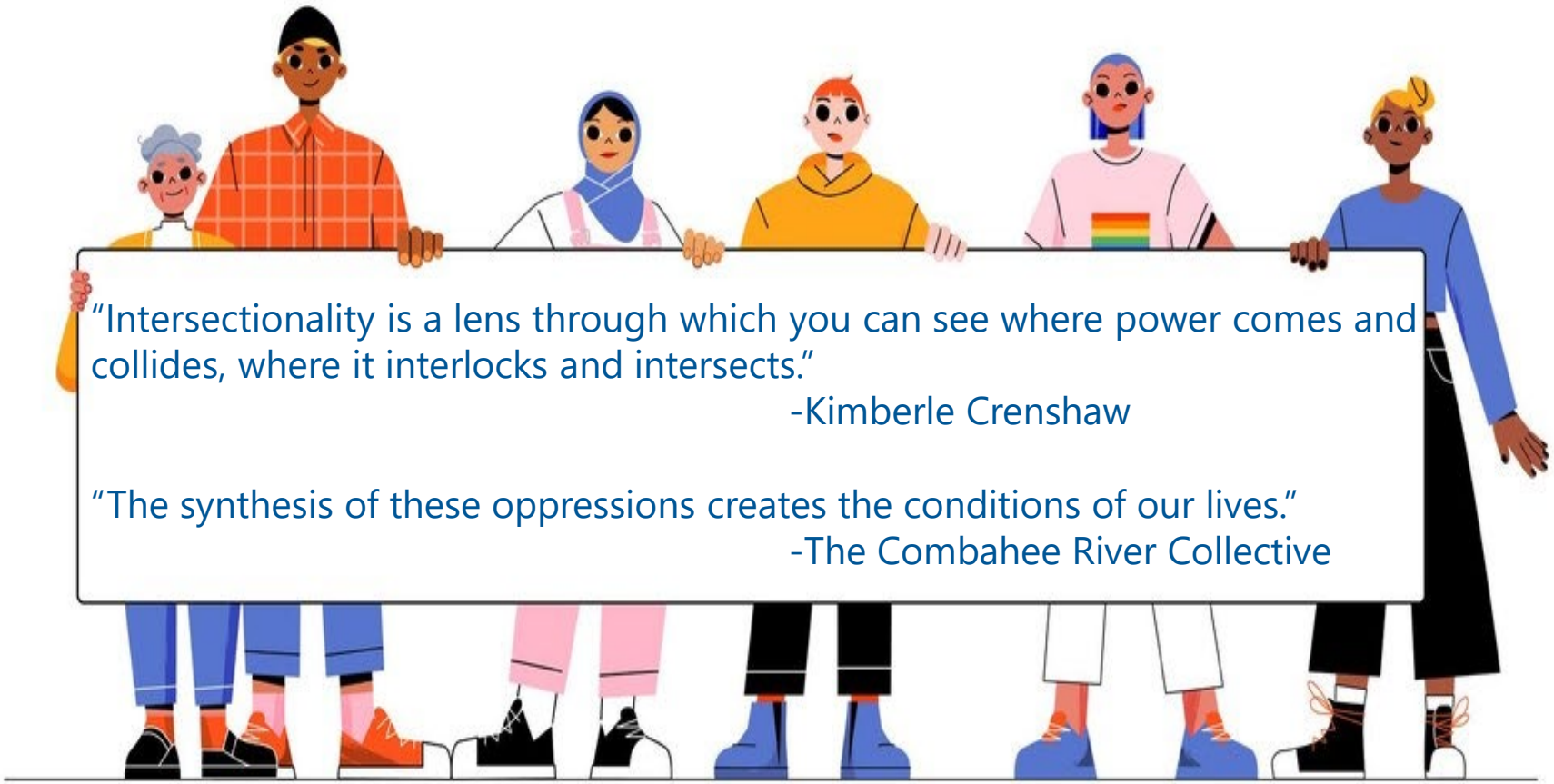
Who We're Working With



"Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects."

-Kimberle Crenshaw

"The synthesis of these oppressions creates the conditions of our lives."

-The Combahee River Collective

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Questions to ask ourselves

- How do I feel about my body? My weight?
- What are my beliefs about Health at Every Size?
- How do I feel when I hear about trauma?
- Am I able to hear details of violence and stay present for my client?
- What kind of support and self care do I have in place?

- How do I work with clients from different life experiences?

Race	Sexual orientation
Class	Gender Identity
Ethnicity	Physical ability
Nationality	Immigration status
Religion	Age

- If I'm a survivor or in recovery, am I doing my work?
- Am I comfortable with silence?

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How Do We Get There?

Qualities of a good therapeutic relationship:

- Mutual trust, respect, and caring
- General agreement on the goals and tasks of the therapy
- Shared decision-making
- Mutual engagement in "the work" of the treatment
- The ability to talk about the "here-and-now" aspects of the relationship with each other
- The freedom to share any negative emotional responses with each other
- The ability to correct any problems or difficulties that may arise in the relationship (1)

Our trauma survivor clients with eating disorders often come in with little or no trust, many failed attempts at getting help and very low self esteem. They have been misdiagnosed and misunderstood.

1.“THE IMPORTANCE OF THE RELATIONSHIP WITH THE THERAPIST” HTTPS://WWW.FAMILY-INSTITUTE.ORG/BEHAVIORAL-HEALTH-RESOURCES/IMPORTANCE-RELATIONSHIP-THERAPIST

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But What Do We Actually Do?

Connection comes first. Spend time getting to know them.

– What initially brought them in? The ED or the trauma?

– Do a detailed life story if you have time. Where do the ED and trauma collide?

– How do you feel in the room with them?

– How do you feel before and after a session?

– Do we disclose our own history of ED or trauma?

– What if you don't believe them?

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“Other people had it worse than me. Lots of people are sicker than I am”

- Help clients have compassion for themselves.
- How to deal with the frustration of working with someone who doesn’t believe they deserve help.
- How to use the relationship to reflect back to the client their worth and dignity.
- How to deal with ranking of pain.

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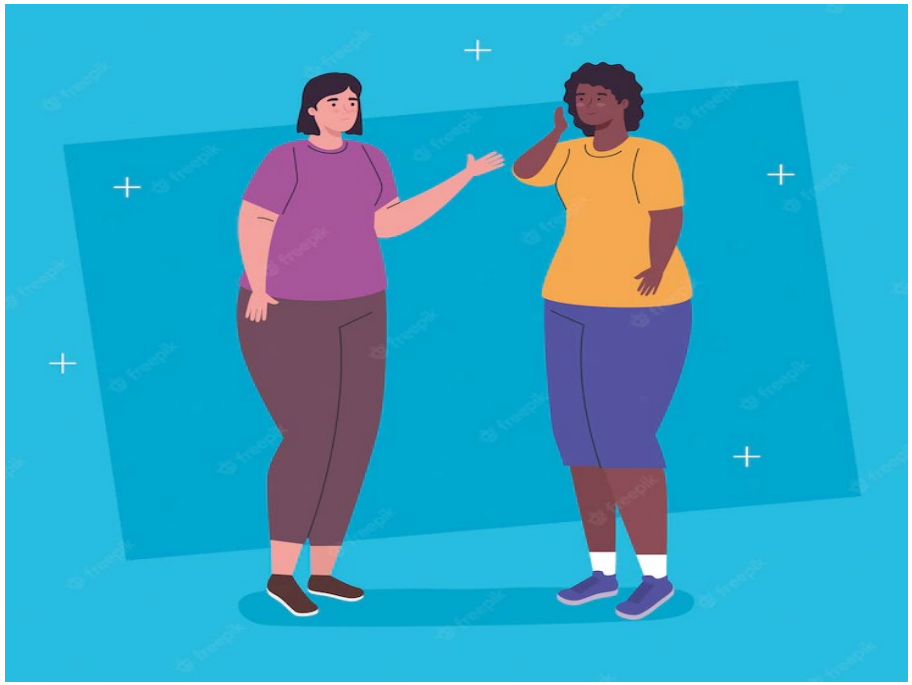
Empathy and Unconditional Positive Regard

- For our client
- For ourselves
- Find something to like about even the most difficult client
- You may be the first person to show the client respect and empathy
- Be aware of how important this relationship may be for them



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Things to Say

- Survivor
- Fat*
- I believe you
- Your body is perfect just the way it is (do not say this to trans clients struggling with body dysphoria)
- None of it was your fault
- Would you like to talk about it?
- What can I do to support you?
- Is it ok with you for me to …

Please Don't Say

- Victim
- Are you sure that's what happened?
- You're looking healthy
- Obese
- Overweight
- You just need to eat
- You don't look sick/anorexic/like you puke
- It couldn't have been that bad/it could have been worse
- You have to report this

*Fat is a descriptor being reclaimed by the size advocacy community

Examples of Working with Trauma and Eating Disorders

- Insistent on a certain meal plan or certain foods: does that work?
- Confrontational: when, how, and when not
- Highly selective eaters: whose issue is it really?

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How to be an Ally

1. Listen and ask.
2. Understand your own privilege and be willing to use it.
3. Apologize when you make a mistake.
4. Tell them that you believe them.
5. Create a safe space.
6. Be authentic in the room with them.
7. Do what you say you're going to do. Follow through.
8. Walk the talk.
9. Do not touch without asking first.
10. Do not make body related comments unless you have a conversation first.
11. Use neutral language when talking about food.

8 tips for being an ally to your queer or trans loved one with an eating disorder.
https://withinhealth.com/blog/posts/18-tips-for-being-an-ally-to-your-queer-or-trans-loved-one-with-an-eating-disorder

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Handouts and References

Paper on Nutrition and Stress: https://www.hsph.harvard.edu/nutritionsource/stress-and-health/

Lie et al. Stressful life events among individuals with a history of eating disorders: a case-control comparison. BMC Psychiatry 2021. Oct 13; 21 (1):501 PMID: 34645394

Hardaway et al. Integrated circuits and molecular components for stress and feeding: implications for eating disorders. Genes Brain Behav. 2015 Jan; 14(1): 85–97. doi: 10.1111/gbb.12185

Youssef N. et al. The Effects of Trauma, with or without PTSD, on the Transgenerational DNA Methylation Alterations in Human Offspring. 2018 *Brain Sci. 8*(5), 83; https://doi.org/10.3390/brainsci8050083

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Resources

Diet Culture/Body Shaming

- https://www.apa.org/monitor/jan04/weighing
- https://www.nationaleatingdisorders.org/blog/recognizing-and-resisting-diet-culture

PTSD and Trauma

- https://www.ptsd.va.gov/understand/common/common_adults.asp#:~:text=Going%20through%20trauma%20is%20not,assault%20and%20child%20sexual%20abuse.
- https://www.echotraining.org/we-love-science/

Therapeutic Relationship

- https://www.goodtherapy.org/blog/eating-disorders-and-the-therapeutic-relationship-0910184
- https://www.socialworktoday.com/archive/070708p20.shtml
- https://www.apa.org/monitor/2021/11/feature-cultivating-empathy

Trauma and Eating Disorders

- https://www.verywellmind.com/the-influence-of-abuse-trauma-on-disordered-eating-1138267
- https://seedsofhope.pyramidhealthcarepa.com/the-link-between-trauma-and-eating-disorders
- https://www.tandfonline.com/doi/full/10.1080/10640266.2021.1985807

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Thank you!

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