TRAUMA-INFORMED APPROACHES TO EATING DISORDERS

Andrew Seubert, NCC, LMHC • Pam Virdi, MEd, RMN, CPN • Editors

Delivers a proven treatment model for clinicians in all orientations

This unique, hands-on clinical guide examines the significant relationship between trauma, dissociation, and eating disorders and delivers a trauma-informed phase model that facilitates effective treatment of individuals with all forms of eating disorders. It describes, step-by-step, a four-phase treatment model encompassing team coordination, case formulation, and a trauma-informed, dissociation- and attachment-sensitive approach to treating eating disorders.

Edited by noted specialists in eating and other behavioral health disorders, Trauma-Informed Approaches to Eating Disorders examines eating disorders from neurological, medical, nutritional, and psychological perspectives. Dedicated chapters address each treatment phase from a variety of orientations, ranging from EMDR and CBT to body-centered and creative therapies. The book also reveals the effectiveness of a multifaceted, phase model approach. Recognizing the potential pitfalls and traps of treatment and recovery, it also includes abundant psychoeducational tools for the client.

KEY FEATURES:

• Examines eating disorders from neurological, medical, nutritional, and psychological perspectives
• Highlights the relationship between trauma, dissociation, and eating disorders
• Maps out a proven, trauma-informed, four-phase model for approaching trauma treatment in general and eating disorders specifically
• Elucidates the approach from the perspectives of EMDR therapy, ego state therapy, somatosensory therapy, trauma-focused CBT, and many others
• Provides abundant psychoeducational tools for the client to deal with triggers and setbacks
• Offers the knowledge and expertise of over 20 international researchers, medical professionals, and clinicians
Trauma-Informed Approaches to Eating Disorders
Andrew Seubert, NCC, LMHC, is the cofounder of ClearPath Healing Arts Center in Corning and Burdett, New York. A licensed psychotherapist for 35 years, he has an extensive background in existential-Gestalt Therapy and in music therapy, and provides eye movement desensitization and reprocessing (EMDR) consultation and training for clinicians. Andrew specializes in working with trauma, posttraumatic stress, eating disorders, and the integration of spirituality and psychotherapy.

His first book, *The Courage to Feel: A Practical Guide to the Power and Freedom of Emotional Honesty*, was published in 2008. He has authored a chapter in *EMDR Solutions* on the use of EMDR with clients with intellectual disability and coauthored an article on the same topic in 2011 for the *Journal of EMDR Practice and Research*. He has written two chapters on eating disorders for *EMDR Solutions II* and has completed *How Simon Left His Shell*, a fable and user’s guide based on *The Courage to Feel*, to teach emotional honesty to children and adolescents.

Pam Virdi, MEd, RMN, CPN, is an accredited EMDR consultant, integrative psychotherapist, lecturer, and supervisor who now works full-time in private practice with adults, couples, and young people in Birmingham, UK. She specializes in the treatment of eating disorders, complex trauma, and posttraumatic stress disorder (PTSD). She is an accredited member of The British Association for Counselling and Psychotherapy and EMDR Europe. Originally trained as a psychiatric nurse, Pam has devoted the last 24 years to the National Health Service (UK) as a specialist psychotherapist and trainer in an eating disorder service in Birmingham.

As a lecturer, she has developed, coordinated, and delivered programs of study up to master’s level and directed a year-long Eating Disorder Pathway (part of a BSc Mental Health Studies degree) at Birmingham City University for 8 years. She has served as a member on the editorial board of the *European Eating Disorder Review Journal* (1998–2008) and has created and chaired national special interest groups for eating disorders, both generally and EMDR specific.
Andrew:
For Erin Leah and all of those who suffer from eating disorders, and for the village—the families and clinicians—who walk with them.

Pam:
For my sons, Alex and Jordan.
Contents

Contributors xi
Foreword by Michael P. Levine, PhD xv
Preface xix
Acknowledgments xxi
Introducing Our Terms xxiii

SECTION ONE: OVERVIEW AND RECOGNIZING THE TERRITORY 1

1. The Many Faces of Eating Disorders: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Other Specified Feeding or Eating Disorder (OSFED), Bulimarexia, and Orthorexia 3
   Maria Zaccagnino, Martina Cussino, Chiara Callerame, and Cristina Civilotti

2. Trauma and Eating Disorders: The State of the Art 15
   Johan Vanderlinden and Giovanni Luca Palmisano

SECTION TWO: TRAUMA TREATMENT IN EATING DISORDERS: A COMPLEX AFFAIR 33

3. Recognizing the Territory: The Interaction of Trauma, Attachment Injury, and Dissociation in Treating Eating Disorders 35
   Holly A. Finlay

4. The Centrality of Presence and the Therapeutic Relationship in Eating Disorders 45
   Carolyn Costin

SECTION THREE: BRAIN, BODY, AND EATING DISORDERS 57

5. The Neurobiology of Trauma and Eating Disorders 59
   Rayane Chami and Janet Treasure

6. What Doctors, Dietitians, and Nutritionists Need to Know 75
   Edward P. Tyson and Carolyn Hodges Chaffee
SECTION FOUR: THE PHASE MODEL—PHASES I AND II  87

7. Assessing “Trauma-Driven Eating Disorders”: A Road Map Through the Maze  89
   Pam Virdi and Jackie Nicholls

8. The Preparation Phase  105
   Andrew Seubert

9. Discovering the Power of Movement: Dance/Movement Therapy in the Treatment of Eating Disorders and Trauma  115
   Susan Kleinman

10. The Courage to Feel: Eating Disorders and the Case for Emotions  123
    Andrew Seubert

11. Neurofeedback and the Eating Disordered Brain  135
    Amelia McGinnis

SECTION FIVE: APPROACHES TO TRAUMA PROCESSING AND EATING DISORDERS—PHASE III  147

12. Interpersonal/Relational Psychodynamic Treatment of Eating Disorders  149
    Jean Petrucelli

13. Eye Movement Desensitization and Reprocessing (EMDR)  165
    DaLene Forester

14. Trauma-Focused Cognitive Behavioral Therapy and Eating Disorders  179
    Irene Rovira

15. Ego State/Parts Work in the Treatment of Eating Disorders  193
    Andrew Seubert and Robin Shapiro

16. IFS (Internal Family Systems) and Eating Disorders: The Healing Power of Self-Energy  209
    Jeanne Catanzaro, Elizabeth Doyne, and Katie Thompson

17. Structural Dissociation in the Treatment of Trauma and Eating Disorders  221
    Kathleen M. Martin

18. Second Helpings: AEDP (Accelerated Experiential Dynamic Psychotherapy) in the Treatment of Trauma and Eating Disorders  235
    Natasha C.N. Prenn and Jessica K. Slatus

19. Eating Disorders and Hypnosis  249
    G. Trevor Hadfield

    Phil Mollon

21. Somatic Experiencing: The Body as the Missing Link in Eating Disorder Treatment  275
    Paula Scatoloni

© Springer Publishing Company
Contributors

Madeline Altabe, PhD
Visiting Lecturer of Psychology
Georgia State University
Atlanta, Georgia

Michael E. Berrett, PhD, CEDS
Psychologist
CEO and Cofounder, Center for Change
Orem, Utah

Chiara Callerame, PhD
Psychotherapist and EMDR Practitioner
EMDR Center for Eating Disorders
Milan, Italy

Jeanne Catanzaro, PhD
Center for Self-Leadership
Licensed Clinical Psychologist
Brookline, Massachusetts

Carolyn Hodges Chaffee, MS, RDN, CEDRD
Director, Upstate New York Eating Disorder Services
Elmira, New York

Rayane Chami, MSc
PhD Student
Institute of Psychiatry, Psychology, and Neuroscience
King’s College
London, United Kingdom

Cristina Civilotti, PhD
Psychotherapist and EMDR Practitioner
EMDR Center for Eating Disorders
Milan, Italy

Carolyn Costin, MA, Med, MFT, CEDS
Director of the Carolyn Costin Institute
Malibu, California

Sabree A. Crowton
Doctoral Student
Department of Counseling Psychology
Brigham Young University
Provo, Utah
Martina Cussino, PhD, CEDS  
Psychotherapist and Accredited EMDR Europe Consultant  
EMDR Center for Eating Disorders  
Milan, Italy

Marnie Davis, MA, LMHC, CEDS  
Certified EMDR Therapist  
Founder and Director, A Place for Change  
Maitland, Florida

Cynthia “Cyd” Davis-Hubler, MA, LMHC  
Counselor and Art Therapist  
Eating Disorders Treatment Center  
Albuquerque, New Mexico

Elizabeth Doyne, PhD  
Private Practice  
Licensed Clinical Psychologist and Certified IFS Therapist  
Rochester, New York

Holly A. Finlay, MA, LPCC, CEDS, CSP, F. IAEDP  
Clinical Director and Cofounder  
Eating Disorders Treatment Center  
Albuquerque, New Mexico

DaLene Forester, PhD, LMFT, LPCC, CEDS  
Psychotherapist, Private Practice  
Director and Trainer, Advanced Education Institute (AEI)  
Former President and Board Member of EMDR International Association  
Redding, California

Deborah A. Good, PhD, ATR-BC, ATCS, LPAT, LPCC  
Past President of the American Art Therapy Association  
Past President of the Art Therapy Credentials Board  
Albuquerque, New Mexico

G. Trevor Hadfield, MBBS, AKC, MRCS, LRCP, DCH, DRCOG, MFFP, RCOG, Adv Dip Clin Hyp  
Medical Doctor (retired), Therapist and Lecturer in Clinical Hypnosis  
Windmill Health Care and Birmingham City University  
Gentleshaw, Rugely, United Kingdom

Susan Kleinman, MA, BC-DMT, NCC, CEDS  
Creative Arts Therapies Supervisor and Dance/Movement Therapist  
The Renfrew Center  
Coconut Creek, Florida

Michael P. Levine, PhD, FABD  
Professor Emeritus of Psychology  
Kenyon College  
Gambier, Ohio
Rachel Lewis-Marlow, MS, EdS, LPC, LMBT  
Codirector and Cofounder  
Embodied Recovery Institute  
Chapel Hill, North Carolina

Kathleen M. Martin, LCSW  
EMDRIA Approved Consultant and Trainer  
Martin Counseling and Consulting Services  
Rochester, New York

Amelia McGinnis, LCSW  
Director, McGinnis Counseling and Consulting  
Lamont, Pennsylvania

Phil Mollon, PhD  
Clinical Psychologist, Psychoanalyst, Energy Psychotherapist  
Letchworth Garden City, United Kingdom

Jackie Nicholls, DClinPsy, MSc, BSc (Hons)  
Consultant Clinical Psychologist, Systemic Family Therapist, EMDR Europe Accredited Practitioner  
Hereford, United Kingdom

Giovanni Luca Palmisano, PhD  
Volunteer Researcher, Department of Psychology  
University of Bari  
Bari, Italy

Jean Petrucelli, PhD  
Clinical Associate Professor at New York University  
Faculty at Institute of Contemporary Psychotherapy (ICP)  
New York, New York

Natasha C. N. Prenn, LCSW  
Senior Faculty  
AEDP Institute  
New York, New York

P. Scott Richards, PhD  
Professor, Department of Counseling Psychology  
Brigham Young University  
Provo, Utah

Irene Rovira, PhD  
Director of Psychology Postdoctoral Program and Psychology Coordinator  
Center for Eating Disorders at Sheppard Pratt  
Baltimore, Maryland

Paula Scatoloni, LCSW, CEDS, SEP  
Private Practice  
Cofounder, Embodied Recovery Institute  
Chapel Hill, North Carolina
Andrew Seubert, NCC, LMHC  
Private Practice  
Cofounder and Codirector, ClearPath Healing Arts Center  
Corning and Burdett, New York

Robin Shapiro, LICSW  
Private Practice  
Psychotherapist and Consultant  
Seattle, Washington

Jessica K. Slatus, LCSW  
Certified Supervisor  
AEDP Institute  
Boulder, Colorado

Joslyn P. Smith  
Director of Policy and Government Affairs  
Binge Eating Disorder Association  
Severna Park, Maryland

Katie Thompson, LPC, NCC, CEDS  
Private Practice  
Consano Therapy  
Kirkwood, Missouri

Janet Treasure, OBE, PhD, FRCP, FRCPsych  
Professor of Psychiatry  
Institute of Psychiatry, Psychology, and Neuroscience  
King's College  
London, United Kingdom

Edward P. Tyson, MD  
Adjunct Assistant Professor  
Department of Kinesiology and Health Education  
University of Texas  
Austin, Texas

Johan Vanderlinden, PhD  
Department Head, Adult Psychology  
Coordinator, Eating Disorder Unit of the University Psychiatric Center  
Catholic University of Leuven  
Leuven, Belgium

Pam Virdi, MEd, RMN, CPN  
Psychotherapist, Private Practice  
Birmingham, United Kingdom

Maria Zaccagnino, PhD  
Psychotherapist and Accredited EMDR Europe Consultant  
EMDR Center for Eating Disorders  
Milan, Italy
If you are, or are working to become, a clinician who treats eating disorders, you will encounter what are sometimes called “complex presentations.” Quite often, the people who are understandably, but inadequately, categorized in this way have some form of anorexia nervosa, bulimia nervosa, or binge eating disorder, compounded by significant levels of anxiety and depression and a history of trauma, which has left in its wake a propensity for dissociation, substance abuse, somatoform (e.g., conversion) symptoms, nonsuicidal self-injury, and/or personality disorder.

The person who “presents” and, typically, suffers in this “complex” manner might well meet the current Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) criteria for posttraumatic stress disorder (PTSD). Anyway, the complexity present for treatment providers will almost certainly be extended by body image problems and by intense existential “issues” that eerily reproduce, in the person’s life and in the treatment sessions themselves, the crises that constitute Erickson’s stages of psychosocial development: trust versus mistrust; autonomy versus shame/doubt; initiative versus guilt; industry versus inferiority; intimacy versus isolation.

I am not a clinician. From 1979 to 2012 I was a professor in the Department of Psychology at an Ohio liberal arts college, where I taught courses in abnormal psychology, clinical psychology, and eating disorders. This position afforded me numerous opportunities to discuss trauma, as well as eating disorders, with scholars in English, Classics, History, Women’s and Gender Studies, and Holocaust Studies. Based on my background, I think it important for all of us interested in the overlap between trauma studies, trauma-informed approaches to therapy, and eating disorders to be reminded periodically that the concept of trauma itself is, and has been since at least the time of Homeric tradition before the 7th century BCE, freighted with complexity and controversy (see Jones & Wessely, 2006; Micale & Lerner, 2001; Shay, 1994; Zoellner, Bedard-Gilligan, Jun, Marks, & Garcia, 2013).

This is, in part, because of the fact that the meanings of trauma are inextricably tied to fundamental assumptions about being human, assumptions that shape powerful sociocultural and legal practices. For example, trauma, disorder, and recovery (including posttraumatic growth; Joseph, Murphy, & Regel, 2012) are all linked to one or more of the following: (a) the vagaries of a powerful natural world; (b) power, gender, and the ownership and control of bodies; (c) the meanings of family, self, social class, sexuality, and sexual orientation; (d) the relationship between the limits of the human body, psychological resilience, and vulnerability; (e) what a society calls “progress” (e.g., mines that extract resources from deep in the earth; high-speed trains and airplanes; massive skyscrapers that tower over enormous urban developments); (f) the apparently limitless savagery of war; (g) the potential malevolence of some humans toward others, especially children; and (h) the definition of and responsibility for “real” injury, disorder, and disability.

Although acknowledgment of the complexities, controversies, and sociohistorical twists and turns associated with the meanings of trauma is often missing from the
literature on eating disorders, a fair number of articles and individual chapters in edited volumes do emphasize comorbidity between PTSD and eating disorders, as well as the diagnostic, etiological, and therapeutic challenges posed by this combination. This positive state of affairs is attributable in large part to the work of U.S. psychiatrist Timothy Brewerton (see Brewerton, 2015). His presentations on trauma and eating disorders are always packed with clinicians at various stages of their careers, all seeking guidance as to how to help people whose “complex presentations” have perplexed, if not overwhelmed, themselves, their families, and a series of therapists.

Yet, while an online search of books in the 136 libraries connected via the OhioLink system revealed approximately 80 topic areas associated with “PTSD,” not one specifically addressed eating disorders. Expanding the search to “trauma” as a topic yielded approximately 380 areas, with only one focused on eating disorders. Although the links between trauma, PTSD, and eating disorders are of great importance to clinicians and researchers, the only book I could find that is dedicated to this topic was Vanderlinden and Vandereycken’s (1997) co-authored volume titled Trauma, Dissociation, and Impulse Dyscontrol in Eating Disorders, published more than 20 years ago.

Trauma-Informed Approaches to Eating Disorders is clearly a much needed and long overdue book about treatment, written by a diverse group of clinicians and carefully edited to focus on the needs and strengths of clinicians. But focus and timeliness are only part of the foundation for my appreciation of this collection of chapters by experts from different fields. The complexities and challenges that undergird, surround, and even haunt the nature, diagnosis, treatment, management, and understanding of eating–disorders–in-relation-to-trauma are so great, even for veteran clinicians, that they can leave practitioners at any level of experience feeling helpless and exhausted. This book, in a way that would be appreciated by practitioners of acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012), accepts the reality of those feelings and is committed to improving treatment, understanding, and compassion. It delivers hope.

Trauma-Informed Approaches to Eating Disorders is designed to foster respect for complexity and link it to humility in the presence of tragedy, tribulations, and suffering, framed all too often by our own shortcomings as healers. Knowing Andrew, knowing some of the chapter contributors (Carolyn Costin, Michael Berrett, Joslyn Smith), and reading all the chapters, I believe the following is a guiding principle for this book: respect for complexity + humility + hope + courage (defined by the presence of commitment and uncertainty/anxiety) + openness = progress in therapy. I would define this progress as more people with trauma-infused eating disorders receiving effective treatment, including earlier and more accurate diagnosis, from more professionals, who can flexibly draw from a wide variety of approaches, depending on the person, the problems, and the circumstances. Moreover, drawing on my experiences as a psychology professor and as a client in psychotherapy for depression and anxiety, I believe that the progress embodied and envisioned in this book moves us in the direction of therapy as a sacred, interpersonal journey toward the forms of integrative healing that have at their core hard-won wisdom through the making of meaning.

The previously described equation does not imply, let alone demand, that all models and treatment approaches are equally valid. We should indeed honor, for example, the contributions of neuroscience and evidence-based treatments grounded in randomized controlled trials AND we should also (with humility) never lose sight of the prejudices and other dangerous forms of arrogance that have been perpetrated and perpetuated for at least 200 years by psychiatry, psychology, and genetics in the name of “science” (Appignanesi, 2008; Gould, 1981; Valenstein, 1986). One of the great strengths of this book, and one of the major needs that it fulfills, is that it encourages us to consider—and keep an open mind about—multiple,
sometimes vastly different, approaches to a set of complex, multidimensional, socio-psycho-bio disorders that have baffled healers, artists, and sufferers for thousands of years.

Michael P. Levine, PhD
Samuel B. Cummings Jr. Professor of Psychology, Emeritus
Kenyon College
Gambier, Ohio

REFERENCES


Preface

They call us editors, my associate, Pam Virdi, and myself (Andrew Seubert). However, as a contributing author once described our role, we are the stewards of this book. We have been initiators, organizers, and, of course, editors; yet this amazing project has been personal and communal as well as professional. It has been inspired by a lost daughter, wounded friends, and damaged clients, all to the overwhelming impact of painful life events and to the eating disorders (EDs) employed to tolerate the intolerable. And it has been birthed through the hands and the great hearts of contributing authors, clinicians, and mentors: an entire village.

How This Book Came to Be

EDs are dangerous, ubiquitous, usually chronic in nature, and difficult to treat. Anorexia nervosa (AN) has the highest fatality rate (4%) of any mental illness. Bulimia nervosa reveals a fatality rate of 3.9%. Of all American adults, 2.8% will struggle with binge eating disorder during their lifetime.

It was 18 years ago that we lost our oldest child (my stepdaughter, although more like a daughter), Erin Leah, to AN. She was 23 and had struggled with the disorder since the age of 11. Nothing seemed capable of breaking the stranglehold of the anorexia. Nothing and no one. Seven or more hospitalizations, ongoing therapy, family therapy, medications—all came up short, until it was too late. Erin’s passing was, and remains, an inspiration and the motivation for this book.

EDs offer an enormous challenge to therapists because of their complexity, which includes severe medical risk, co-occurring anxiety, depression and personality disorders, an addiction component, and body image distortion—all of this within a media-driven culture of thinness in which starving and purging can for some become lifestyle choices. This complexity is further exacerbated by the presence of painful life experiences or trauma.

The Need for This Book

The only other book to address the presence of trauma in clients with EDs was published in 1997 (Vanderlinden & Vandereycken), and one of its authors, Dr. Johan Vanderlinden, has honored us by contributing to this book with a state-of-the-art literature review. When trauma is understood more broadly, that is, small as well as large events, omission as well as commission, grief and loss as well as attachment injury, it becomes clear that trauma, as well as EDs, is everywhere. Researchers (Brewerton, 2015) have begun to show the relationship between trauma and EDs, but there is very little in the literature to guide the clinician in the nature, role, and treatment of trauma in clients with EDs.

EDs, as well as trauma, require a team approach and multifaceted strategies. Much has been contributed by the medical and nutritional fields, as well as by various therapeutic approaches (e.g., cognitive behavioral, acceptance and commitment, dialectical...
behavioral). Yet, despite the high co-relationship between painful life events, painful relationships, attachment injury, and the etiology of EDs, very little is offered that presents a trauma-informed, dissociation-sensitive, and attachment deficit approach to the treatment of EDs.

The purpose of this edited volume is to begin to fill that gap. Trauma-Informed Approaches to Eating Disorders elucidates the connection between trauma and EDs by offering a trauma-informed phase model, as well as chapters describing the ways in which various therapeutic models address each of those phases. It is a book primarily, although not exclusively, for clinicians, one whose purpose is to inspire, educate, and guide the therapist in serving a most complicated and suffering population.

Intended Audience
Above all, Trauma-Informed Approaches to Eating Disorders is geared toward clinicians who work with clients suffering from the complexities and dangers of EDs and trauma. In consultations with therapists, many times the clinician, faced with his or her first ED client, calls in a panic: “What do I do? Where do I start? How do I do this?” This book intends to answer many of these questions.

This book will be of interest to treatment facilities, and to clients as well, and readily integrates with both traditional and innovative approaches to EDs. It also provides critical information to therapists, doctors, dietitians, and nutritionists—information necessary for proper assessment and treatment recommendations.

Distinguishing Features
Trauma-Informed Approaches to Eating Disorders offers an in-depth exposition of a four-phase model of trauma treatment. It is inclusive in that it then describes how various therapeutic modalities address these phases, particularly trauma resolution, all within the context of ED exigencies. It is as much a “how to” book as it is a disseminator of information. It is also meant to inspire. Our intention, by way of summary, is to support competence, confidence, and hope to clinicians and to open the door to further research and treatment explorations. A continuously updated online website supports this by offering resources that include scripts, books, articles, recordings, treatment facilities, organizations, and websites.

Our clients have been torn in many directions by their histories and cultures. They have been fractured many times over; but they are not broken. The clinician’s challenge is to join the client in a journey to the best in that client. This journey requires a multifaceted and collaborative approach, the very intent and purpose of Trauma-Informed Approaches to Eating Disorders. It does, after all, take a village.

REFERENCES
Acknowledgments

Andrew:
There is gratefulness for many for inspiring and bringing this book to life.

I first thank our children—Zane, Jenna, Ariel, and Jocelyn—for cheering me on, and, above all, my wife, Barbara, for staying the course and helping with the editing, while I spent hours at the computer.

Special thanks go to Sheri W. Sussman, my editor at Springer Publishing Company, for believing in this project, and to Michael P. Levine, whose generous and expert guidance have made him something of a godfather for this book. I am grateful to the generosity of members of the eating disorder community, too many to mention, who provided articles and contacts whenever they could.

This could not have been a solo journey, and with that in mind, I have so appreciated and valued the presence of Pam Virdi, my associate editor. Finally, as always, I am indebted to our clients who, while fighting the good fight and maintaining hope, teach us clinicians how to travel with them.

Pam:
I thank Andrew for inviting me along on what can only be described as a pretty awesome journey. We talked about the need for this book a number of years ago and it has been a huge privilege to join with him and so many others to bring this body of work to publication. Much appreciation to my family and friends who put up with me being absent and who applauded me for having a go at my first venture into the world of book publishing.

A huge thanks to the wonderful library staff at Birmingham and Solihull Mental Health Foundation Trust for going the extra mile in providing me with literature searches and articles. Special mention to Anita who did not sigh once, at least not in my presence, when I booked yet another couple of hours out of her busy day for another “must have” literature search!

Finally, I would like to express heartfelt gratitude to my clients, who have always been my most important teachers.
Introducing Our Terms

■ TRAUMA REDEFINED WITHIN A PHASE MODEL OF TREATMENT

An Expanded Definition of “Trauma”

Trauma, as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), is, unfortunately, quite limiting when it comes to describing painful life experiences.

The first criterion of posttraumatic stress disorder (PTSD), the symptomatic fallout from trauma as described in the *DSM-5*, is “…exposure to actual or threatened death, serious injury, or sexual violence…” (p. 271). The experience of trauma, however, is much more complicated. There are, for example, “big T” and “little t” events that cause pain and the subsequent, negative story that results from adverse experiences. Trauma is not always of epic proportions, such as abuse, death, or life-threatening experience. It can be a harsh word, continued criticism, being embarrassed in front of a first-grade class, or leaving mom for the first day of school. It can be the result of neglect or an act of omission, rather than commission.

Trauma is complicated by temperament, attachment status, and proximity to the event. It must also include grief and loss, as well as life changes resulting from trauma (Greenwald, 2007). Trauma arises from loss of identity, be it due to a brain injury or the loss of a role in life (parent, caretaker). Trauma is painfully more complicated and entrenched in clients with intellectual disability or with any physical or mental chronic condition. In a word, trauma, or painful life experience, appears in many forms in the life of an individual. There is no “one size fits all” when it comes to trauma.

Of great significance is the negative story that unfolds as a result of any trauma. It is what each of us tells ourself about ourself following painful events, both large and small. The story builds over time: “I’m no good,” “There’s something wrong with me,” “I have no worth,” “I’m a loser, hopeless and helpless.” And as the story unfolds without awareness, we unconsciously become characters in that story. These are the stories that the authors of this book hope to dismantle, replacing them with stories of possibility, self-acceptance, and dignity.

A Trauma-Informed Phase Model of Psychotherapy

A phase model provides a clinical map, as well as a structure for this book. There have been various forms of phase models, beginning with Pierre Janet (1859–1947) and continuing up to the present time. Judith Herman (1992) wrote: “Recovery unfolds in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with life” (p. 155). A threefold stage of treatment is also described in the work of structural dissociation: stabilization and symptom reduction, treatment of traumatic memories, and personality integration and rehabilitation (van der Hart, Nijenhuis, & Steele, 2006). In the world of eye movement desensitization and
reprocessing (EMDR), Francine Shapiro (2018) offers an eight-phase model in which the phase of trauma processing is subdivided into five parts (Shapiro, 2001). Greenwald (2007) uses a four-phase model of history and treatment planning, preparation, trauma resolution, and reevaluation and consolidation of gains.

Although the wording differs among these variations of a phase model, the general intent is similar. First, we have to know the client, assess his or her status, and clarify the goals and treatment plan. Second, the client must be prepared for the work ahead. This includes internal as well as external stabilization and skills. Third, the traumatic experience(s) must be metabolized. Finally, the client must be guided in the integration of the newly freed sense of self with present and future circumstances. This entails not only relapse prevention, but also stepping into a larger and more expansive identity.

For this book, we have chosen a four-phase model. The phases are as follows:

1. **Assessment/evaluation**
2. **Preparation**
3. **Trauma processing**
4. **Reevaluation and integration**

Before giving any content description of the four phases, it is important to remember that any model is a theoretical construct. It is the map, not the territory. The phases of trauma treatment can be understood as treatment components that do not have to be addressed in some rigid order. Probably, the only “must” in this approach is that assessment and preparation are required before processing traumata. That aside, clinical decisions as to what is next and what is needed depend on the client. The model is in the service of the client’s dynamic unfolding, not the other way around. Form and structure serve the needs of process and flow.

In speaking with several of our authors, we noticed a concern about rigidity in a phase approach and being forced into a model they might not use. Remember that the phases are guideposts along the ever-changing topography of the client’s inner and outer world. Again, the map is not the territory. Those of you who are seasoned trauma therapists may not consciously use a “phase model.” We would surmise, however, that you instinctively work in a phase approach without having to name it as such and that you intuitively realize that certain steps must precede others. A trauma-informed phase approach is deeply embedded in client centeredness and embraces any and every therapeutic approach. It enables therapist and client to know at any point where they are in the therapeutic journey and where they need to go next. Also, it generates hope in that the client realizes that there is a beginning, middle, and end to their work. Therapy is not supposed to be forever.

**Assessment/Evaluation**

This phase is typically composed of history taking, including both an attachment history and a trauma history. A case formulation connects past trauma with presenting symptoms and, from a trauma-informed perspective, makes sense of the symptoms and of the need to metabolize or process the painful roots of those symptoms. The case formulation organically leads to goal selection and treatment planning that now can include trauma processing (see Chapter 7). Regarding eating disorders (EDs), medical and nutritional assessments are absolutely necessary. In addition, screening for dissociation, mood, and personality disorders is requisite.

The assessment phase more often than not requires the teaching of awareness and basic skills for self-regulation before and during history taking. This phase begins with the first client contact and ends with a treatment plan.
Preparation

The preparation phase (see Chapter 8) supports the client in coping with immediate issues of daily life, as well as for the task of traumatic memory reconsolidation. Often this involves stabilization, both at home and in the client’s relational life. Stabilization, at times referred to as “case management,” also includes medical, nutritional, and psychopharmacological attention.

Preparation also entails developing various skills and resources that enable the client to better deal with everyday life and that strengthen the client for the trauma processing to follow. Personally, we also include short-term successes as part of this phase, a necessity to get clients with EDs onboard with treatment. These goals need to be achievable and of relevance to the client. Maxine, for example, was quite unwilling to address her ED, but quickly engaged in a session that was devoted to helping her set boundaries with her boyfriend. Once we bonded via this collaboration, we were able to slowly approach the ED.

Stabilization, skills, and resource building, as well as short-term successes, are goals in and of themselves and pave the way for successful trauma processing in the third phase. However, they are often required at the very start of the therapeutic journey, even before the assessment/evaluation phase gets underway. As previously mentioned, we will usually introduce skills of awareness, breathwork, and affect management before the tasks of assessment/evaluation are undertaken. “Preparation” skills are taught as needed, not in a rigid order. The client’s needs drive the therapeutic bus.

Trauma Processing

This is where various theoretical models of psychotherapy part ways. The reprocessing phase, the “what” of our model, is undertaken via the “how” of different therapeutic traditions. In this phase, memories (both implicit and explicit) are processed or metabolized and ultimately reconsolidated, so that they no longer disturb the client and no longer color the lens through which the client views himself or herself and the world. For the ED client, this reduces the need for disordered eating patterns that dissociate the client from the traumatic pain and supports change in behaviors that are no longer anchored in unresolved, painful experience.

Reevaluation and Integration

In this final phase, various needs are addressed. Has the trauma processing been completed, or is there still work to be done in that respect? Does the client need to revisit skills to deal with triggers and relapse events? What about future challenges? Body image? And how does the client integrate his or her new story with present relationships? With the rest of his or her life? With the therapist?

SUMMARY

For this book to be of service to clinicians around the world, many of whom are reluctant to work with trauma and/or EDs, we believe that the chapters in this volume (particularly the clinically focused ones) need to address the presence of trauma in the ED population, as well as the phasic components of a trauma-informed model. The authors of the clinically oriented chapters have not been asked to change the way they work to fit these labels, but they describe how their approaches attend to the elements of the four phases, elements required by any effective approach to trauma and EDs.
REFERENCES


Share

Trauma-Informed Approaches to Eating Disorders
SARAH—A CASE STUDY

Sarah, a 15-year-old with anorexia and exercise addiction, was referred to me by her physician after she had passed out on her exercise bike and was hospitalized. At 5 feet 8 inches in height and weighing 82 pounds, it was recommended that she seek an intensive inpatient program. However, Sarah and her family had no money, and she was not able to afford the treatment. I agreed to see Sarah three times per week, working collaboratively with a dietitian and her primary care physician.

In the initial consultation, it appeared that Sarah had an avoidant style and was hesitant to reveal too much of herself. Although Sarah was reticent to change, it was what her parents wanted, and she did not want to disappoint them, especially her father. Sarah’s father had left his first wife. Consequently, her mother, a practicing Catholic and first-time bride, was desperate to make the marriage work. Her mother was a passive, uneducated, and childlike woman, and about 30 years younger than Sarah’s father. Her father was patriarchal, emotionally disconnected, rigid, and work-driven. He ran the family with an iron fist, and the two women protected each other from his hot temper by covering up for each other in matters they deemed private.

Sarah’s father owned a small business, and Sarah and her mother were expected to be there to help every weekend. Unfortunately, the business was shut down because of mismanagement and the family was being sued. Sarah had very few memories of having any childhood friendships other than her next-door neighbor, Carly, who was of the same age. Sarah and Carly spent all their free time together playing hide and seek and jumping on the trampoline in Carly’s backyard. When Sarah was 12 years old, she started her period and her body began to develop curves that drew the attention of Carly’s 15-year-old brother, Sam.

Sam began “playing” with the girls and led Sarah into the closet to hide on multiple occasions where he molested her, while his sister took an excessive amount of time finding them. Sarah was overwhelmed with shame but could not tell her parents. She attended a private Christian school, and her parents were closed-minded and religious. She could not face the consequences of disappointing her parents with being sullied by what she had “allowed to happen.” Sarah was determined to make up for her mistakes and never let it happen again. Even if it meant losing her best friend.
Sarah began focusing on her father’s diet. He was an unhealthy 75-year-old diabetes patient, and she was determined to save him from his poor eating habits. Her mother allowed Sarah to do all the food preparation and feed the family as she saw fit. She became obsessed with diet and exercise. At the time of her hospitalization, she was exercising on a stationary bike for 12 hours per day and eating 300 to 400 calories daily. She would pass out on her bike and tumble to the floor. Her parents would pick her up and put her back on the bike, or face the consequences of her irritable and anxious mood. She began ruling the family with her demands for special foods or refusing to eat altogether. She would stop riding at 2 a.m. and eat a small plate of potatoes, ride until 4 a.m., sleep, and repeat this routine the next day.

The therapy focused on nutritional rehabilitation, weight restoration, and improving her depressed, anxious, and irritable moods. Sarah had difficulty identifying and expressing her feelings and frequently became frustrated in treatment. It proved easier for her to speak through the eating disorder (ED) symptoms than to struggle in therapy with stringing together descriptions and expressing emotions. Over time, her ED symptoms began to ameliorate, and she began experiencing body memories from the sexual abuse. Sitting became intolerable. She could feel the area of her body that had been molested against the surface on which she was sitting. This was uncomfortable and triggering to her. She began to discuss the molestation and devastating shame surrounding what she felt she “didn’t stop from happening.” She described the paralyzing terror she experienced in the closet and her self-hatred for doing nothing to stop it. She loathed herself for no longer being the perfect child her parents knew and labeled herself as “damaged goods.” She was determined to fix the painful past, chronic feelings of not measuring up, and to earn feeling worthy by recovering perfectly.

However, losing her coping tools (restricting food and exercising) at the time she needed them the most was intolerable. Another memory of an oral rape at the age of 6 began haunting her with flashbacks and body memories. This happened close to home in a neighborhood alley. She ran home and told her mother. However, her simple non-nurturing mother who was terrified of the religious implications and her volatile father told her never to tell anyone. She felt unsafe without the anorexic part of her which “fixed” and erased the womanly body.

During this time, she came up with a project that would distract her and help her channel her energy into something positive. She would make a garden in her backyard and grow healthy food for the family. The only place in the yard for the garden butted up against the wall separating her house from Carly and Sam’s house. She began shoveling the “bad dirt” in a trance-like dissociative state from what she perceived as the perpetrator’s side of the yard, filling it in with “good dirt” from the opposite neutral side of the yard. The physical activity driven by her anxiety resulted in significant weight loss, which was relieving to her but drove her into a full relapse.

After her second hospitalization, she was granted scholarship into a treatment program and could work on her anorexic symptoms. She was discharged at normal weight and began working on the trauma, which had naturally surfaced. Not unexpectedly, Sarah again threatened her recovery by dabbling in her eating-disordered behavior to cope with her powerful feelings of shame.

THE GENESIS OF AN EATING DISORDER

What is it that causes some people to develop an ED, and others to manage eating behaviors in a relatively normal manner? The answer is anything but simple. EDs are a biopsychosocial illness. They are the result of a complex interplay of factors
including genes, temperament, social interactions, early attachment, culture, and of course life experiences. These variables come together and affect each other in a perfect storm fashion and may result in ED psychopathology.

Genetics and Neurobiological Deficits

“Lots of people diet or want to lose weight, but relatively few of them end up with anorexia nervosa or bulimia nervosa,” says Walter Kaye, MD. “Culture plays some role—but maybe less so than we thought in the past” (Weir, 2016, p. 2). Behaviors such as dieting and weight loss seem to expose a genetic vulnerability to an ED. “We think genes load the gun by creating behavioral susceptibility, such as perfectionism or the drive for thinness. Environment then pulls the trigger” (Lamberg, 2003, p. 1437). “Rigorous studies suggest that greater than 50 percent of the variance in liability to eating disorders and disordered eating behaviors can be accounted for by additive genetic effects” (Berrettini, 2004, p. 24).

At present, researchers are beginning to sort out the brain regions and neural circuits that underlie the illnesses to identify those areas of the brain that may be, in part, responsible for the genesis of an ED. Research indicates that when anorexics and bulimics sit down to eat a meal, they became worried (Frank & Kaye, 2012). Another study by Kaye, Wierenga, Bailer, Simmons, and Bischoff-Grethe (2013) revealed that in a betting game the brains of anorexics responded differently to what would be positive in a normal brain. Conclusively, the brains of those with EDs differed from those without EDs, suggesting neurobiological deficits. Among these are deficits in executive functioning.

Executive tasks include (a) working memory, (b) response inhibition, (c) set shifting, and (d) central coherence. Set shifting is a major component of executive functioning and involves the ability to move back and forth between multiple tasks, operations, or mental sets. Problems in set shifting may present as cognitive inflexibility or response inflexibility (Miyake et al., 2000).

In addition, central coherence is associated with paying attention to details while integrating global concepts into a broader understanding. An individual with anorexia, for example, who focuses intently on the details of exactly what she has eaten and finds it difficult to consider the long-term health consequences of starvation may be viewed as having weak central coherence (Pender, Gilbert, Serpell, & Abelardo, 2014). In summary, weak set-shifting and a weak internal coherence make it difficult for those with EDs to switch gears. Instead, they perseverate on minor details, subsequently losing the forest for the trees.

Temperament and Personality

Temperament and personality studies have shown that those with EDs have traits and characteristics that may function to maintain the ED. According to the Center for Well-Being at Washington University in St. Louis, “Temperament refers to the automatic emotional responses to experience and is moderately heritable (i.e., genetic, biological) and relatively stable throughout life” (Cloninger, 2015, para. 2).

Cloninger’s Temperament and Character Inventory (TCI), which is based on a psychobiological model, attempts to explain the underlying causes of individual differences in personality traits and measures four temperament dimensions showing a heritable bias. These are Novelty Seeking, Harm Avoidance, Reward Dependence,
and Persistence (Cloninger, Svrakc, & Przybeck, 1993). Studies using the TCI have exposed characteristics that are common to those with EDs.

The metaphor of the *Turtle and the Hare* aptly describes those with anorexia and bulimia, respectively. People with anorexia nervosa display turtle-like behavior, including high levels of harm avoidance and personality traits characterized by worrying, pessimism, and shyness as well as low levels of novelty seeking. Individuals with bulimia nervosa have high levels of harm avoidance, like anorexia sufferers, but the avoidance tendency is paired with high levels of novelty seeking, including impulsivity and preferring new or novel things (Fassino et al., 2002). The *Turtle and Hare* metaphor is congruent with temperament research, which shows that people with binge ED have higher levels of harm avoidance and novelty seeking and lower levels of self-directedness as compared to healthy controls (Grucza, Przybeck, & Cloninger, 2007).

**Emotions**

People with EDs have difficulty with emotional regulation. Emotional regulation is the ability to recognize and modulate emotions appropriately and in keeping with personal values. The Difficulties in Emotion Regulation Scale (DERS) is used to measure (a) difficulties in awareness, acceptance, and understanding of emotions and (b) strategies to manage emotions and impulse control, and to maintain goal-directed behavior while in distress. Studies using the DERS show that for women with either anorexia nervosa or bulimia nervosa, more ED symptoms were significantly correlated with higher emotional dysregulation (Fiore, Ruggiero, & Sassaroli, 2014; Racine & Wildes, 2013).

Alexithymia, which is the inability to identify and express feelings in words, is common among our clients. Simultaneously, many of our clients describe feeling “too much,” or “like I don’t have a skin to protect me from feeling everything,” and report being shamed for their unique emotional sensitivity. Consequently, they learn to manage this perceived weakness using ED behaviors. The ED obsession, which is all-consuming, provides internal distance from feeling.

**Attachment**

Bowlby (1969) found that a secure relationship with at least one adult is crucial for the development of adaptive emotional regulation. Early cries of hunger, followed by the caregiver’s attunement or misattunement (experienced by the infant as emotional regulation or a lack thereof), formulates the internal working model or template of the early attachment relationship between the infant, caregiver, and significant others. If the attachment is insecure, a basic sense of trust that allows the child to tolerate separations, regulate affect in a mature way, and thrive in other future attachments will be diminished.

In summary, the caregiver’s feeding style, whether attuned or misattuned, sets the stage for the child’s feelings of either deserving or being unworthy of loving care. Research has shown that insecure attachment has been found to be positively linked to disordered eating (Ward, Ramsay, & Treasure, 2000). Regarding Sarah, the misattuned attachment with her mother greatly affected her sense of worthiness. It seems that the core belief in clients with EDs is a variant of “I don’t measure up, I shouldn’t exist, I should be invisible, I am undeserving or unworthy.”
The Family System

The importance of family systems for those with EDs is well documented. These families are polarized and unbalanced in terms of power. Children need a unified front to feel secure. They need to know that the parents cannot be split and the children do not have more power to make decisions than one or both parents.

One aspect of a relatively functional family is the ability to successfully navigate the waters of change and normal development of the members without breaking apart. The families of those with EDs become rigidly cohesive in the face of change (Stierlin & Weber, 1989). It is no accident that tweens who are entering adolescence, or teenagers leaving home for the first time, develop an ED. When the natural separation process begins, the parents tug tightly on the reigns of the family system, and the teen struggles to find an alternative way to individuate. The teen may use an ED to disconnect within the family system itself. The security and consistency of ED rules serve as a boundary and a safety net which the family cannot provide.

Families of those with EDs are often perfectionistic and secretive. Feelings are not aired in public or within the family system (Stierlin & Weber, 1989). Acting out thoughts and feelings rather than learning to accurately identify and express emotions becomes the language of the child who develops an ED. Sarah’s family was patriarchal and unbalanced. Sarah and her mother shielded each other from her father’s rigid ideology, criticism, and control. In addition, cohesion and secretiveness was the order of the day. Sarah knew that her mother needed her to remain in this relational triangle, or the family system would splinter: Consequently, Sarah used anorexia nervosa to disconnect while keeping the family system intact. The eating disorder supplanted an age-appropriate separation and individuation.

TRAUMA

A working definition of trauma, recently defined by the Substance Abuse and Mental Health Services Administration (2014), is as follows: “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful, or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” (p. 7). This definition is all-encompassing as it includes both “big T” and “little t” events. Trauma, therefore, may include events of epic proportions or developmental insults such as public humiliation, verbal abuse, or sleights.

Brewerton (2007) recently synthesized a review of current information describing the role of stress, trauma, and adversity as risk factors in the development of EDs. The scientific literature has shown that trauma may preclude, or increase the risk of occurrence for, EDs not only in adults, but in adolescents and children as well. In fact, some investigation outcomes suggest that those with EDs have a trauma history and it is the posttraumatic stress disorder (PTSD) that predicts the development of an ED (Brewerton, 2004, 2007). In other words, the PTSD response to underlying traumatic events is a possible predictor of the development of an ED.

Sarah presented with PTSD at the age of 19 years when I began seeing her for therapy. As described earlier, she had experienced both “big T” and “little t” traumatic events in childhood. In terms of attachment, mother was only willing to be available to her when Sarah’s needs fit in with father’s religious schemata of the perfect family. This included...
no playtime with friends on weekends and only during the week if father was at work. The oral rape she experienced at the age of 6 years was followed by a lack of repair by her mother and hidden from her father. This response taught her that appearance trumped emotions, and that silence and hiding was a preferred approach to coping rather than exposing the ugly realities of her life, even within her own family. Regrettably, both parents’ inability to face life’s messiness likely set her up to be revictimized. When Sarah endured repeated molestations by her next-door neighbor at 12 years of age, the only skill set she had was to remain speechless and rely on her own limited ability to self-regulate.

■ THE WINDOW OF TOLERANCE

As mentioned earlier, people with EDs have difficulty with emotional dysregulation. “People with PTSD or trauma-related disorders are characteristically predisposed to experience hyper-arousal (‘too much’ activation) or hypo-arousal (‘too little’ activation), or they may oscillate between the two states” (Ogden, Minton, & Pain, 2006, p. 26). The window of tolerance (Figure 3.1), or the zone of optimal arousal, depicts the area between hyper- and hypoarousal in which emotional and physiological arousal are managed without disrupting the entire system. “Cortical functioning is maintained, which is critical for integration of information on cognitive, emotional, and sensorimotor levels” (Ogden et al., 2006, p. 27).

The zone of hyperarousal, which sits above the window of tolerance, corresponds to the response of the autonomic nervous system when the person experiences too much activation. At this level, the sympathetic nervous system is preparing for fight, flight, or freeze. Information cannot be processed effectively, and the person may experience flashbacks, body memories, emotional reactivity, or hypervigilance, all of which are PTSD symptoms.

The zone of hypoarousal, which sits below the window of tolerance, corresponds to the autonomic response when the person is overwhelmed to the point of shutting down. In this state, the client may “experience a numbing sense of deadness or emptiness, passivity, and possibly paralysis” (Ogden et al., 2006, p. 26).

**FIGURE 3.1** The window of tolerance.
Each person has a habitual ‘width’ of the window of tolerance that influences his or her overall ability to process information. People with a wide window can cope with greater extremes of arousal and can process complex and stimulating information more effectively. “People with a narrow window experience fluctuations as unmanageable and dysregulating. Most traumatized clients have a narrow window and are more susceptible to becoming dysregulated by normal fluctuations in arousal” (Taylor, Koch, & McNally, as cited in Ogden et al., 2006, p. 28). Not surprisingly, our clients with EDs and underlying traumas present with a narrow window of tolerance. To continue functioning optimally, our clients learn to adjust levels of arousal using ED behaviors. Bingeing, purging, and restricting can be used to downregulate, or rev up energetically. The ability to self-modulate difficult emotions gives clients a sense of control and personal effectiveness, which is lacking in people with EDs. Simultaneously, they can escape uncomfortable feelings of dysregulation and operate within predictable parameters with expected outcomes.

The window of tolerance can be used as a cognitive tracking tool for clients to use to monitor emotional intensity. I consistently ask my clients where they are in the window of tolerance to help them learn to identify and regulate themselves outside of the therapy sessions. When our clients become adept at identifying symptoms of dysregulation, they become aware of potential triggers, learn when to self-modulate, and generally feel more in control. Sarah discovered that her anorexic behaviors were in direct response to feeling anxious. Her anxiety was sparked by sensations of heaviness, or in her words “feeling fat,” which reminded her of the curvaceous pubescent state her body was in when she was molested by Sam. If Sarah could rid herself of the sensory reminders, she could distance herself from the memories, and the reality of the molestation. Connecting the dots between becoming hyperaroused and being triggered helped her understand the need for distance from her memories. This enabled her to view her anxiety as a red flag, not a true threat to be immediately extinguished. In addition, this knowledge helped her to slow down and work through the anxiety facing her demons using mindfulness and curiosity. Ultimately, Sarah’s body dysmorphia decreased and she learned that her body was not the enemy—it was trying to save her from disintegration caused by traumatic events.

**DISSOCIATION**

As described in the previous section, those with EDs have a lower window of tolerance or threshold of response. Consequently, they have heightened vulnerability to traumatic events leading to dissociation and other methods of numbing, including the use of the ED itself.

There has been much discussion in the literature about the most accurate definition of dissociation. Is dissociation an internal event that can only be described subjectively by the client, or is it measured more objectively by symptoms? In other words, is it a felt internal state, or an observed external state? For the simplicity of this chapter, “Dissociation in trauma entails a division of an individual’s personality, that is, of the dynamic, biopsychosocial system as a whole that determines his or her characteristic mental and behavioral actions” (Nijenhuis & van der Hart, 2011, p. 418).

Sarah modulated her intolerable emotions through food restriction paired with an exercise addiction. This behavior put her into a trance-like dissociative state that helped
her to downregulate excessive arousal created by thoughts, intrusive images, or physical sensations. In these extremes, Sarah could disconnect and distance herself from the sullied self who was ashamed about freezing in the closet and not stopping the abuse. If she separated herself from the sullied self, she could function. When she did not follow her anorexic rules, however, the sullied self or part threatened to break through the dissociative barrier she had created and overwhelm her with intolerable emotions, memories, and physical sensations.

■ PUTTING ALL THE PIECES TOGETHER

Moulton, Newman, Power, Swanson, and Day (2014) found that both emotional dysregulation and dissociation were significant mediators between childhood trauma and eating psychopathology. In addition, emotional dysregulation has been reported to mediate the relationship between insecure attachment and EDs (Ty & Francis, 2013). Bowlby (1973) considered the idea that when caregiving interactions are insensitively attuned, the infant could develop multiple incompatible internal representations of self and attachment figures, instead of unitary or cohesive attachment. A connection between attachment and dissociation is implied in this language.

Finally, as stated earlier, PTSD has been found to be a predicting factor for the risk of EDs. Exactly what does all this mean? If you boil down this complex soup of variables and mediating factors, it seems that our clients with EDs often begin life with a misattuned caregiver leading to emotional dysregulation and increased emotional vulnerabilities. Subsequently, they are much more likely to experience life as jarring because of the inability to adjust and adapt. As a result, our clients learn to respond in psychopathological ways that serve them by protecting and preserving their abilities to function in the world.

In a nutshell, the ED, which appears to contain elements of dissociation, is a means of adapting to trauma. Is it any wonder that, when our clients’ ED symptoms remit, traumatic experiences, whether epic events or with developmental origins, rise to the surface? Sarah could not make lasting progress until the ED was addressed and she was able to resource herself using a skill set that would help her stay physiologically grounded. The trauma could then be attended to, and the family system could be deconstructed and reorganized.

■ THE WHOLE ENCHILADA: TRAUMA, ATTACHMENT INJURY, AND DISSOCIATION

The cycle of being flooded with early, unprocessed trauma upon remittance of ED symptoms, followed by relapse, reduces the foundation of treatment to shifting sand. Unless the trauma and the ED are treated simultaneously, treatment becomes futile at best: fraught with multiple relapses, behavioral substitutions, feelings of hopelessness, and premature termination.

The subsequent chapters of this book offer treatment components and methods to clinicians who need to address this complex and dynamic system, or, put more simply, the whole enchilada.
REFERENCES


© Springer Publishing Company


CHAPTER 15
Ego State/Parts Work in the Treatment of Eating Disorders
Andrew Seubert and Robin Shapiro

■ INTRODUCTION

In the spirit of this chapter, the “I” who weaves everything together shall henceforth be designated the “self.” The elements that are woven together are contributions by two author parts: Andrew Seubert and Robin Shapiro. Both parts have learned to collaborate with each other and, at times, integrate.

The Self
A caveat: Our writers do not cover extreme forms of dissociation, specifically dissociative disorders not otherwise specified (DDNOS) and dissociative identity disorder (DID). Yet, the basic skills required to work with both are the stuff of this chapter. In their seminal book, *Ego States: Theory and Therapy*, Watkins and Watkins (1997) describe a continuum of dissociation from differentiation to DID. Differentiation is the way we shift our presentation, also known as our persona, when we move from home, to job, to socializing. From a “self” point of view, it is done somewhat consciously, albeit automatically. At the other end of the dissociative continuum are the extreme forms of dissociation in which behaviors and reactions are often outside the self’s conscious awareness. This chapter explores parts or ego states somewhere in the middle of the two that are invested in one or the other form of eating disorder (ED). “Ego state” and “part” are used interchangeably in this chapter.

■ WHAT ARE EGO STATES OR PARTS?

Robin begins with a short neurological explanation of ego states, their purpose, and the difference between dysfunctional and dissociated ego states.

Part Robin
“Humans, like other animals, have wiring for all kinds of states: waking, sleeping, eating, connecting, playing, showing aggression, and, when needed, inhibiting these states.... The neurons in our big brains are constantly preparing us for the future. We have organized neuronal clusters in us for all that we habitually do, feel, and think, mostly in an unconscious, automatic way. When we have a new experience, do new activities, go to a new place, or feel a strong feeling, our brains start to build connections with the...
thoughts, emotions, and actions that go with the new experience. If life or conscious practice puts us in the same situation over and over, we develop thousands of thicker, stronger neuronal connections. We have conscious and unconscious programs for most of what we do and much of what we think and feel” (Shapiro, 2016, pp. 27–28).

“When a trauma is big enough or happens often enough, we may develop strong, reflexive pathways of response that act separately from our most conscious, thinking, planning brain: dissociative states” (Shapiro, 2010, p. 17). All dissociative states are ego states. They can be simple: total shutdown, full-on aggression, or terror that are triggered, but do not fit the current situation. They can be complex, with ages, names, and specific “jobs” in the system. In simple traumas or personality-disordered people, all states may be in conscious awareness. In DID or disorders of extreme stress not otherwise specified clients, the states are often not known to the “self” or “front person” or to each other.

Not all ego states are dissociative. Think of yourself in your therapist role, or playing with your dog or kids, or driving…. These roles call on different “parts” of you but are generally not separated by dissociative barriers. These are nondissociative ego states. As therapists, we may use similar techniques with dissociative and nondissociative states: Bringing the most competent, present-oriented parts to the front, and putting them in charge of caring for other parts and running the current life.

■ A BRIEF OVERVIEW OF EGO STATES/PARTS WORK AND THEIR COMMON ELEMENTS

The Self

The notion of “parts” of one’s self extends back through centuries and cultures. The term “ego states” was first used by Paul Federn, a disciple of Sigmund Freud. Over the course of time the use of “parts” language has come into favor because it grew out of vernacular expressions, such as “a part of me wants to go, and another part of me doesn’t.” It is simply more user friendly.

Andrew begins with an overview of various traditions of parts, which, although not exhaustive, can uncover the common and universal characteristics of ego state work.

Part Andrew

Work with personality parts has been with us for quite a long time. In the 11th century, a female Tibetan Buddhist teacher, Machig Labdrön, developed a strategy called “feeding your demons.” Allione (2008) writes: “This demon might be addiction, self-hatred, perfectionism, anger, jealousy, or anything that is dragging you down, draining your energy” (p. 5). She continues, “Giving our demons form by personifying them brings inchoate energies or harmful habitual patterns into view, allowing them to be liberated rather than leaving them as invisible destructive forces” (p. 8). In a word, she is describing the need to recognize and make contact with these “demons” to then be able to collaborate with them.

In the previous century, Janet (1907) used the term “dissociation” to describe systems of ideas that were split off, and thus “not in association” with other ideas within the personality (Watkins & Watkins, 1997). Carl Jung described a “complex” as having “the tendency to form a little personality of itself. It has sort of a body, a certain amount of its own physiology…in short, it behaves like a partial personality (citation).” Their intent was to get to understand that which was split off to work with it.
Roberto Assagioli (1888–1974) created Psychosynthesis (Assagioli, 2000) in which he studied the client as a personality and a soul. For him, human growth resulted from a combination of ego development and peak experiences (moments of creativity, insight, and unitive experiences). He addressed what he referred to as “subpersonalities,” some of which emulated higher qualities and some that resisted integration. He focused on bringing together disparate or conflicting parts of the person, using terms like “recognition,” “acceptance,” “co-ordination,” “integration,” and “synthesis.”

Fritz Perls (1893–1970), the founder of the Gestalt tradition, used his empty chair technique to resolve what he termed “polarities” within his clients (Polster & Polster, 1973). Various aspects of the person were placed in different chairs, and the client was asked to enter the consciousness of each part to achieve mutual understanding, collaboration, and integration.

The approach I personally use in working with parts has been mostly influenced by the Gestalt tradition and the seminal work of John and Helen Watkins.

John and Helen Watkins referred to their work as ego state therapy (1997), building upon the work of Paul Federn. They described an ego state as an “organized system of behavior and experience whose elements are bound together by some common principle, and which is separated from other such states by a boundary that is more or less permeable” (p. 25). They saw ego states developing “to enhance the individual’s ability to adapt and cope with a specific problem or situation” (p. 29). No one, I believe, had been so clear as to the nature and purpose of ego states or parts up to this point. Their approach was similar to others in emphasizing getting to know parts, their purpose, and how to work together.

In very recent times, we have seen the development of two major approaches to parts work. The first is the Internal Family System (IFS) of Schwartz (1995), which combines principles of a family systems approach with an understanding of the multiplicity of the mind (see Chapter 16). Personality parts are ascribed to functional groups: exiles (who hold the pain from trauma), managers (who prevent painful emotion from reaching consciousness), and firefighters (who clamp down on painful feelings that get by the efforts of the managers). The purpose here is to get parts to work together to “unburden” the exile parts of their stored pain and to reconnect to the self, which for Schwartz is a spiritual concept.

Likewise, we have also seen the development of structural dissociation (SD; van der Hart et al., 2006). This is not the place for an in-depth description of this or any other approach (for that, see Chapter 17), but suffice it to say that the SD approach organizes the personality into “prototypical” parts that are dissociated from each other, parts that have specific purposes. Apparently normal parts (ANPs) are the parts that face and adapt to daily life. Emotional parts (EPs) are the parts that are stuck in or carry the pain of traumatic experiences. The task of this phase-oriented therapy is to support all parts in overcoming various phobias and achieving stabilization in Phase 1. Phase 2 addresses the trauma, whereas Phase 3 focuses on integration and rehabilitation.

The point of this brief romp through various approaches to ego state/parts work is to highlight the common elements they seem to share, elements I teach with the acronym RUG-C.

“R” represents the recognition of parts or ego states, the realization of multiplicity in the human species and the necessity of making some kind of contact with parts of the individual’s internal system that usually lie outside of consciousness, yet influence reactions and behaviors. “U” emphasizes the task of understanding the purpose or raison d’être of each part: Why do you do what you do? What brought you into existence? What are you trying to accomplish? “G” reminds us to express gratitude for what that part has
done to help the person navigate emotional waters and endure painful life events. It also signifies the need to negotiate goals because the original goals of an ego state are formed in childhood, and thus are outdated and counterproductive. Finally, “C” brings us to the stage of collaboration: How can we achieve these goals together (parts, self, and therapist)? What is needed for stability in the present (skills and resources) and what is needed to metabolize the burden of trauma?

These elements of ego state work are distilled from the traditions described, as well as from my work with courageous clients. Robin and I stand gratefully on these many shoulders. The overall purpose of ego state work is to interact with the experienced part, rather than thinking and/or talking about it. Eating-disordered parts are not the totality of the person, although it may seem that way quite often. They have operated automatically and reflexively, but with an ego state approach, they become known to the client (self) and each other, making the unconscious conscious. The client also becomes known to the part(s). Conscious dialogue can then take place, bringing out of the shadows dysfunctional and disruptive parts that are still stuck in past, painful experience, inhibiting healthy functioning in the present. This is about the relationship and the process of becoming known.

■ DISSOCIATION AND EATING DISORDERS: PHASE I—EVALUATION

The Self

As you can see in Chapter 3, EDs are dissociated experiences, which is why they can be so difficult to treat if the therapist focuses primarily on thoughts and behaviors.

It is so common for the clinician, attempting to use reason and common sense with a client’s starving or bingeing behaviors, to ask: “What now?” The problem is that the therapist is interacting with the prefrontal part of the client’s brain, whereas the “parts” of the brain attached to the ED are hiding out in deeper, nonverbal parts of the brain (see Figure 15.1). They are dissociated; hence, the need for ego state approaches with EDs to create contact between the adult consciousness and the ED parts and between therapist and parts. Here is Andrew’s story of how he first became aware of that and the need to evaluate for the presence and degree of dissociation in clients with EDs.

FIGURE 15.1  Conversation between therapist, adult consciousness (CSS) and ego states.
Part Andrew

Elsewhere (Shapiro, 2009) I have written, “If I am not able to tolerate who I think I’ve become due to trauma, then I must create a new identity, or at least displace the shameful and painful aspects of experience elsewhere, in an identity that is perceived as a ‘not-I.’ The shame and pain must be rendered a-part, split off, so that the person can function in daily life. Immediate painful emotion is avoided; but suffering is created” (pp. 193–194).

JB was an intelligent, attractive woman in her 40s, a mother of two boys, married to a man who could not understand her refusal to eat. She had been through several hospitalizations for anorexia nervosa (AN), yet returned to the same behaviors upon each release. At the end of a given session, she delivered one of those “one-foot-out-the-door” bombshells.

“You need to know something about me,” she said. “If I feel happy, that will make me fat!”

It did not take a great deal of brain power to realize that her statement was not the thinking of an intelligent adult. It came from somewhere or something else that sounded much younger. In a subsequent session, while exploring the first time she was teased by her siblings for being fat at the age of 7, she blurted: “I don’t like that seven-year old. She’s the reason I feel all this pain!” The split and lack of understanding between client and ego state was evident.

The evaluation phase is often an ongoing, not-so-neat part of the therapy. It includes the crucial aspect of relationship building between client and therapist, gathering of various histories, medical/nutritional attention, and, importantly, the assessment of levels of dissociation, which are inevitably present in EDs (see Chapter 3). Our focus in this chapter is on assessing for dissociation. Here are some of the signs I have noticed when a dissociative part is afoot in various forms of EDs:

- Stuck, intractable—typical in the addictive aspects of EDs.
- Responding without conscious choice—compulsive, addictive.
- Developmentally delayed—age inappropriateness. Poor space/time orientation.
- Shame base: Hiding from it and protecting against it.
- Separatistic quality—acting outside of higher good of the whole, for example, stuffing or starving.
- Trauma-informed aspect: disproportionate reacting in present because of past unhealed wound/deficit.
- Internal civil war—“I know one thing, but feel another.”
- Emotional signals: stuck emotions, looping, avoidance, numbing, “over” reacting.
- Cognitive signals: thinking patterns indicative of a younger state of development, for example, illogical, black/white, generalized.
- Somatic signals: body disturbances (unexplained pain, tension, numbness...). Disconnected from body signals of hunger or satiety.
- Behavioral signals: repeated, persistent, compulsive, avoidant, aggressive, passive/aggressive, self-harming.

My partner, Robin, points out the following:

- Spaces out easily.
- Loses coherence when speaking about childhood events (Siegel, 1999) or cannot remember much of childhood years.
- Uses different voices, inflections, or age-specific language.
- Is easily triggered into feelings of abandonment, defensiveness, or clinging.
• Has otherwise unexplained headaches, nausea, or pelvic pain.
• Shows inappropriate affect when discussing distressing events.
• Speaks in the third person about the self.

In addition, among others, there are the following instruments for screening and diagnosing dissociation:

1. Dissociative Experience Scale (DES)—Bernstein and Putnam (1986)
2. Dissociative Disorders Interview Schedule—Ross (1987)

This is not the place to explore the advantages of each, but to know of their existence, and to recognize the indicators (listed previously) of the presence of ego states.

■ PHASE 2—PREPARATION

Part Andrew

Much of the preparatory work with EDs involves getting to know the internal, dissociated system of parts. Although there are approaches to ego state work that organize the internal system into categories or functional groups, my own preference is to simply follow what is given. When the client shows indications of dissociation, as in the case of JB, it is then that I invite that part or parts into a visualized conference room or meeting place (or to the “Dissociative Table” of Fraser, 2003), by asking, “I’d like to speak to the part(s) that believes that being happy will make her fat.” This is the first of the RUG-C strategies—recognizing the part behind the problematic symptom or behavior. My first contact with JB’s parts that held this thought sounded something like this (questions from the therapist were addressed through the adult client to the parts):

JB: I’d like to speak with the part or parts that believes that being happy will make her fat.
Parts: We’re here. There are two of us.
JB: And who might you be (parts aren’t given names unless a name is offered)?
Parts: Blob and the Claw.
Andrew via JB: I’d like to get to know you, so could you tell me what you would like me to understand most about each of you?
JB (JB listens to what the parts have to say, and then reports that to the therapist):
The one called Claw started out protecting. Uh…it won’t let me feel happiness, because it can be taken away. If I don’t feel it, it can’t be taken away…. And the Blob tries to keep bad things from happening to me, by getting me to control everything around me…the little things I can control, because everything else is out of control.
Andrew (asking the client to inquire of the parts): Are they tired of doing all this?
JB (reporting back): Uh, I think so. Yes, because they want help.

And so began the journey of approximately 5 years. Much of preparation is making contact with and understanding the purpose of ego states. From that point onward, finding common goals and collaborating to achieve them was more within reach. Without these RUG-C strategies, parts remain dissociatively split off and unreachable. Clinically, we experience this as an impasse, “resistance,” and double binds. However,
remember that there is a purposeful survival need behind every block and that you cannot heal what you do not know.

Much of the protective, avoidant need revolves around the inability to tolerate anxiety, shame, and other intense emotions (see Chapter 10). When preparing the client and client parts for daily life and for processing past events, the affective education must be delivered to the parts in language appropriate to the age of that part. A 7-year-old part of JB was teased at that age by an older and younger sibling about being fat. “7” had to learn to tolerate sadness, anger, and shame attacks before we could proceed with any processing of that painful event. However, “7,” at the time of the teasing, had no one, except for her cat, who would listen to her, which brings in the need during preparation for the creation of resources.

Part Robin

“The point of ego state therapy is to find internal resources, bring them to the front of consciousness, enhance them, have them help heal the distressed parts, and bring choice and conscious control to the whole of each client’s system” (Shapiro, 2016, p. 41). Ego state interventions bring appropriate chosen (not reflexive) capacities to current functioning. Here are a few of my favorites (Shapiro, 2016, p. 42): Ego state work can

- Create awareness of normal or pathological state-switching, and bring them under conscious control.
- Bring a mature adult state to the front to deal with people, situations, and emotions.
- Heal trauma by creating a true “dual attention” between parts stuck in a traumatic event, and the here-and-now adult in the relatively safe world, and then pull the traumatized part into the safe present, in an integrative way.
- Bring former resources to current situations.
- With more dissociated clients, bring the adult ANPs into conscious stewardship of all states (van der Hart, Nijenhuis, & Steele, 2006).
- Remove negative introjects, also known as parentectomies and abuserectomies.
- Culturectomies, removing internalized cultural strictures (think expectations about race, appearance, class, gender roles, etc.; Shapiro, 2016, pp. 29, 30).
- Bring a more resourced “future self” to bring hope to and help deal with current situations.

The Self

In terms of preparation, we have reviewed the need to know the dissociative system of an ED client, develop an understanding of why a part does what it does, and create new goals and collaboration. In addition, we have seen the need for affective skills and the development of resources. Another major concern that needs to be addressed from the first meeting onward is the client’s attachment status and needs because attachment injury appears to be quite prevalent among ED clients (see Chapter 3). Although attachment enhancement is taking place between a client and therapist, ego states that contain early injuries need to be contacted and supported in achieving attachment repair (AR), ideally before entering the processing phase of treatment, for without much of a
sense of self (developed during the first years of life) trauma processing might easily stall. Andrew and Robin use similar approaches to ego state AR, integrating work from Watkins and Watkins (1997), Steele (2005), Schmidt (2009), Pace (2005), the Gestalt tradition (Polster & Polster, 1973), O’Shea (2009), and Paulsen (2017).

Part Andrew

There are various terminologies to describe the process of going back in time, as it were, to deliver to a “young part” of the self what was missing in terms of early nurturing and caregiving. I simply call it reparenting. The problem is that the absence of early attachment leads to self-deficits, and, without much of a sense of self, trauma processing can come to a grinding halt.

At times the AR is the treatment, particularly involving implicit memory. There is the possibility of working systematically and chronologically with development stages in the case of pervasive attachment injury (reparenting the birth baby, the 1-year-old, 2-year-old, etc.) or AR that is specific to the ego state that is involved in a particular memory (reparenting the 4-year-old part before processing the 4-year-old’s memory). There is also the consideration of resources. Does the adult client want to feel able to reparent by him/herself? Does the client need one or several resources? Internal resources (helper parts, spiritual, nurturing and protective parts, future self) and/or external supports (grandmother, friends, Mother Teresa, inspirational people)?

Here is an example of setting this up:

Andrew: That 7-year old part of you will need some support to clear up that memory of the time your siblings teased you for being fat. Would you be up for reparenting her and giving her what she needs to be stronger?

JB: Yes…but I don’t know if I can do it alone.

Andrew: Who or what could do this with you?

JB: My grandmother. She was the only one who really cared about me. And now she’s gone (tears)…. 

Andrew: Can she be with you in spirit and go back in time to help you support “7”? 

JB: Yes, yes. It’s just sad, but she can be with me. She always was.

Andrew: Then let’s do it.

I made sure that JB was grounded in her adult, parent, and professional consciousness. I asked her to imagine her grandmother being with her and then proceeded with the reparenting steps that can be remembered by using the letter “R” as a mnemonic device:

- **Recognize** the part that has been neglected historically and by the client as well.
- **Regress** to the child part by having the adult go back in time and introduce him/herself and any resources to the child.
- **Rescue** the child part if stuck in the memory (“Freeze the memory and invite the child out…”).
- **Repair** the child’s attachment wounds by asking how she or he is doing and what she or he might need.
- **Return** with the child (if the child part is willing) to present time and to a safe place.
- **Renew** contact with the child part on a daily basis (“Talk to the child!”; Steele, 2007).
The Self
Here is a wonderful example from Robin showing how this looks while working with a client entrenched in emotional, binge eating.

Part Robin
Grace was 27, single, professional, bright, personable, and a lifelong binge eater. When she walked into her apartment, she would grab any and every carb in the house, and eat until all was gone. She would eat a quart of ice cream, followed by a can of frosting, followed by many pieces of bread. When the food was gone, she would feel remorse, call herself names, and dive into shame and depression.

Grace was an only child with two professional, working parents. Her parents were not abusive, but neither were they attentive. They often did not get home until after 7 p.m., leaving young Grace alone in the house after school for several hours and not serving dinner until after 8 p.m. Grace, feeling hungry, lonely, unloved, and unlovable, would binge every day after school. When adult Grace came home from work, she reenacted the same scenario.

Here’s how we fixed it:
I. Finding the adult
Robin: Grace, I need two pieces of you up front. Go inside and find that brilliant designer part of you, the one that knows design and how to be assertive with people at work.
Grace: Got her! I’m thinking of dealing well with a difficult client yesterday.
Robin: Great! Feel your grown-up smarts and your ability to set limits.
Grace: Totally.

II. Finding the child part
Robin: Can you find that nurturing part of you? Remember when you took care of that sick friend?
Grace: I’m feeling the loving, caring, worrying part of me, right now.

III. Rescuing the child
Robin: Now I want you to walk up to that little one, introduce yourself, and tell her that you’re going to get her out of there, feed her good stuff, and make sure that she never,
ever has to be in a house without a caring adult, again. Would she like that? (Client nods.) Great! Let’s do this!

So, pick up that little girl, and start sweeping up the years, picking up every age that was home alone, feeling awful, and eating anything she could find….When you have them all, bring them up to right here and right now, with us. Are they okay to become one little Grace? (Nods.) Let Little Grace see you as you are now: Tall, successful, assertive, and with the ability to take care of kids, buy and make tons of good food, and have it on hand for good snacking and great meals. You can even make food for other people!

IV. Putting adults in charge

Look that Little Grace in the eye. Tell her that you’re her grownup and that you are in charge of almost everything. You, Ms. Nurturing-Professional woman, are in charge of the grown-up life, and of making sure there’s always good food in the house, and making sure that there’s always good snacks, and making sure that Little Grace never, ever feels alone, ever again. Anytime she feels lonely, she can feel Big Grace holding her. In fact, Big Grace, you tell Little Grace that she can never be alone, because she lives inside Big Grace. Do you feel the grownup body with the little girl piece inside? (Nods.) Great!

The Self

And here is a synopsized example from Andrew’s client, JB.

Part Andrew

JB, after almost a year of AR, was ready to process the memory of “7” being teased about being fat by her siblings. In contacting “7” via a conference room meeting, it was clear that “7” was still a bit shaky. I asked JB if she could go back in time, take “7” out of that memory, and nurture, support, and encourage her.

JB: I don’t know if I can do that…. I’m kind of shaky myself (here we see enmeshment, weak boundaries between adult and younger part).

Andrew: You’ve chosen your grandmother as a major support in your life. Would it help to bring her in spirit with you to help “7” while helping you stay in the adult mode?

JB: Uh, okay. I think that would work.

Andrew: Then I’d ask you to bring up a sense of your grandmother being with you…. Now let both of you go back in time through the years… the forties, thirties, twenties, teens, until you’re with “7.” Let me know when you’ve done that and you’re with “7.”

JB: Okay. We’re with her.

Andrew: Tell her what she needs to hear…especially that she’s a beautiful child, that she’s so okay and so lovable just as she is, no matter what her brother and sister say….

JB: (strong emotional reaction, tears…) My grandma is hugging her! She always gave me the best hugs. It felt so good (more tears as the boundary between JB and “7” blur) ….

Andrew: Let yourself be “7” for a few moments. Feel it all, how good and how sad all at once, but stay in touch with my voice (minutes pass…). JB, it’s time now to be the adult for “7.” Can you hear my voice?

JB: Nods.
Andrew: Okay. Remember all you do and are as an adult. Your two sons, your husband, the work you do coaching kids at school, your personal training business…. Got that?

JB: Yes, yes….

Andrew: So please take a few belly breaths, and ask “7” if she would like to return to present time with you and your grandma.

JB: Yes, she does. I think she’s really relieved.

Andrew: Great. So, if you and your grandma would take “7” by the hand and move forward up through the years. Eight, nine, ten…the teens, twenties, thirties, all the way up to present time, and bring “7” to that safe and peaceful place of yours and let her know that you’ll check in with her daily. And let me know when all that is in place.

The reparenting was successful, and JB proceeded to metabolize the memory to where it no longer disturbed her at all. “7” was finally free.

---

**PHASE 3—TRAUMA PROCESSING**

**The Self**

How one metabolizes or neutralizes a traumatic event depends on the therapeutic model used. Regardless of exactly how one accomplishes that, the basic concept of a trauma-informed approach is that if a memory is stored in a state-specific form (the way it originally happened, with feelings, sensations, etc.), it influences the way we feel, think, and react in the present when we are reminded (also known as triggered) of the original event. In other words, if Uncle Harry abused me when I was 6 years old, and Uncle Harry had a beard, then the sight of a bearded man in the present will activate the unprocessed memory of Uncle Harry. I then react in the present with the thoughts, feelings, and body sensations of a 6-year-old. To live fully in the present, I need to deactivate the past memory, which has been buried, but buried alive.

EDs often develop as a way of gaining control of or avoiding feelings and need to be addressed in their dissociated form (ego states) and in the context(s) in which they arose (memories). Robin and Andrew use several strategies to achieve the “how” of trauma processing with ED clients. I’ll let them speak for themselves, which they usually do! It’s hard to get a word in here.…

**Part Robin**

**USING EGO STATE THERAPY AND MINDFULNESS WITH POSTTRAUMATIC STRESS DISORDER (PTSD)**

Gary, a morbidly obese man in his 40s, was becoming diabetic. He came to therapy to change his nocturnal binging. When he was small, his abusive father would violently sexually and physically assault him, late at night, when the rest of the family was asleep. At that time, Gary would eat raw sugar and anything else he could find in an attempt to anesthetize himself. In his current, safe house, that young part would “kick in” each night when Gary’s wife and children went to bed, and Gary would binge in a similar way.

Robin: Gary, how old is that kid part of you who binges at night?

Gary: Four to about 12.
Robin: And how old are you, now?

Gary: Forty-five.

Robin: Great! Can you get that 45-year old professor, the one who is the great father, up to the front of you?

Gary: He’s here.

Robin: Think about a time when you were protective of your children. Can you feel that love and protectiveness in you? (He nods.) Great! Let’s do a rescue! Let’s go back to that 4-year old in the kitchen with the sugar. Can you feel him inside? (Nods.) Introduce yourself, so he doesn’t think you’re a creep and ask him if he’d like to escape that kitchen and abuse.

Gary: He really wants to!

Robin: Great! Can you take his hand, and you and he start coming up the years sweeping up every age of you that got abused, all the way to until you got out of the house. … Bring that kid/those kids all the way up to now, to this safe room with me. Now show him around here, and then to where you live now and where you work. Is your dad in sight in any of these places? Show them how many years it’s been since you’ve seen that bastard…. Show them the safety of your current life….And let them see your grown-up body and that no one is going to take you on!

Tell that kid/those kids that you don’t need sugar and food to make yourself not feel, because you are big enough to have feelings now. And show them again, that your current life is very safe.

Because the abuse had been so pervasive and impacted so many ages, we came up with this:

Robin: So, here’s the plan: Every night, when it’s bedtime, you’re going to sit on your comfortable, safe, chair in your comfortable, safe, den, in your comfortable and safe house. You’re going to notice the safety, and notice if any of the kid states arise. If you feel fear or those kid states arise, your adult, present-oriented, self will give them a tour of your present life and let them know that all parts of you are safe and there’s no need to stuff food; no need to protect yourself from big feelings, like you used to do.

For a few months, Gary sent me a brief, nightly email about his mindfulness exercise. When he sat and oriented to the present time, he did not binge. Once every few weeks, when otherwise triggered, he would not sit and he would binge. Now, 6 months later, he no longer binges. He is losing weight, and his blood sugar is under control.

Part Andrew

Vivian was a delightful and lively 17-year-old high school student who struggled with anorexia and body image. It all began when she was sexually abused by a peer at the age of 12. We had not yet had the opportunity to process the 12-year-old memory, when she came to session relating a more recent event.

During a class trip on a bus ride the week before, sitting next to a boy she had always considered a good friend, she was shocked as he began to fondle her, ignoring her protests as she tried to push him away. She reported this to her principal, but discovered that some of her classmates were blaming her for making a big deal of it.

Earlier, Vivian had been struggling with her body image, but was finding that what she saw in the mirror was becoming more positive, particularly because she had been staying with her eating plan, taking her brain and body out of a starvation mode.
When she arrived for her session and told me of the fondling incident, I asked her to close her eyes and imagine what her body image looked like in the mirror. The image had worsened. She imagined cuts over her now enlarged body, dressed shabbily, with bugs swarming around her head.

Her body image, as she imagined it, had become diagnostic, revealing a painful increase in her shame state (see more in Chapter 25). To alleviate this sudden shame attack, I decided to attempt clearing out the most recent event, though convinced that the fondling event 5 years earlier was feeding her reaction to the bus trip. For this, I used the Eye Movement Desensitization and Reprocessing (EMDR) protocol (see Chapter 13).

At the end of the EMDR processing of the bus experience, I checked to see if there was any disturbance left. “Nope!” I then inquired as to whether a positive belief about herself felt true when she thought about the incident. “Totally!” Finally, I invited her to do a body scan while focusing on the memory and the positive belief simultaneously to see if the scan was clear. “Clear!” I then asked how the overall experience was for her.

Vivian: Weird! I’ve never had something like the bus thing happen, and then feel totally okay! Weird!
Andrew: Would you be willing to see if the image of the girl in the mirror has changed?
Vivian: Sure. (After a few minutes of bringing up the image of herself in a mirror…) It’s different. The bugs are gone and the body is not so big. There are still some of the cuts, but she doesn’t look so much like a street person!
Andrew: Sounds like you just did something very, very important.

“The Self”

After the processing of painful life events, the client must still deal with present triggers and future challenges. Here is how Robin followed up with her client, Grace.

Part Robin

Making a Plan:

Robin: What kind of food are you going to get into your house for you and Little Grace?
Grace: I need to get easy, fast stuff, for snacks, that’s not too carb-heavy: pre-cut carrots, great cheese, and a big chunk of great ham for cutting and snacking. Then some easy meals stuff, until I can really cook. Maybe some of the healthier frozen dinners. And this weekend, I could cook up a storm, for left-overs for the week—maybe a good soup or stew with veggies and meat.
Robin: How does Little Grace feel about the menu?
Grace: She’s scared, because it’s different, and it won’t fix the lonely feeling. She’s upset!
Robin: Turn her around to you again, and let her see she’s not going to need that sugar stuff to make the feeling go away, because you’re going to be there, connecting with and feeding her.
Grace: Oh, you’re right! She’s settling in again.

Practicing the plan:

Robin: So, you’re going shopping, you’re taking the good food home, and you’re parking the car at your apartment. Imagine sitting in the car and engaging that kid. Can you imagine finding Little Grace and telling her, “We’re going into our apartment together...”
and I’m going to feed you the good stuff we bought. Any time you feel lonely, you need to notice I’m there. If I, Big Grace, feel lonely, I can name that feeling, feel it, like Robin taught us, and later, call up a friend, or find them on Facebook. I have a car and can go visit people if I want. I'm grown up!

Now imagine walking into the apartment after your talk. How will it be?

Grace: Better. I’ll have a plan. And I won’t be leading with the kid part of me!

In the next session, Grace reported that she had a kitchen full of good food, and was able to connect with her “kid part” before she went into the house to eat a good snack and make dinner. As a competent adult, she started making plans to go out to dinner or have people over, so that she would not be home alone. She still binged occasionally, on days that she was especially distressed, but usually not on walking in the door or on the sugary foods of her childhood.

The Self: And Here Are a Few Thoughts From Andrew.

Part Andrew

Particularly with JB’s 7-year-old part, ongoing support was needed after she desensitized her memory of being teased. Basically, the addiction to restricted eating had to be addressed not only behaviorally (eating plan), but also at the emotional roots of the behavior. In a word, she was encouraged to bring full awareness to her thoughts, feelings, and body sensations that took place at the first thought of, or urge to, restrict. Dealing with body image at its dissociated ego state source (e.g., the shame response of Vivian) is another example of dealing with the causal level of an ongoing trigger.

Mindful awareness is in and of itself an act of courage. It is the first step in inviting the client to face the emotions, feel them, and free them, thereby reducing the need for the ED. This is particularly true of the anxiety that ED clients often experience before eating and the shame experienced after eating. The only way to reduce these automatic reactions is to go toe to toe with them (see Chapter 10).

After past events have been processed, situations and relationships in the present and future still possess an emotional charge of their own via second-order conditioning. Robin and I (this is where we integrate!) have found that whether we are processing memories, neutralizing present triggers, or facing future feared situations, addressing these issues at the dissociated heart of a disorder can make all the difference, and a difference that will endure.

The Self

And so our chapter ends: togetherness and collaboration. And this is precisely what we seek with our clients. EDs are very difficult to treat in that they demand attention on so many levels: psychological, emotional, physical, behavioral. We believe that it is the reality of dissociation that makes this work all the more difficult, a reality that demands an invitation to all parts of our client to come together and collaborate in the service of healing.

REFERENCES


