EATING DISORDERS AND TRAUMA

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NHS Tayside Eating Disorders Service

NHS Tayside Eating Disorders Service

- NHS Tayside Eating Disorders Service was established in 2008
- The service is based at 15 Dudhope Terrace, Dundee, and provides outpatient assessment and treatment to adult sufferers of eating disorders in Dundee, Angus, and Perth and Kinross
- The service comprises a small, multidisciplinary team, with Psychiatry, Psychology, Nursing and Dietetic representation
- The service receives approximately 160 referrals per year, from predominantly Primary Care (e.g., GP) and Secondary Care (e.g., CAMHS, APTS, CMHTS)
- The service forms part of the North of Scotland MCN for Eating Disorders, and has shared access to 10 inpatient beds at the Eden Unit in Aberdeen

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Eating Disorders

- A group of psychiatric conditions related to body image disturbance and abnormal eating behaviour/compulsive activity
- 90% present in females
- 30-50% become long-term, chronic problems
- Eating disorders have the highest mortality rate of all psychiatric conditions
- 50% of those who meet diagnostic criteria for Anorexia Nervosa in the community do not access treatment

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Anorexia Nervosa (AN) ICD-11

Anorexia Nervosa is characterised by significantly low body weight for the individual's height, age and developmental stage that is not due to another health condition or the unavailability of food (BMI less than 18.5 kg/m2 in adults and BMI-for-age under 5th percentile in children and adolescents)

Low body weight is accompanied by a persistent pattern of behaviours to prevent restoration of normal weight, which may include behaviours aimed at reducing energy intake (restricted eating), purging behaviours (e.g., self-induced vomiting, misuse of laxatives), and behaviours aimed at increasing energy expenditure (e.g., excessive exercise), typically associated with a fear of weight gain

Low body weight or shape is central to the person's self-evaluation or is inaccurately perceived to be normal or even excessive

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Bulimia Nervosa (BN) ICD-11

Bulimia Nervosa is characterised by frequent, recurrent episodes of binge eating (e.g., once a week or more over a period of at least one month). A binge eating episode is a distinct period of time during which the individual experiences a subjective loss of control over eating, eating notably more or differently than usual, and feels unable to stop eating or limit the type or amount of food eaten

Binge eating is accompanied by repeated inappropriate compensatory behaviours aimed at preventing weight gain (e.g., self-induced vomiting, misuse of laxatives or enemas, strenuous exercise)

The individual is preoccupied with body shape or weight, which strongly influences self evaluation. There is marked distress about the pattern of binge eating and inappropriate compensatory behaviour or significant impairment in personal, family, social, educational, occupational or other important areas of functioning

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Binge Eating Disorder (BED) ICD-11

Binge eating disorder is characterised by frequent, recurrent episodes of binge eating (e.g., once a week or more over a period of several months). A binge eating episode is a distinct period of time during which the individual experiences a subjective loss of control over eating, eating notably more or differently than usual, and feels unable to stop eating or limit the type or amount of food eaten

Binge eating episodes are not regularly followed by inappropriate compensatory behaviours aimed at preventing weight gain (e.g., self-induced vomiting, misuse of laxatives or enemas, strenuous exercise)

There is marked distress about the pattern of binge eating or significant impairment in personal, family, social, educational, occupational or other important areas of functioning

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Avoidant Restrictive Food Intake Disorder (ARFID) ICD-11

Avoidant-restrictive food intake disorder is characterised by avoidance or restriction of food intake that results in:

1) the intake of an insufficient quantity or variety of food to meet adequate energy or nutritional requirements that has resulted in significant weight loss, clinically significant nutritional deficiencies, dependence on oral nutritional supplements or tube feeding, or has otherwise negatively affected the physical health of the individual;
2) significant impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g., due to avoidance or distress related to participating in social experiences involving eating)

The pattern of eating behaviour is not motivated by preoccupation with body weight or shape

Restricted food intake and its effects on weight, other aspects of health, or functioning is not due to unavailability of food, not a manifestation of another medical condition (e.g., food allergies, hyperthyroidism) or mental disorder, and are not due to the effect of a substance or medication on the central nervous system including withdrawal effects

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Over-Evaluation of Shape and Weight

- Common to Anorexia Nervosa, Bulimia Nervosa, and many atypical disorders
- Self-worth is judged largely in terms of shape and weight, expressed in a range of ways:
  - extreme dissatisfaction with shape and weight
  - morbid fear of fatness
  - relentless pursuit of thinness
  - repeated body checking, or its avoidance
  - mislabelling of emotional and physical states as ‘feeling fat’

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Anorexia Nervosa (AN)

- 1% prevalence among females and 0.5% prevalence among males, with a significant increase in the incidence of those aged 10 to 14 in the past 7 years

Bulimia Nervosa (BN)

- 2% prevalence in the general population

Binge Eating Disorder (BED)

- 4% prevalence in the general population

Avoidant Restrictive Food Intake Disorder (ARFID)

- Population prevalence as yet unknown

16% of people over 16 screened positive for a possible eating disorder (NHS England, 2019)

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Anorexia Nervosa

- Amenorrhea
- Cold intolerance
- Constipation
- Fatigue

- Bradycardia
- Dental erosion
- Dry, orange/yellow skin
- Hair loss, lanugo
- Hypotension
- Low body temperature
- Low weight
- Oedema

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Bulimia Nervosa

- Abdominal bloating/pain
- Constipation
- Dental complaints
- Oligomenorrhea
- Swollen cheeks
- Weakness

- Dental erosion
- Oedema
- Russell's sign
- Salivary gland hypertrophy

Eating Disorders and Trauma
Nature, Incidence and Prevalence

- Anger, irritability
- Anxiety
- Decreased self-esteem
- Depression
- Lability
- Personality changes
- Psychotic episodes
- Social withdrawal

- Apathy
- Decreased concentration
- Food preoccupation
- Poor judgement
- Unusual eating habits

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Predisposing Factors

- Genetics (54-84% heritability)
- Biochemistry (serotonin, leptin, ghrelin, orexin)
- Family structure disruptions
- Separation and loss
- Early feeding/social difficulties (Autism)
- Abuse
- Search for autonomy
- Adolescent crisis
- Low self-esteem
- Social pressure to be slim

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Precipitating Factors

- Interpersonal conflicts
- Separation and loss
- Sexual conflicts
- Increased range of pressure to succeed
- Adverse comments on appearance
- Feeling fat and dieting

Eating Disorders and Trauma
Nature, Incidence and Prevalence

Perpetuating Factors

- Rewards of weight loss
- Increased sense of self-control
- Increased sense of approval
- Increased concern from others
- Increased avoidance of adolescent tasks
- Fear of fatness

Eating Disorders and Trauma Linkages

Does Trauma Cause Disordered Eating?

There is a significant association between adverse life experiences and eating disorders:

- Individuals who had experienced any type of childhood abuse were three times more likely to develop an eating disorder (Caslini et al, 2016)
- Individuals who had experienced childhood abuse had an earlier age of eating disorder onset, more severe psychopathology, and higher frequencies of bingeing and purging (Molendijk et al, 2017)
- Individuals who experienced attempted or completed rape in the three months before starting college were more likely to have developed disordered eating by the end of their first semester (Collins et al, 2014)
- PTSD at baseline predicted disordered eating at three years in a population-based longitudinal study of military personnel (Mitchell, 2016)

Eating Disorders and Trauma Linkages

Does Disordered Eating Cause Trauma?

The primary physical traumas induced by eating disorders are from malnutrition, and all body systems are impaired (Tyson and Hodges-Chaffee, 2019):

- Individuals with AN have decreased grey matter in various regions of the brain, and those with BN have increased grey matter in the frontal and striatal areas (Van den Eynde et al, 2012)
- Cognitive slowing can effect academic, occupational and athletic performance, as well as impacting relationships and placing the individual at increased physical risk

Trauma can result from eating disorder treatment:

- Physical examination may require weighing and touching
- Hospitalisation can lead to separation from family and friends
- Tube feeding is invasive

Eating Disorders and Trauma Mechanisms

Early attachment experiences, negative self-beliefs and dissociation may function as mediating factors between trauma and eating disorders (Vanderlinden and Palmisano, 2019)

Individuals with eating disorders have a lower ‘window of tolerance’/threshold of response – they have heightened vulnerability to trauma, leading to dissociation and numbing by starving, bingeing, purging, etc. (Finlay, 2019)

PTSD symptoms have been found to mediate associations between sexual trauma and disordered eating among college students (Dubosc et al, 2012) and adults (Holzer at al, 2008)

Most studies are cross-sectional in nature, and use different definitions of, and methods to measure, trauma

Eating Disorders and Trauma
Eating Disorders: Recognition and Treatment (NICE, 2017)

Anorexia Nervosa (AN)

- Eating Disorder-focused Cognitive Behavioural Therapy (CBT-ED)
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)
- Specialist Supportive Clinical Management (SSCM)

Bulimia Nervosa (BN)

- Bulimia Nervosa-focused guided self-help
- Eating Disorder-focused Cognitive Behavioural Therapy (CBT-ED)

Binge Eating Disorder (BED)

- Binge Eating Disorder-focused guided self-help
- Eating Disorder-focused Cognitive Behavioural Therapy (CBT-ED)

Eating Disorders and Trauma
Trauma-Informed Approaches

Trauma-Informed Approaches to Eating Disorders (Seubert and Virdi, 2019)

Four-phase Model of Therapy:

1. Assessment/Evaluation (eating disorder, attachment, trauma)
2. Preparation (stabilisation, resource building, goal-setting)
3. Trauma Processing (memory processing and reconsolidation)
4. Reevaluation and Integration (future challenges, relapse prevention)

NES National Trauma Training Programme (2016)

1. Trauma Informed Practice (awareness-raising and signposting)
2. Trauma Skilled Practice (training and consultation)
3. Trauma Enhanced Practice (trauma therapy)
4. Trauma Specialist Practice (high-intensity trauma therapy)

Eating Disorders and Trauma
Trauma-Informed Approaches

Enhanced CBT (CBT-E) for Eating Disorders

- Transdiagnostic in scope:
  - suitable for Anorexia Nervosa, Bulimia Nervosa and atypical eating disorders
  - treatment is tailored to the specific psychopathology present rather than diagnosis
- Two versions:
  - F ('focused') version addresses the specific eating disorder psychopathology
  - B ('broad') version addresses, as needed, clinical perfectionism, core low self-esteem, interpersonal difficulties and mood intolerance

Eating Disorders and Trauma
Trauma-Informed Therapy

CBT-ED

- At least 20 sessions for BN/BED and 1-2 years for AN
- Trauma work can be done concurrently or sequentially
- Behavioural change proceeds cognitive change

Behaviour Modification

- Focus on nutritional and symptom stabilisation, and not trauma processing
- Engage, educate, motivate, nurture coping skills, set homework
- Explain linkages between trauma, eating disorder, self-image, interpersonal relationships
- Explain use of starvation/bingeing/purging to regulate emotion
- Use imagined and in vivo exposure with containment, grounding, relaxation, etc.

Eating Disorders and Trauma
Trauma-Informed Therapy

Cognitive Modification

- Identify and modify negative automatic thoughts, faulty assumptions and negative core beliefs, while validating emotions –

  'I will never be safe'

  'If I disappear, no one can hurt me again'

  'The world is unsafe and I am powerless'

Maintenance and Relapse Prevention

- Develop a wellness plan, identifying warning signs and potential challenges (e.g., life transitions, future intimate relationships, pregnancies, etc.)

Eating Disorders and Trauma
Trauma-Informed Therapy

MANTRA

- MANTRA helps patients to understand what causes their Anorexia Nervosa. It focuses on what is important to them personally, and on encouraging them to change their behaviour when they are ready. Families and carers can be involved in treatment too
- Treatment is at least 20 sessions long; the first 10 should run weekly, and the next 10 can be scheduled on a flexible basis

Eating Disorders and Trauma
Trauma-Informed Therapy

Specialist Supportive Clinical Management

- SSCM teaches patients about nutrition and how their eating habits cause their symptoms. The patient is set a target weight and given help to reach it
- Treatment lasts for at least 20 weekly sessions

Eating Disorders and Trauma
Trauma-Informed Therapy

‘You were born with the ability to change someone’s life. Don’t waste it’

(author unknown)

Trauma-Informed Approaches to Eating Disorders

Seubert and Virdi, eds. 2019