Body Positivity and Self-Nurturance in Clients with Disordered Eating Behaviors

Lori Kucharski, MA, LMFT, LPC, CEDS-S
Certified EMDR Therapist, Consultant, & Training/Credit Provider
AAMFT-Approved Supervisor
Certified Eating Disorders Specialist/Supervisor

Introduction

- lorikucharski@emdrcenterofthepikespeakregion.com
- Training Norms, Confidentiality, and Trigger Warnings

Disordered Eating

What is it, and what causes it?

FEEDING AND EATING DISORDERS

DSM 5 DIAGNOSES:

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge-Eating Disorder (BED)
- Avoidant/Restrictive Food Intake Disorder (ARFID; e.g., pseudodysphagia (fear of swallowing or choking) or emetophobia (fear of vomiting). Not body-image or weight-based)
- Pica (non-nutritive/non-food)
- Rumination Disorder (regurgitation/spitting out food--often sx of AN/BN
- Other-Specified/Unspecified (OSFED & UFED)

LIMITATIONS:

- Less than 85% target weight as SUGGESTION for AN criteria, not mandatory. Use clinical judgment and advocate for insurances to not deny on this criterion.
- Aside from Pica, can only diagnose 1 ED at a time.
- Disordered eating is about one's relationship with her or his Self. Often, disordered eating does not happen in isolation (meaning, emerges or exacerbates during times of trauma), and remission of one disorder's symptoms may lead to another (e.g., reducing or eliminating binges, but increasing restriction or purging).
- Not included in diagnostic vernacular: Orthorexia, Anorectic Obesity, Compulsive Overeating, or Emotional Overeating; Diabulimia
  - Lethality: https://www.mirasol.net/learning-center/eating-disorder-statistics.php

EPIDEMIOLOGY

According to ANAD, 30 Million, or 1 in 10 Americans are dx at some point during their lifetime with an ED! USA and Western Europe demonstrates more ED than other geographical areas, but ED occurrence/reporting is overall increasing.

- Being younger OR older
- Female (17-25% fat tissue increase in puberty; social/cultural factors; males under-reporting? Researcher bias?)
- Athletic/competition programs/aesthetics
- Childhood abuse/neglect*
  - Evidence-Based Research
    - ACE Study
      - Weight loss may be an attempt to become invisible; weight gain may be a way of developing protection or due to the thought that weight=unattractive=less/no abuse=safety.
      - Weight fluctuation could be an attempt to not be the weight "in the same body" one was in during abuse. Disordered eating, etc. can be a form of self-harm; it can also be a form of receiving/accepting support and feeling lost without it.
      - 21-59% of ED patients had childhood abuse/neglect; 1-35% in general population; 5-46% in general psychiatric population (Molendijk et al., 2017; Meta-analysis)
    - Increase in comorbidity, suicidality, severity, earlier onset, and binge/purge type

(Brewerton, 2007; Brewerton, 2015; Mitchison & Hay, 2014; Seubert, 2009; Seubert & Vi[illegible] Smink et al., 2012)

“Every ‘disorder’ has its purpose, the reason(s) why it came into existence. It is typically the default response for a client in dealing with adverse life experiences, often not productive, but the best the client can do” (Seubert & Virdi, 2019, p. 1).

*CHILDHOOD ABUSE/NEGLECT FACTORS

- Food withheld as punishment
- Punishment for not eating food
- Anger/family dynamics at table
- Sexual abuse (or any abuse) when food/smell is nearby/involved
- Being shamed/judged by parents/peers for eating choices
  - Family systems dynamics: control/rigidity; perfectionism; narcissism; image-based worth); family values/beliefs/habits around food/exercise
- Internal pressure to apologize for food choice/amount
- Afraid to eat in public/in front of others, etc.
- Way to control criticizing or bullying
- Purging (including exercise) as ways to purify the body, cleanse, feel clean again, worthy, or loveable.
- Lack of nurturance (e.g., “binger” reduces anxiety through food; “anorectic” by food representing “the rejecting, traumatizing object to be denied” (Shapiro, 2009, p. 116)
- Be careful with temperament; while there are correlations (e.g., perfectionism), ANYONE can develop an eating disorder, not just “Type-A” personalities.

(Brewerton, 2007; Brewerton, 2015; Mitchison & Hay, 2014; Shapiro, 2009)

“…when a patient with bulimia has her head in the toilet purging her guts out, I want to understand the part of her that was in such unbearable pain that whatever she felt inside of her could not be tolerated or contained”

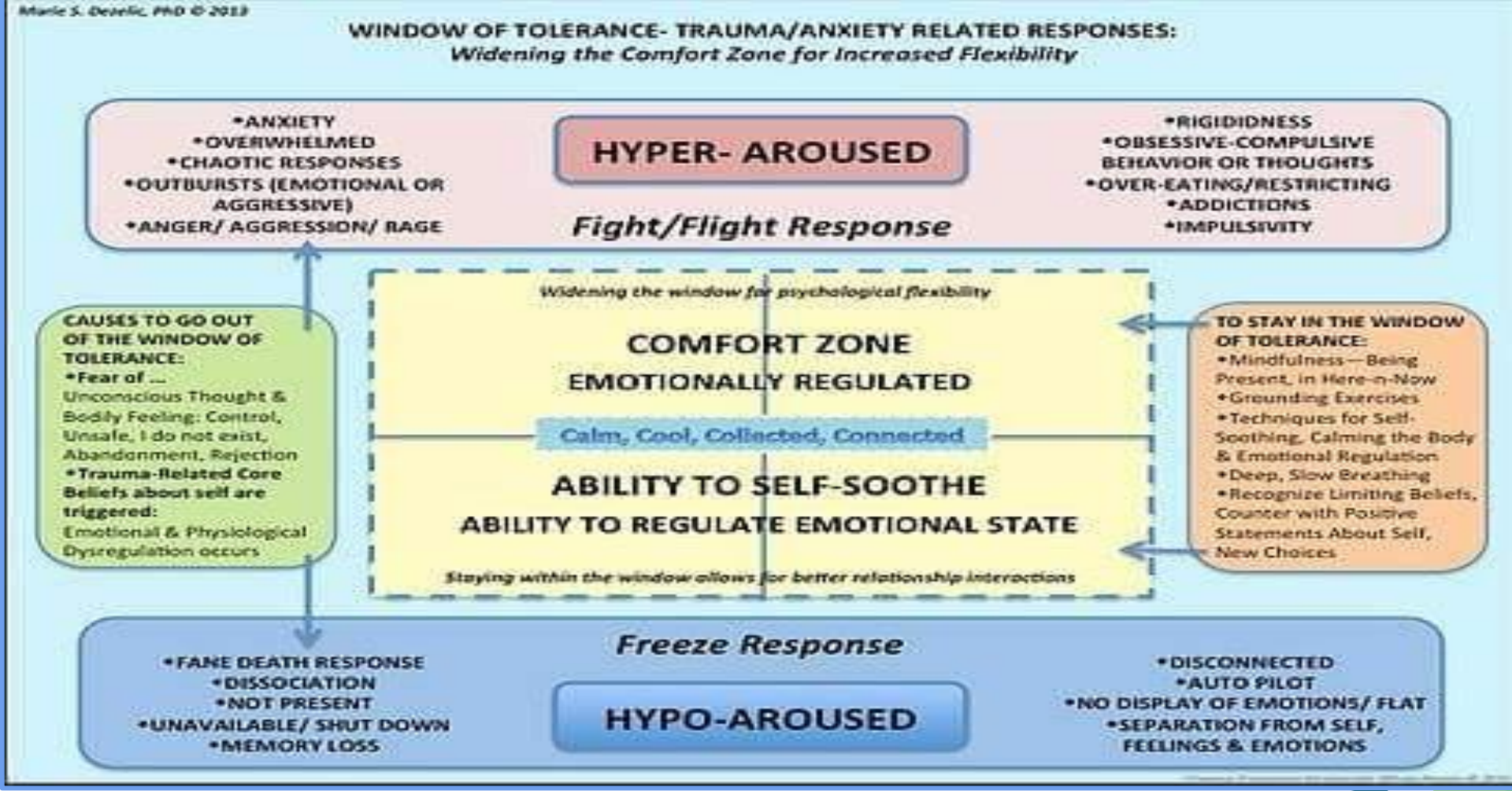
(Seubert & Virdi, 2019, p. 155).

DISORDERED EATING AS DISSOCIATION

- Inability to stay in window of tolerance (internal and external factors involved)
- Polyvagal response
- Reinforced with endorphin/neurotransmitter release and secondary gain (praise/envy of others)
- Higher rates of dissociation in ED: purging and compensatory bx
- Attachment/Attunement Deficits
  - Symbolic significance of food (soothing, nurturance, etc.)
  - First connection between self and other
  - Object-Relations and controlling symbol of trauma
  - Literally the survival of the species--becomes a fear-based dependency of or avoidance of out of need for survival

(Aarts et al., 2015; Amianto et al., 2016; Bahrami et al., 2013; Fuller-Tyszkiewicz & Mussap, 2008; Johnson, n.d; Milan & Acker, 2014; Moulton et al., 2015; Pugh, Waller, & Esposito, 2018; Seubert & Virdi, 2019; Palmisano et al., 2018; Shapiro, 2009)

Disordered eating and related behaviors are an attempt to quiet the mind and control the body. This further fractures mind-body awareness.



NEUROBIOLOGICAL PROCESSES

- (Stress → overeating) vs. (stress → loss of appetite). Endorphin responses; reward systems (e.g., dopamine) are directly impacted by hormonal fluctuation.
- Cortisol: NPY (decrease satiety) to HPA axis, ghrelin, leptin resistance, etc. Adrenal fatigue/HPA axis overload and cortisol exhaustion. Prolonged exposure to stress = loss of neural activity/dendritic branching/myelination.
- Regulated by hypothalamus, which is regulated by limbic system.
- SPECT scans indicate changes in blood flow in limbic system.
- Cortisol/HPA axis overload -> serotonergic effect (loss of serotonin levels)--> decrease in satiety/increase in food intake (e.g., hyperphagia) PLUS malnourishment (serotonergic effect improves with weight restoration)
- Epigenesis; altered DNA methylation
- Children who receive attunement and experience healthy attachment post-trauma may experience less epigenetic expression of DE. Infants/Children who don't have caregivers who attune to them when they are in sympathetic response will learn to dissociate and go into parasympathetic response--some also use disordered feeding bx. as self-soothing.

(Brewerton & Brady, 2014; Palmisano, Innamorati, & Vanderlinden, 2016; Seubert & Virdi, 2019; Shapiro, 2009)

NEUROBIOLOGICAL PROCESSES, continued

- Risk of malnutrition → brain function. Nutritional deficits responsible for disrupting neurotransmitter production that regulates mood.
- Slows down metabolic rate; body cannot tell if it is hungry or full. Starvation mode. Restricts even more. Reduction in digestive enzymes as well, leading to bloating, constipation, and other gastrointestinal problems.
- Malnourished body creates malnourished brain (exacerbates eating disorder/strengthens the disorder. Myelin sheath disruption: needs fat. Reduction in memory, loss in brain matter and changes to brain structure. Cognitive dysfunction leads to performance issues, which can end up being more traumatizing.
- Abnormalities in blood flow, glucose metabolism, and serotonin receptors. Serotonin: made in the gut and directly impacted by how someone eats. Both carbohydrate and protein needed to produce serotonin.
- Problems with feeling cold all of the time, even when others are comfortable. Using layers to stay warm. Takes hot baths; blood vessels dilate, drops blood pressure, and the individual may pass out in the shower.

(Johnson, n. d., Seubert & Virdi, 2019; Shapiro, 2009)

GENETIC FACTORS

- At least 4 studies replicating results of polymorphism, or the study of genetic variations and why some individuals respond to stress in an unhealthy manner, while other individuals respond to stress with more resilience:
  - 5-HTTLPR (related to serotonin): higher levels of BN and BED
  - DRD4 (related to dopamine): higher levels of AN
  - DRD2 (related to dopamine): possibly higher levels in BED
  - 22% to 76% variance/heritability in ED attributed to genetics
    (Brewerton, 2007; Mitchison & Hay, 2014; Content Analysis)
  - GABA-A (related to calm/relaxation): correlated to addictions
    (Brewerton & Brady, 2014)

Section Conclusion:

Disordered Eating is more prevalent than we realize and often is a feature of dissociation and correlated with trauma.

Body Positivity

A Solution for Body Image Concerns and Dysmorphia

Health at Every Size/Anti-Diet Approach/Body Positivity Movement: "A non-diet paradigm focused on health instead of diet."

- Focus on pleasure through intuitive eating and mindful movement. Respect, love, and nurturance for Self. Focus on health and wellness, not weight. Fat ≠ unhealthy; thin ≠ healthy. Correlation between BMI and disease or weight and health status, NOT causation/homogeneous.
- Considers socio-political-cultural factors, such as access to healthcare, genetics, and intersectionality. Inclusivity, not exclusivity.
  - "War on obesity" as fat-phobic. "Healthy weight" promotes weight stigma.
  - Media focus on diet industry/fear-based; fat people in media as "bad" characters or self-deprecating humor.
  - "Obesity prevention" insinuates we need to prevent others from being like you or me, or just prevent you or me! "When you say you want to get rid of obesity/childhood obesity, it feels like you want to get rid of us!"
  - Fat-discrimination: larger couples turned down by adoption agencies, etc.
  - Smaller-body/Thin Privilege: Advantages that smaller-bodied individuals have because a thinner body size is what society has deemed preferable.
  - For more information, please visit haescommunity.com & www.sizediversityandhealth.org

Health at Every Size/Anti-Diet Approach/Body Positivity Movement: "A non-diet paradigm focused on health instead of diet."

- Arguments against the body positive movement: It's ignoring the obesity epidemic Rising costs of healthcare, etc. In reality, when people are happy at home in their body, they naturally practice intuitive eating and mindful exercise, and health improves.
- There is NO risk to body positivity. It allows the client to learn how to trust themselves so they are non-dissociative/regimented around food/exercise. Significant, anecdotal evidence from people who gave themselves permission to eat what they wanted when they wanted, and after a few days to a few weeks to months, after the initial fear/control dynamic lost its power, gravitated towards nutritious food. When we're not depriving ourselves, and we love and respect ourselves, we are more comfortable being at home in our bodies and treating our bodies well. But we have to deal with the root causes to get there.
- "The HAES approach does not focus on any measure of body weight, shape, or size, but instead encourages a "'fulfilling and meaningful lifestyle' through eating according to internally directed signals of hunger or satiety and engaging in what is termed reasonable levels of physical activity" (Penney & Kirk, 2015).

Health at Every Size/Anti-Diet Approach/Body Positivity Movement: "A non-diet paradigm focused on health instead of diet."

- Correlation between weight stigma, trauma, and increased disordered eating risk.
  - Weight stigma and discrimination causes psychological and physiological harm (e.g., cortisol elevation, etc.). This perpetuates secondary or tertiary traumas or leads to new, primary traumas.
    - This may be viewed by the medical community as a result of obesity, not stigmatization or discrimination, which further perpetuates the cycle.

Options for Clients:

- Health at Every Size
- Body Respect (both by Linda Bacon)
- Body Positive Power (Megan Jayne Crabbe)
- Embody: Connie Sobczak & Elizabeth Scott
- Intuitive Eating (3rd ed.) & Workbook
  - Intuitive Eating Workbook for Teens

Body respect, positivity, or even neutrality helps repair attachment disrupt and helps the individual who did not have attuned caregivers now be able to re-parent oneself--attuning to the body, mind, spirit, and soul.

INTUITIVE EATING

Finding your hunger--learning to distinguish physiological hunger from emotional triggers and to also distinguish different degrees of hunger.

Feeding your hunger--getting off externally-imposed diet regimens and eating when physically hungry that which you are hungry for.

Breaking into the binge/purge/diet cycle.

Stopping at satiation--learning to distinguish different degrees of physiological satiety and to stop eating when satisfied and before becoming overly full.

Examine habits around activity and eating; relationship with food; stress levels; relationships; sleep quality.

Therapeutic Process

Assessment, Treatment Planning, and Intervention

COMMONLY-USED, EVIDENCE-BASED ED TX APPROACHES

- Family-Based Treatment (FBT)
- Dialectical Behavior Therapy (DBT)
- Enhanced Cognitive Behavioral Therapy (CBT-E)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Acceptance and Commitment Therapy (ACT)

It is common to use more than one approach or systems theory/ies when approaching disordered eating.

No matter the therapeutic modality, all clients may benefit from a disordered-eating, trauma-informed approach that addresses dissociation.

TREATMENT TEAM APPROACH

- Liability
- Ethical/Legal implications
- Involves:
  - Primary Care Practitioners
  - Functional Medical Practitioners
  - Naturopathic Physicians
  - RD's and Nutritionists
  - Psychiatrists and Therapists
  - School Counselors and Teachers
  - Parents/Caregivers (and siblings prn)
  - Supports prn (e.g., coaches)

- Discussions around:
  - Level of Care
  - Recommended treatment modalities
  - Nutritional counseling
  - Specific psychological interventions
  - Medications (e.g., SSRI's vs. controversial tricyclics)
  - Criteria for discharge
  - Recommended energy intake and weight gain
  - Feeding supplements
    - Phosphate, Thiamine, Zinc, Potassium, Vit. D., Magnesium
  - Artificial feeding

(Hilbert et al., 2017)

TREATMENT TEAM APPROACH

What do Do:

- Focus on wellness, somatic intuition, and restoration of health.
- Avoid focus on numbers (scale, reps, calories, clothing size, etc.).
- Take a non-judgmental, accepting, body-positive stance.
- Be aware of own biases.
- Demonstrate awareness of fat phobia and client's preferred terms (e.g., "living in a larger body" or "fat.");
- Use health journal vs. diet journal; eating plan or wellness plan vs. diet.
- See ED's as "fear-based illness with a drive for safety." Their words "I won't" really mean, "I'm scared." (Or "I can't").

What NOT to Do:

- Make statements such as, "You don't look like you have an eating disorder!"
- Comment on appearance, weight loss, etc.
- Remark on need/goals for weight-gain.
- Use triggering terminology.
- Compare (e.g., fat-shaming vs. smaller-body pressures).
- Discuss/promote diet plans/strategies that worked for YOU.
- Power-struggle or forcefully take away CL's autonomy/control."NO" always means "NO." The only time we may have to override the "NO" is in the case of life-threatening illness that requires involuntary care, and even then, all providers have a duty to remain as respectful and informative as possible, and to elicit consent as much as possible

(Johnson, n. d., Seubert & Virdi, 2019)

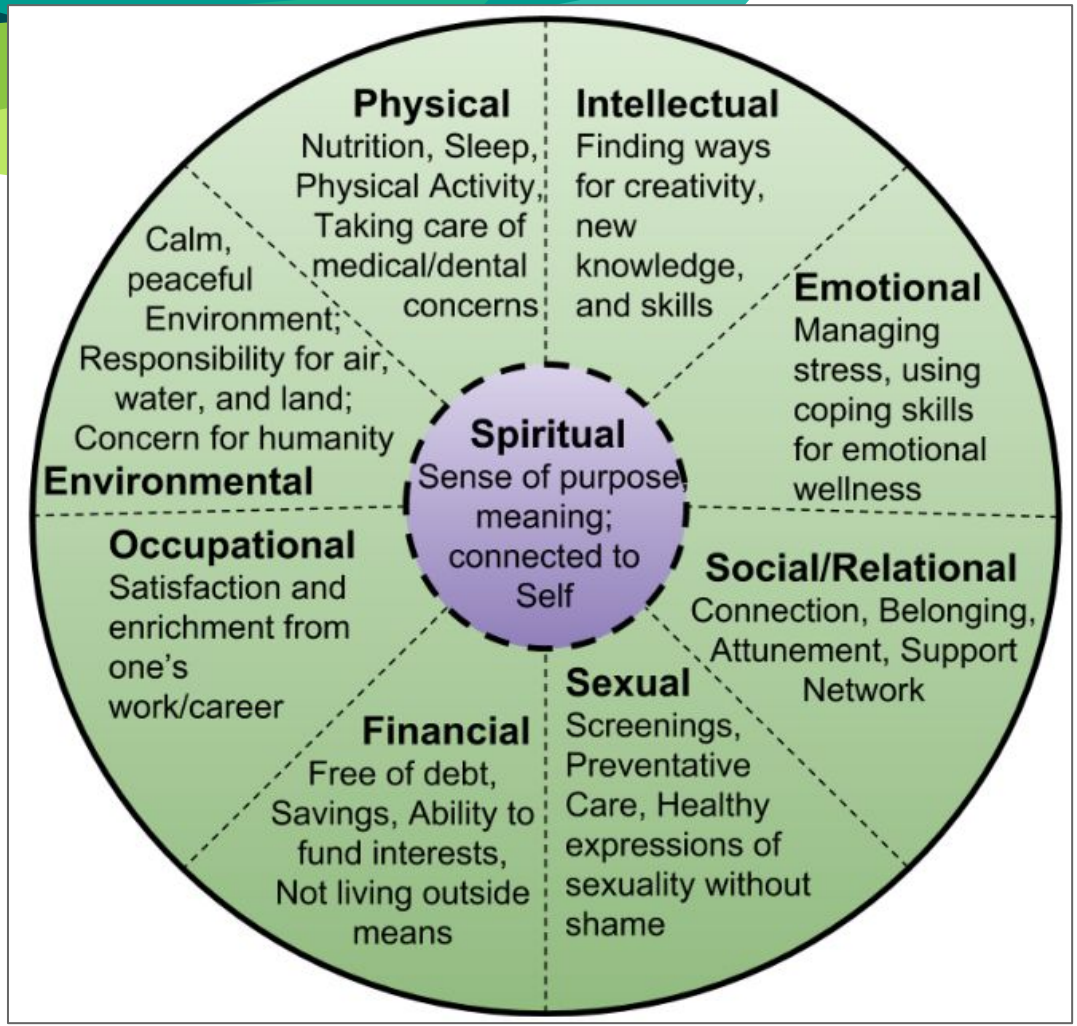
TREATMENT TEAM & APPOINTMENT REMINDERS

- Teach medical & dental professionals to seek permission at every step of a procedure or exam and to educate the client exactly on how their body will be touched/examined, etc.
- Teach clients to ground themselves as needed during appointments by saying factual things like, “My name is Sam. I am 23 years old. I live in Colorado Springs, CO,” doing 5-4-3-2-1, etc.
- Teach clients that they can take a trusted, safe person to their medical and dental appointments.
- Set boundaries in appointments/therapy/groups around talk about losing weight.
  - Triggering language may create endorphin/adrenaline rush similar to how it feels for DE clients to lose weight. It may also perpetuate shame. Help practitioners accept client unconditionally and not “prescribe” weight loss. This can be retraumatizing and reinforce worthlessness.

TREATMENT TEAM & APPOINTMENT REMINDERS

- Metabolic testing/BCA is important because bloodwork may look “normal,” and CL’s may not believe they are malnourished/have an ED. They may not attribute their fatigue, irritability, poor concentration/memory, weakness, etc. to ED/malnourishment. The body can “look” healthy and not BE healthy.
- Teach clients and practitioners that we need a MINIMUM of 1500 calories a day to live--organs use up all of that! Needs to be net, not gross, after exercise, etc. 1200 calories a day is outdated!
- See a dentist--not just with bulimia!
- DO create a world that celebrates diversity in body size, ability, and expression.

(Greater Manchester West, n. d.; Seubert & Virdi, 2019; Shapiro, 2009; Treasure, 2009)


Physical
Nutrition, Sleep, Physical Activity, Taking care of medical/dental concerns
Intellectual
Finding ways for creativity, new knowledge, and skills
Emotional
Managing stress, using coping skills for emotional wellness
Social/Relational
Connection, Belonging, Attunement, Support Network
Sexual
Screenings, Preventative Care, Healthy expressions of sexuality without shame
Financial
Free of debt, Savings, Ability to fund interests, Not living outside means
Occupational
Satisfaction and enrichment from one's work/career
Environmental
Calm, peaceful Environment; Responsibility for air, water, and land; Concern for humanity
Spiritual
Sense of purpose, meaning; connected to Self

ASSESSMENTS

Eating Disorder Assessments

- BEDS-7 (Adult Binge Eating Disorder Screener)
- BES (Binge-Eating Scale)
- EAT-26 (Eating Attitudes Test)
- EDE-Q (Eating Disorder Examination Questionnaire; sometimes called EDE)
- EDE-A (Adolescent version)
- BDDE-SR: Body Dysmorphia/Image Assessment

Trauma and Dissociation Assessments

- ACE
- PCL-5 with Criterion A
- Cambridge Depersonalization Scale
- SDQ-20
- MID

ASSESSMENT QUESTIONS

- Secondary traumas related to ED, (seizures, medical emergencies, overdoses, choking, etc.)
- Weight trends (e.g., rapid weight losses or gains)
- Frequency of purging bx (vomiting, over-exercise, laxatives, medications, etc.)
- Activity levels, including cycles of compulsive exercising, over-exercising, & sedentary bx
- Body image concerns
- Cultural/social/relational factors influencing the ED
- Nature of eating and weight-related symptoms (e.g., most/least/desired weight; types of diets)
- Frequency, quantity, and types of food eaten AND avoided
- Rituals around eating and underlying beliefs (past/familial and present)
- Fluid intake (dehydration vs. water intoxication)
- Use of diet products
- Awareness of correlation between ED and emotions
- Shame/secrecy (varies among DE; orthorexia, e.g.)

(Seubert & Virdi, 2019)

ASSESSMENT QUESTIONS

- What was each parent/caregiver's message to the client about:
  - Food
  - Eating
  - Their weight/weight in general
  - Their body
  - Having their needs met
  - Their feelings
  - Handling feelings
  - Satisfaction
- Level of Care needed (see handout): nationaleatingdisorders.org/toolkit/parent-toolkit/level-care-guidelines-patients
- Cognitive functioning/malnourishment
- SI/HI/Crisis
- Denial
- Impulse control (stealing, spending, substance abuse, self-harm, etc.)
- Significant dissociation (Cambridge Depersonalization Scale & MID)
- Therapeutic alliance
- Binge/Purge/Restrict Cycles, including using substance use, etc. increasing during periods of time
- Ability to tolerate positive affect

(Leeds, 2018; Shapiro, 2009; Seubert & Virdi, 2019)

Interventions & Strategies

Parts work for Dissociation and Disordered Eating

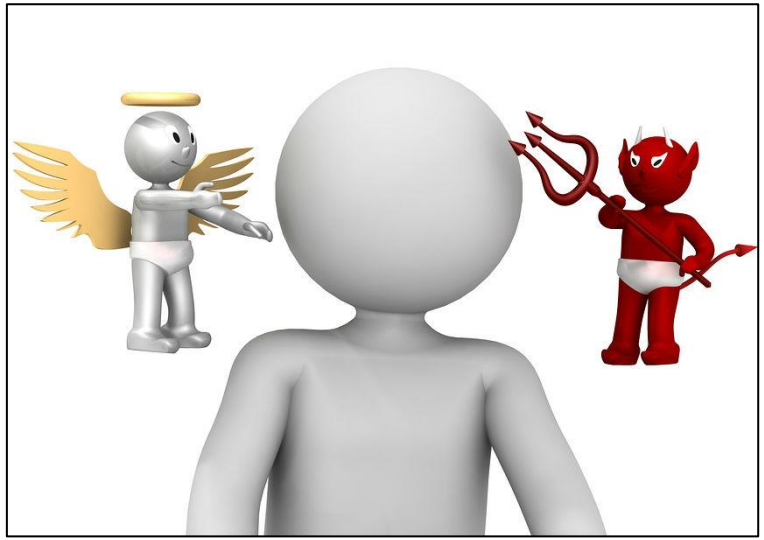
NEGATIVE COGNITIONS
(ASSESSMENT & PARTS EXTERNALIZATION)

- If I eat, I'll get fat.
- I need to (disordered bx) to not think about/feel _____.
- I need (disordered bx) to _____ (e.g., calm/comfort myself, stay safe, etc.).
- I have to be thin to be _____ (e.g., happy, successful, worthy, safe, ok, loved, etc.).
- Eating fills my _____ (e.g., emptiness, loneliness, etc.).
- I won't have _____ (e.g., attention, safety, security, happiness, control, nurturance) if I don't have my (disordered bx).
- My needs/I am too big.
- I am disgusting.

(Shapiro, 2009)

Roles of Food/Exercise Intervention
(Letter to Externalize Parts, etc.)

Best Friend
Committed Significant Other
Loving Parent
Fun Relative
Supportive Teacher
Loyal Helper
Controlling Boss
Relentless Coach
Abuser/Assaulter
Nagging/Critical Parent
Cheating Significant Other
Fairweather Friend



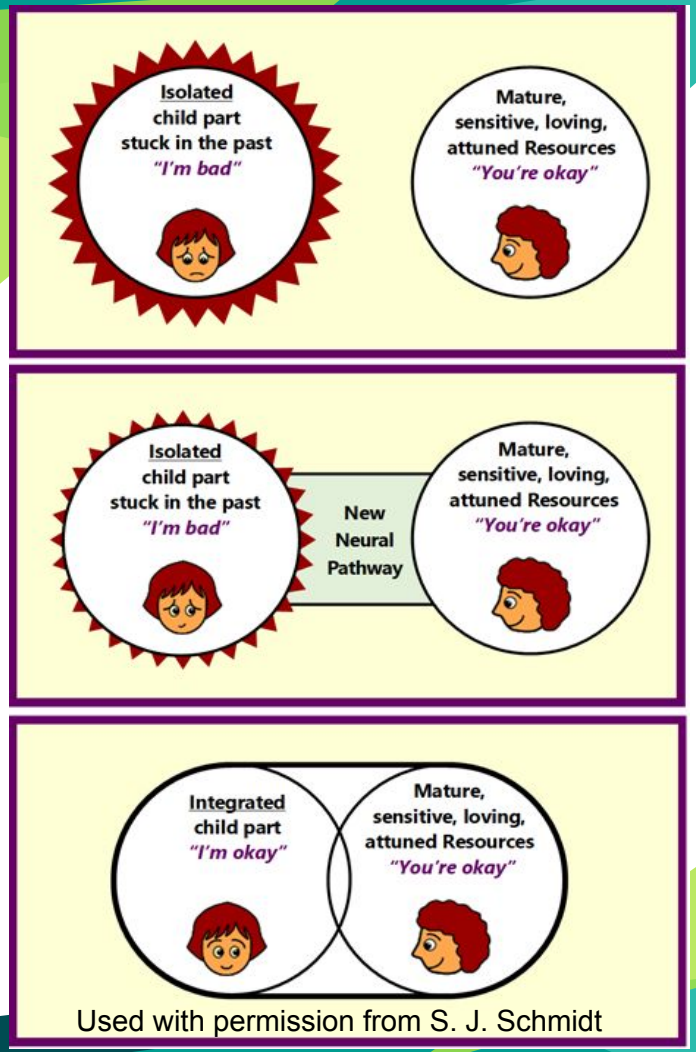
PARTS WORK

- Questions for Parts (elicits permission; collaboration):
  - How old are you?
  - When did you come into existence?
  - What do you want me to know about you?
  - What are you most afraid of?
  - What does _____ (fatness/thinness) represent to you (e.g., lack of control, weakness, victimhood, being teased as a child, etc.)?
  - Are you tired of constantly having to think about food/exercise/health/etc.?
  - Are you tired of constantly hating yourself/body?
  - Are you happy? Would you be interested in feeling better/stronger?
  - Would you be interested in working together to feel better/stronger, perhaps in a way that does not hurt you or your body?
  - What do you need from me?
  - Where are you feeling this in your body?
    - What does that feeling want for you/say to you?

(Shapiro, 2009, pp. 201, 208)

PARTS WORK

- Increases Affect-Tolerance Skills
  - Calm/Safe Place and Safety mechanisms
  - Container exercise
  - Nurturing/Protective Figures
  - Resourcing (Shapiro, 2009)
- Helps Reparent the Parts
  - Adult part to child parts: Attunement, validation, support, and resolution
  - Calm/Safe Place(s) for child parts
  - Take child parts out of traumatic situation to safe place
  - Collaboration to Reintegration (Seubert & Virdi, 2019; Shapiro, 2009)



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PARTS WORK

- Note: May take months for CL to be able to identify a CSP/Resource figure.
- Monitor for iatrogenic injury/abreaction
- Ego State Theory/IFS Mapping
  - Younger parts will need to realize that system must eat for survival.
  - Adult part(s) will need to have compassion for younger parts and that each part has a purpose for survival of system.
  - Clinician recognizes ED/DE's survival instinct, however misguided, and establishing goals that ED/DE parts will be able to work with.
  - Collaboration (Emphasized rather than integration).
  - Dissociative Table/Meeting Place
  - Using Empty Chair technique with parts.
  - Parts will either blame each other or accept blame (e.g., sad/scared part eats; persecutory part re-enacting trauma calls sad/scared part names.
  - Person in Mirror technique: Imagine seeing themselves in a mirror and to dialogue with the image as a part

 (Seubert, 2018; Seubert & Virdi, 2019; Shapiro, 2009)

Self-of-the-Therapist Activity

Reflecting on the HAES philosophy and Intuitive Eating Approach, what do you agree with, and why? What do you disagree with, and why?
(You may share out loud or consider privately)

(Private Meditation for Parts regarding Body Positivity to conclude)

Website Resources for Clients and Clinicians

Disordered Eating

http://www.iaedp.com/webinars-schedule/

https://www.eatingrecoverycenter.com/professionals/education-events/on-demand-professional-development

https://www.edcatalogue.com/

https://www.edcatalogue.com/category/for-professionals/

http://www.maudsleyparents.org/bookreviews.html

Body Positivity

https://www.sizediversityandhealth.org/content.asp?id=210

https://bodypositiveyoga.com/rebellion/

https://www.curvyyoga.com/

https://www.thebodypositive.org/

Gurze/Salacore Resources, FEAST, NEDA, ANAD, Moderation Movement: Facebook groups for professionals, individuals, and parents/loved ones.

Legal Aide

www.kantorlaw.net

Webinars, etc. on her website, including how to document EBTs to maximize insurance authorizations for ED.

Thank you for your attendance and participation!

Any questions?

You can find me at
lorikucharski@emdrcenterofthepikespeakregion.com

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