The Social Construction of Eating Disorders: A paradigm shift in conceptualization & treatment.

Presented by:
Bren Michelle Chasse, LMFT

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This workshop is not a substitute for EMDR training, TRM training, or Ego State training, etc. These therapy models should only be practiced by a mental health professional trained through EMDRIA, the Trauma Resource Institute, Ego State ("parts") work or other approved organization(s). Legal, ethical, clinical, and cultural standards can change quickly, and it is ultimately the responsibility of each individual therapist to remain informed on all relevant changes.

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Bren Michelle Chasse, LMFT

Ms. Chasse is the founder of Anchor Psychotherapy, Inc. and is a leading trauma expert in Pasadena, California. Ms. Chasse specializes in the experience of psychological trauma. She is EMDR-Certified and an EMDRIA Approved Consultant. Additionally, she has trained at a master level in Attachment-Focused EMDR and Ego States ("parts work").

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LEARNING OBJECTIVES

- Participants will be able to identify the relationship between trauma, particularly sexual trauma, and the development of eating disorders.
- Participants will be able to identify the role of language, memory storage, and *polyvagal theory*, as they pertain to the neurobiology of trauma.
- Participants will be able to identify 3 societal myths regarding eating disorders.
- Participants will be able to identify the intersection of race, class, & sexuality in the social construction of eating disorders.
- Participants will be able to identify 3 resourcing strategies.
- Participants will be able to identify an integrated treatment approach for working with eating disorder clients.

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"TYPICAL" EATING DISORDERED PERSON

Young, white, female, Western culture, heterosexual, upper SES, high-achieving, perfectionist, dichotomous thought process

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Do Eating Disorders Really Require Our Attention?

- Every 62 minutes at least one person dies as a direct result of an eating disorder. (Eating Disorders Coalition, 2019)
- Eating disorders have the 2nd highest mortality rate of any mental health condition → surpassed only by opioid addiction. (Chesney et al., 2014)
- 13% of women over 50 yo engage in disordered eating behaviors. (Gagne et al., 2012)
- 16% of transgender college students report having an eating disorder. (Gagne et al., 2012)
- 35% of female college athletes and 10% of male college athletes were shown to be at risk for anorexia. (National Center on Addiction & Substance Abuse, 2003)
- 58% of female college athletes and 38% of male college athletes were shown to be at risk for bulimia. (National Center on Addiction & Substance Abuse, 2003)
- Significant increased risk for suicide among **ALL** eating disorders → calls for intensive attention from clinicians. (Fitcher & Quadflieg, 2016)

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COMORBIDITY

- 2014 Study (*n* > 2400 individuals hospitalized for an ED) (Tagay et al., 2014)
  - 97% had one or more co-occurring conditions
    - 94% presented with a mood disorder (predominantly MDD)
    - 56% presented with an anxiety disorder
      - 20% = OCD
      - 22% = PTSD
      - 22% = alcohol/substance use disorder
  - 1 in 4 presented with symptoms of PTSD
  - 38% regularly engage in self-harm
- Significant correlation between ED's and BPD also shown. (Mangweth et al., 2003; McElroy et al., 2006)

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PHYSICAL CONSEQUENCES

APA Practice Guidelines: (American Psychiatric Association, 2000)

- Physical Consequences Directly Associated with ED's Include:
  - Malnutrition
  - Cardiovascular compromise:
    - Patients with normal EKG's may still present with:
      - Cardiac irregularities
      - Variations with pulse and blood pressure
      - Higher risk for sudden death
  - Arrested sexual maturity & growth failure
  - Prolonged amenorrhea (> 6 mons.), which may result in irreversible osteopenia (bone weakness) & high rate of fractures
  - High rate of abnormal CT brain scans found in > 50% of patients with Anorexia

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ANOREXIA NERVOSA

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health.
- Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.
  - **Restricting Type:** This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
  - **Binge-eating Purging Type:** During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviors (e.g., self-induced vomiting, abuse of laxatives, diuretics, or enemas).

(American Psychiatric Association, 2013; Photo Credit: iStock by Getty Images)

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RESEARCH

- 0.9% of American women and 0.1% of men suffer from anorexia in their lifetime. (Hudson et al., 2007)
- 1 in 5 anorexia deaths are the result of suicide. (Arcelus et al., 2011)
- 50-80% genetic risk factor for developing anorexia or bulimia. (Trace et al., 2013)
- Approximately ½ of anorexia patients present with comorbid conditions: (Ulfebrand et al., 2015)
  - Mood disorders
    - 30-50% of anorexia patients present with a comorbid mood disorder.
      - More common in binge/purge subtype than restrictive type.
  - Anxiety disorders
  - Obsessive Compulsive Disorder
  - Social Phobia
- Young people 15-24yo with anorexia have a 10x higher risk of dying as a direct result of the condition, compared to non-eating disordered peers. (Smink et al., 2012; Fichter & Quadflieg, 2016)

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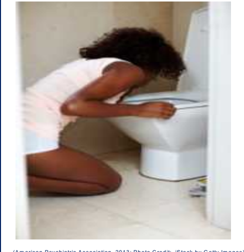
BULIMIA NERVOSA



(American Psychiatric Association, 2013; Photo Credit: iStock by Getty Images)

- Recurrent episodes of binge eating, characterized by both of the following:
  - Eating, in a discrete period of time (e.g., 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
  - A sense of lack of control overeating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent, inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; abuse of laxatives, diuretics, or enemas, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average, at least 1x/week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

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RESEARCH

- 2007 study (*n* = 9,282 English-speaking Americans) inquired about a variety of mental health conditions: (Hudson et al., 2007)
  - 1.5% of women & 0.5% of men met criteria for bulimia during their lifetime.
    - Translates to approximately 4.7 million females and 1.5 million males
- Estimated 30-70% of those with bulimia present with a comorbid addiction disorder.
- Shoplifting common due to the high cost of the quantity of food required, combined with impulse control issues.
- Lifetime prevalence data suggests bulimia is significantly higher in Latino and African-American populations.
- Approximately 34% of those with bulimia also present with significant self-harm.
- Males identifying as bisexual are at a greater risk for developing bulimia compared to their heterosexual peers.

(Marquez et al., 2011; Smink et al., 2012)

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BINGE-EATING DISORDER (BED)

- Recurrent episodes of binge eating, characterized by both of the following:
  - Eating, in a discrete period of time (e.g., 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
  - A sense of lack of control overeating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average 1x/week for 3 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia or anorexia.

(American Psychiatric Association, 2013; Photo Credit: iStock by Getty Images)

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RESEARCH

- Because of the challenges of BED being acknowledged as its own distinct disorder, the research regarding BED is significantly more limited than that of anorexia and bulimia. (Hudson et al., 2007)
- 2007 study (*n* = 9,282 English-speaking Americans) inquired about a variety of mental health conditions: (Hudson et al., 2007)
  - 3.5% of women & 2% of men met criteria for BED during their lifetime.
  - Results showed BED is greater than 3x more common than anorexia and bulimia COMBINED!
  - BED is more common than breast cancer, HIV, & schizophrenia.
- BED clients: approximately 60% = female; approximately 40% male (Westerberg & Waitz, 2013)
- 3 of 10 people seeking weight loss treatment show signs of BED. (Westerberg & Waitz, 2013)

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OBESITY vs. BINGE EATING

- NOT mutually inclusive → Obesity ≠ Binge Eating
- OBESITY:
  - Chronic & progressive disease that affects every organ & system in the body. (Flegal et al., 2001)
  - Obesity impacts an individual's quality of life, as well as one's emotional well-being. (Flegal et al., 2001)
  - Epidemic with the greatest prevalence & incidence in the U.S. (Flegal et al., 2001)
  - Annual allocation of healthcare resources for the disease and related comorbidities are projected to exceed $150 billion in the U.S. (Flegal et al., 2001)
  - Obesity is currently the second leading cause of preventable death in the U.S. (Flegal et al., 2001)

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U.S. Military Service Personnel

- Longitudinal study (T1 n = 48,378; T2 n = 42,174) following active duty military personnel over 3-year period:
  - 5.5% of women and 4% of men had an eating disorder at the beginning of the study.
  - Within just a few years of continued service, 3.3% more women and 2.6% more men developed an eating disorder.
- Controlled for: length of deployment (avg. = 9 mons.); exposure to combat trauma; external factors (e.g., divorce, comorbid conditions).
- Limitation: Data based on self-report. Sample size prevented researchers from conducting structured clinical interviews → suggests prevalence is likely much higher!

(Jacobson et al., 2009)

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Weight Stigma Among U.S. Military Service Personnel

- Prevalence of being overweight or obese among active U.S. military service personnel has tripled in the past 15 years. (Armed Forces Health Surveillance Center, 2001a; Bray et al., 2009)
- Consequences are high for those unable to consistently "*make weight*"
  - Increased risk of early discharge from the military
  - Reduced access to upward mobility in terms of rank promotion
  - Vulnerable to being unable to deploy or re-enlist (Armed Forces Health Surveillance Center, 2001b; Packnett, Niebuhr, Bedno, & Cowan, 2011)
- Outcome variables to weight-based stigma similar to those found in the civilian population. (Ashmore, Friedman, Reichmann, & Musante, 2008; Puhl, Andreyeva, & Brownell, 2008; Puhl & Heuer, 2009; Seacat, Dougal, & Roy, 2014; Vartanian & Novak, 2011)
- Due to the emphasis on fitness as part of the military culture, uniformed service members are at increased risk for:
  - Body dissatisfaction
  - Compensatory behaviors, unhealthy weight control practices
  - Disordered eating practices

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MYTH: *The Behavior is Attention-Seeking*

- Positive AND negative attention → chronic self-deprecation
- Go to great lengths to avoid any form of attention (especially if it may lead to detection/exposure of their secret).
  - e.g., exercising in the middle of the night; hiding food/trash from take-out
- Avoidance of food-centered events:
  - e.g., "I ate a late breakfast/big lunch." "I'm a vegan/vegetarian."
- Experience severe anxiety and distress when forced to eat in front of others.
  - Often pick at the food or move it around the plate.

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What I do NOT see in my office

- People occasionally eat during session in my office.
- Never ONCE has someone with an ED or significant body shame eaten in my office.

Caption: Portrait of obese young woman eating cupcakes during therapy session with female psychiatrist.

(Photo Credit: iStock by Getty Images)

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NEVER has this occurred in my office.

Caption: Emotional plump girl holding cake in right hand and looking at her therapist; serious young woman suffering bulimia since childhood

(Photo Credit: iStock by Getty Images)

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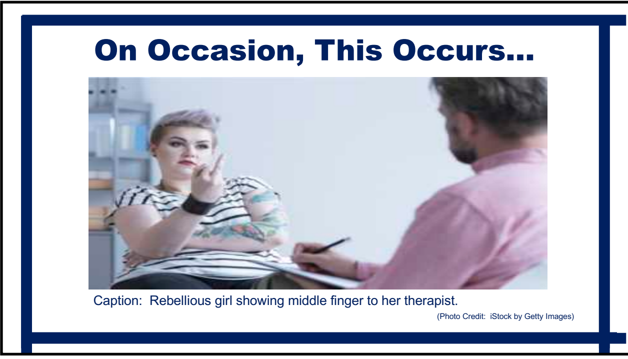

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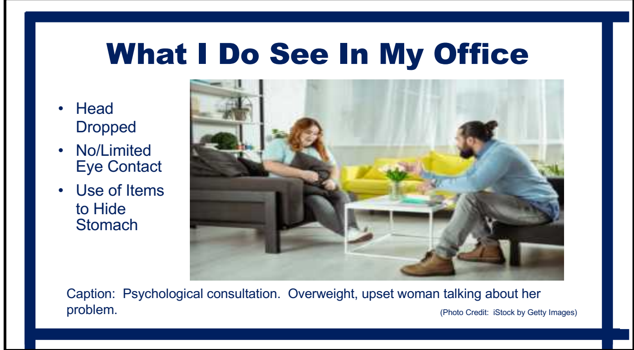

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MYTH: *The Media is to blame!*

- Contributory, but **NOT** a causal relationship.
- Disordered eating commonly observed in those of a young age, with limited access to the media.
- Often individual's weight will dramatically change several times across the lifespan.
  - Substantial and recurrent weight fluctuations raise complex and painful issues questions about what it means to be "embodied" when an individual's body may be in a frequent state of flux.
  - Sudden weight loss/gain often leaves an individual with little time to adjust to a change in body dimensions.

(Thompson, 2014)

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OVERWEIGHT WOMEN DO WORKOUT…& IT DOESN'T LOOK LIKE THIS…

Description: Obese female eating greasy burger instead of sports workout, lack of motivation, laziness.

Description: Obese woman struggling in workout, straining fat woman working out in fitness club & reaching for donut.

Description: Greasy unhealthy food for obese woman, young overweight woman eating big greasy fattening sandwich at workout in gym, concept of food obsession.

(Photo Credit: iStock by Getty Images)

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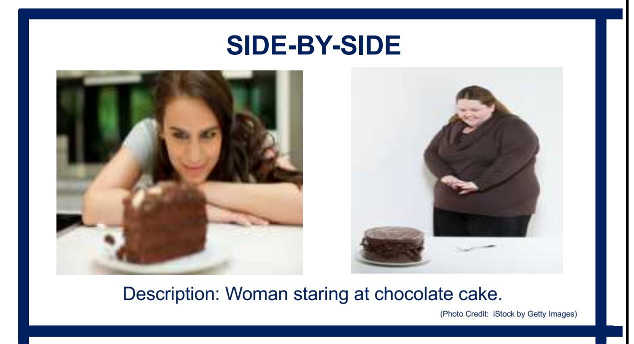
SIDE-BY-SIDE



Description: Woman staring at chocolate cake.

(Photo Credit: iStock by Getty Images)

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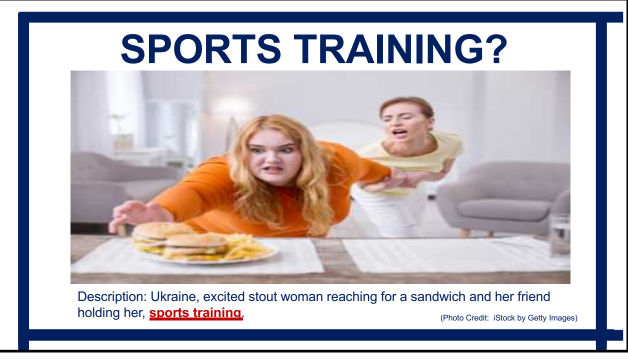
SPORTS TRAINING?



Description: Ukraine, excited stout woman reaching for a sandwich and her friend holding her, **sports training**.

(Photo Credit: iStock by Getty Images)

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WHAT'S IN A FACE

PANIC
FEAR
ANGST
INTENSE
RAGE
SHOCK
DETERMINATION
GRIT

(Photo Credit: iStock by Getty Images)

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MYTH: *A drive to obtain the perfect physique.*

- Client is not driven toward "thinness."
  - Seeking a sense of value and self-worth.
    - Assigned their value personal value to the arbitrary numbers on a scale.
- The Magic Number = Feedback Loop
  - When they hit this number and do not experience a sense of self-worth, it reinforces feelings of failure and worthlessness.
- If it were about achieving the perfect physique, they would enter a maintenance phase.
  - No value placed on nutrition or health.

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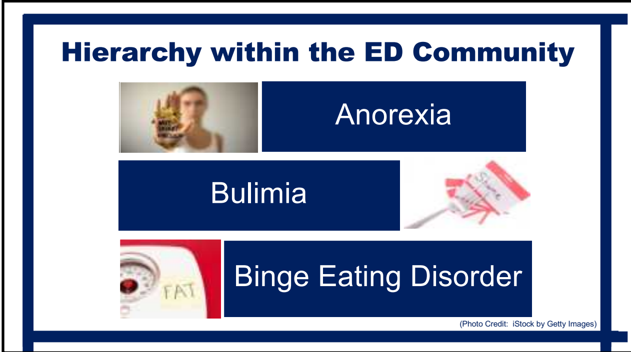

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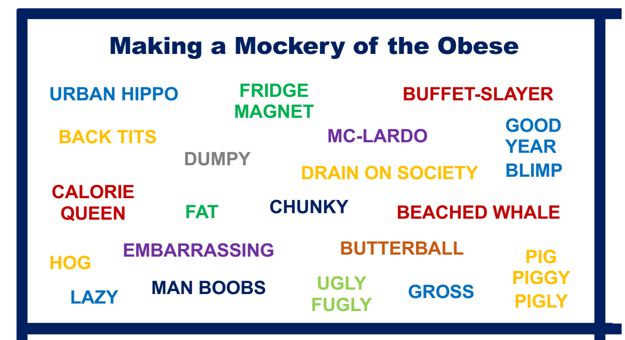

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LIMITATIONS OF THE DSM 5

- It is **NOT** trauma-informed, nor is it designed to be viewed through a trauma-informed lens.
  - Studies of the DSM over time have consistently shown poor rates of statistical reliability in diagnoses (Chmielewski et al., 2015).
  - Focus is on intake/output, weight, & behavior → all measurable variables
- Within our own field, we continue to refuse to give language to the primary sources of trauma → labeling problematic/undesirable behavior in ways that are stigmatizing and/or blame the victim.
  - e.g., Oppositional Defiant Dx, ADHD, Bipolar, Intermittent Explosive Dx; Disruptive Impulse Explosive Dx, Dysregulated Social Engagement Dx
  - Z-Codes: Most common sources of trauma are given diagnostic labels without any official standing (not reimbursable diagnoses).
  - Dismiss the social causation of many of the contributing factors & replace them with symptom-based diagnoses (labels of dysfunction and mental impairment).

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CONSPIRACY OF SILENCE

- Definition: A secret agreement to keep silent about an occurrence, situation, or subject, especially to promote or protect selfish interests (Merriam-Webster's Collegiate Dictionary, 1999).
- DSM = $$$ (Chmielewski et al., 2015).
- "*Developmental Trauma Disorder*" (DTD) (Van Der Kolk, 2014)
  - Bessel Van Der Kolk, MD & colleagues:
    - Developed a validated rating scale (*N* = 350 children and their parents/foster parents)
    - 2009 submitted the proposed new diagnosis of DTD to APA for DSM 5 consideration
    - Identified a consistent profile for children who develop w/in the context of ongoing danger, maltreatment, and a disrupted caregiving system.

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A DEAFENING RESPONSE

Matthew Friedman, MD, Ph.D.

- Executive Director of the National Center for PTSD & Chair of the relevant DSM subcommittee.
- Chair of the Trauma, Stress, and Dissociative Disorders Sub-Work Group for DSM-5.

"DTD [is] unlikely to be included in the DSM-5. The consensus [is] that no new diagnosis [is] required to fill a missing diagnostic niche…The notion that early childhood adverse experiences lead to substantial developmental disruptions is more clinical intuition than a research-based fact."

- 1 million abused/neglected children annually in the US ≠ "*diagnostic niche*" (Kilpatrick & Saunders, 1997)

(U.S. Department Veterans of Affairs)

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DEFINITION OF TERMS

BODY CONSCIOUSNESS: Ability to reside comfortable in one's own body.
- Includes the ability to experience oneself as grounded in and connect to one's own body.

EMBODIMENT: Ability to understand where one's physical body ends, and another's body begins.
- Allows an individual to simultaneously feel unique & connected to the world.

BODY INTEGRITY: Ability to control what does and does not go into one's body.
- Includes protection against unwanted touch, control of food intake, & regulation of bodily functions.

COMPULSORY HETEROSEXUALITY: Largely invisible, but enormously powerful force that delineates the range of what is socially considered acceptable sexuality. (Thompson, 1994)

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VICTIM PRECIPITATION THEORY

DEFINITION: Asserts that victims to criminal events that harm them through victim facilitation or victim provocation. (Timmer & Norman, 1984)
- Pervasive throughout the criminal justice system → often resulting in a secondary trauma.
- e.g., dressed provocatively, left the lights on, didn't have adequate security such as window locks

- Absolutely no current legislation or protection against overt discrimination.
  - Cannot file claim under the ADA → obesity is not considered a protected class.
  - Being identified as a protected class may be additionally stigmatizing & perpetuate further bias.
- Discrimination & publicly shaming people of size is considered justifiable because:
  - Assumption is they are personally responsible for their circumstances.
  - Belief that the solution lies within the person of size.
    - e.g., exercise more, stop consuming high caloric meals, diet, care more about their appearance

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GENERAL TRAUMA STATISTICS

- Nearly 3 million children in the US are reported annually as victims of child abuse and neglect.
  - 1 million are classified as serious and credible enough to require local DCFS or the courts to take action. (Kilpatrick & Saunders, 1997)
- Individuals with a trauma history & an eating disorder demonstrate high levels of dissociative symptoms. (Brewerton, 2004; Brewerton et al., 1999)
  - Binge eating & purging are reinforced → anesthetizing (Brewerton, 2007)
    - Reduced hyperarousal & anxiety
    - Reduced numbing & avoidance
    - Results in a cycle that gets consistently reinforced

"Today me will live in the moment unless it's unpleasant in which case me will eat a cookie." – Cookie Monster

(Photo Credit: Evans, 2015)

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PTSD & EATING DISORDERS

- In cases of severe and enduring anorexia, research has shown unresolved trauma and/or PTSD can be an important perpetuating factors in the maintenance of symptoms. (Brewerton & Dennis, 2015)
- Individuals with bulimia, BED, or any binge eating have significantly higher rates of PTSD than individuals without an eating disorder. Two major national representative studies showed significantly higher rates of PTSD in those with an eating disorder:
  - 44% bulimia
  - 38% BED (Dansky, 1997; Hudson, 2007)
    - When subclinical (partial) forms of PTSD are considered, well over half of bulimics have PTSD or significant PTSD symptoms. (Brewerton, 2007; Mitchell et al., 2012)
- Female victims of assault = 1.86 times more likely to develop bulimia compared to those not victimized. (Mitchell et al., 2012; Brewerton et al., 1999)

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SILENT PTSD

- Distressed & traumatized children, wherein the roots of their trauma history are less obvious:
  - They rarely disclose any details regarding their traumatic experiences.
  - They may be shut down, "suspicious," "paranoid," exceptionally compliant ("*fawning*"), or aggressive toward others.
  - They may have frequent meltdowns or emotional responses that, to school staff, hospitals, first responders, or poorly informed providers, appear to be disproportionate to their experience in the moment.
  - Increased shame and attributions of self-blame.
    - Locus of control
  - Self-preservation.
- Case Example: "Child B"
  - Confirmation bias

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CHILDREN & SEXUAL TRAUMA

- In 2016, DCFS agencies substantiated, or found strong evidence to indicate that 57,329 children were victims of sexual abuse. (U.S. Department of Health & Human Services, 2018)
  - 80% = a biological parent
  - 6% = other relatives
  - 5% = "other" (e.g., from siblings, strangers)
  - 4% = unmarried partners of a parent
- 1:9 girls & 1:53 boys under age 18 experience sexual abuse/assault at the hands of an adult. (Finkelhor, 2014)
  - 82% of all victims under 18 yo are female. (Department of Justice, 2000)
- Females ages 16-19 are 4 times more likely than the general population to be victims of rape, attempted rape, or sexual assault. (Department of Justice, 1997)
- Children that experience sexual abuse/assault are 4 times more likely to experience PTSD as adults → speaks to the long-lasting psychological impact of childhood sexual assault. (Zinzow et al., 2012)

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SEXUAL TRAUMA & EATING DISORDERS

- Correlation between sexual violence & eating disorders (*n* = 3310 females & 2382 males): (Michell et al., 2012)

ANOREXIA	BULIMIA	BED
Females: 48%	Females: 41%	Females: 35%
Males: 68%	Males: 24%	Males: 16%

- Likelihood of an eating disorder diagnosis among military veterans with sexual trauma is nearly 2 times higher, particularly among male vets, compared to vets with no reported sexual trauma. (Blais et al., 2017)
- Sexual trauma disrupts body consciousness by creating confusion/mistrust for bodily sensations.
- Sexual trauma destroys an individual's body integrity.
- Sexual trauma can result in a rupture of embodiment:
  - Disconnect between brain & body
  - May no longer feel a sense of ownership over their own body
- Sexual trauma in the form of incent results in confusing messages regarding personal safety, the ability to experience safety with others, & ruptures attachment.

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Consequences of Neurological Shutdown

- When fully integrated = right & left hemisphere of the brain work as a team.
- Having one side of the brain shutdown = debilitating.
- Impaired ability to perceive possibilities.
- Narrows ability to create new possibilities → always in a state of defending against something.
- Left Hemisphere Deactivation:
  - Impaired ability to organize experience into logical sequences
  - Impaired ability to translate our shifting feelings & perceptions into words
  - No access to Broca's Area.
  - Impaired Sequencing:
    - Can't identify cause & effect.
    - Can't grasp the long-term effects of our actions (more likely to make poor decisions).
    - Can't make coherent plans for the future.

(Van der Kolk, 2014)

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The Experience of "*losing your mind.*"

- **Experience of a loss of executive functioning!**
- Triggers = right brain reacts as if the traumatic event is happening in the present.
- Limited left brain access also limits awareness that one may be re-enacting the past—only know they are enraged, terrified, ashamed, or frozen → lack of integration
  - Integration REQUIRES re-activation of the left hemisphere (EMDR).
- Physiological measures reinforce re-experiencing (e.g., increased heart rate & increased BP).

(Van der Kolk, 2014)
(Photo Credit: iStock by Getty Images)

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WHEN WE HAVE NO WORDS

Accounting of a traumatic event
→
fragmented memories, "snapshots," non-linear, disorganized

(Photo Credit: iStock by Getty Images)

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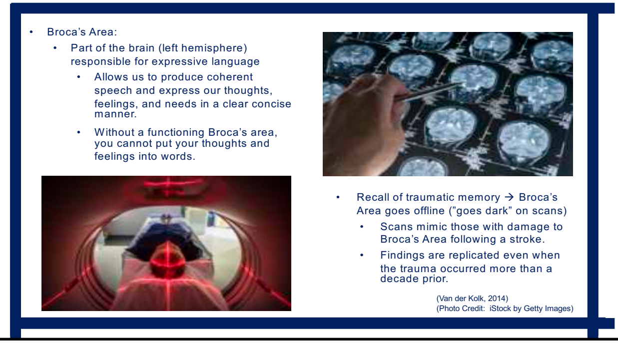

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Meaning Making

- **ALL** trauma is non-verbal
- *Cover Story*: socially acceptable explanation for Sx and behaviors
- Brodmann's Area 19:
  - Part of the occipital lobe cortex in the human brain (connected to the amygdala & anterior cingulate)
  - Responsible for registering images when they first enter the brain
  - Includes shape-recognition with feature extraction
  - *Ordinary Conditions* → raw images are registered and rapidly diffused to other brain areas responsible for meaning making
  - *Recall of traumatic memory* → increased brain activation in this area
    - Accounts for the Sx of re-experiencing and flashbacks
    - Findings replicated even when the trauma occurred more than a decade prior.
- Brain scan data of Broca's Area + Brodmann's Area 19:
  - Suggests the brain interprets trauma memories as if they are occurring in real time

(Van der Kolk, 2014)

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Understanding Polyvagal Theory

- Amygdala: Connected to every part of the brain EXCEPT the prefrontal cortex.
- Emotions are a direct response to stimuli (internal & external).
- Brain has one goal only → KEEP THE ORGANISM ALIVE!!!
  - Nervous system is constantly running in the background (outside of conscious awareness) to support the brain's goal.
  - Nervous system can hijack the brain and take over our emotional experience.
    - Designed to be adaptive: snake vs. garden hose

4 STATES: GROUNDED, FIGHT, FLIGHT, COLLAPSE

- **GROUNDED**: (within our window of tolerance)
  - State of rest/relaxation
  - Capable of social engagement
  - Freedom of movement
  - Emotionally regulated
  - Capable of being curious, creative, and explorative (somatically driven)

(Porges, 2011)

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MOBILIZATION OR COLLAPSE

- **FIGHT/FLIGHT**:
  - State of mobilization → body prepares to preserve life
    - Scan the environment
    - Brain releases cortisol, epinephrine, and NP4
    - Blood rushes away from the brain and to our muscles/extremities
    - Spike in heart rate and BP, digestion slows
    - Visceral experience of fear
    - Senses are hyper-focused
  - *The hope of preservation is present → we believe we have a chance at survival*
- **FREEZE/COLLAPSE**:
  - State of demobilization → form of self-preservation in response to the feeling of impending death (Last ditch effort to survive!).
  - GOAL: Its function is to keep us frozen, as an adaptive mechanism, to help us survive to either fight/flight again.

(Porges, 2011)

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TRIGGER WARNING

Are You There?

Extremely Loud & Incredibly Close

(Daldry, 2012)

https://www.youtube.com/watch?v=dykB0OmLGDc&feature=youtu.be

(Photo credit: IMDb)

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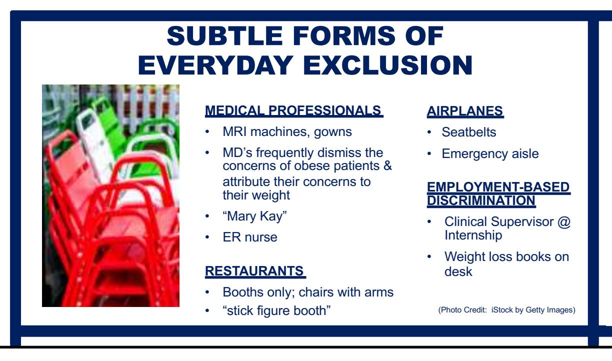

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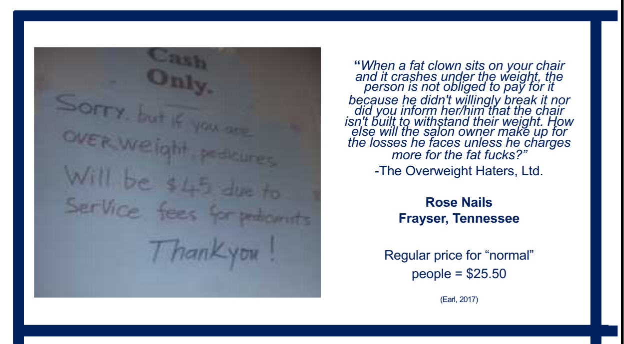

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Originally aired on HBO on September 6, 2019.

(Real Time with Bill Maher, 2019)

https://www.youtube.com/watch?v=Dm4TAdiEFn0&feature=youtu.be

Photo credit: HBO Network

64

Originally aired on CBS on September 12, 2019.

(The Late Late Show with James Corden, 2019)

https://www.youtube.com/watch?v=Ax1U04c4qaw&feature=youtu.be

Photo credit: CBS Network

65

Shame is NOT a Call to Action!

- 79% of weight-loss program participants report coping with weight stigma by eating more food. (Andreyeva et al., 2008)
- American elementary school girls who report they read magazines: (Martin, 2010)
  - 69% report pictures influence their concept of the ideal body shape
  - 47% report pictures make them want to lose weight
- Weight teasing has been shown to be a predictor of weight gain, binge eating, and extreme weight control measures: (Golden et al., 2016)
  - Approximately 40% of overweight girls & 37% of overweight boys are teased about their weight by peers & family members.
- Weight stigma poses a significant threat to one's psychological and physical health.
  - Research shows it is a significant risk factor for an increase in depression, low self-esteem, and body dissatisfaction. (Andreyeva et al., 2008)

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Anchor Psychotherapy, Inc.

Intersection of Race, Class, & Sexuality

67

HISTORICAL BIAS & DICOTOMY OF RACE

- **Social Construct:** heterosexual, teenaged/young adult, white, high-achieving, upper SES, female
  - Based on a false universalism. Belittles the "typical" client & completely ignores marginalized individuals.
- **Sample of Convenience:** The stereotype of ED's as a "*golden girls' disease*" is more indicative of which women have been studied rather than that of actual prevalence.

White Women

- Frivolous
- Obsessed with appearance

Black Women

- Unattractive "mammies" (*women deemed as lacking the necessary ability to be sexual*)
- Incapable/not affected by pressures to be thin
- Slavery – no legal right to one's own body
  - Legitimized sexual exploitation
  - Invisibility reinforced as black women are portrayed as bodies w/out minds
    - Assumption → incapable of developing problems that are both psychological and physical.

(Thompson, 1994)

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THE ROLE OF RACE

RESEARCH

- People of color are more likely to suffer from an ED
  - Black teenagers are 50% more likely than white teenagers to exhibit bulimic behavior (Goerree et al., 2011).
  - Hispanic adolescents significantly more likely to suffer from bulimia than non-Hispanic peers (Swanson et. al, 2011).
  - Higher prevalence of BED in all minority groups (Swanson et. al., 2011).

ACCESS TO SERVICES

- People of color are significantly less likely to receive help regarding their relationship with food (Becker et al., 2003).
- People of color with self-acknowledged eating/weight concerns were significantly less likely than white participants to be asked by a doctor about ED symptoms, despite similar rates of ED symptoms across ethnic groups (Becker et al., 2011).

ENVIRONMENTAL FACTORS

- Disproportionately exposed to higher levels of stress due to multiple minority group status.
- More likely to experience chronic racism, reduced access to education, lower SES.

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CLINICAL BIAS

CLINICAL BIAS (Gordon et al., 2006)

- *n* = 91 clinicians
- 1 of 3 passages (only difference is race: African-American, Caucasian, Hispanic) describing disturbed eating patterns of fictional character named *Mary*.
- Asked to indicate problem & rate anxiety, depression, & eating disorder symptoms
- Data:
  - 44% identified white woman's behavior as problematic
  - 41% identified Hispanic woman's behavior as problematic
  - 17% identified black woman's behavior as problematic
    - Clinicians were also significantly less likely to recommend that the black women should receive professional help.
- Results: Data suggests clinicians may have race-based stereotypes about eating disorders that could impede their identification of symptoms in African-American females.

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THE ULTRA-ORTHODOX JEWISH COMMUNITY

RESEARCH

- Empirical data is limited—largely due to an insular community with great shame attached to mental health.
  - Study of "ultra-Orthodox" and Syrian Jewish communities in Brooklyn, New York found that 1 out of 19 girls met clinical criterial for an eating disorder.
    - Rate approximately 50% percent higher than the general U.S. population.
    - Study was conducted with the express agreement that results would not be published. (Sacker, 2010)
  - Study of high school students (13 yo – 30 yo) in Toronto (*n* = 868) showed that 25% of Jewish females (compared to 18% of non-Jewish females) met clinical criteria for an eating disorder. No significant differences found between Jewish and non-Jewish males. (Pinhas et al., 2008)
- Obesity rates are relatively low among this population. (Rabin, 2011)

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HISTORICAL SIGNIFICANCE

HISTORICAL CONTEXT (Rabin, 2011)

- Uniquely complex → pressure to preserve the ethnicity & the culture
- NY has a long history of lobbying for religious exemptions
- Transgenerational Trauma → Holocaust
  - No legal right to one's own body
    - Level of dissociation required for survival → may result in genetic loading/predisposition to PTSD
  - An entire generation of people that learned about hate before they learned about love

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A VEIL OF SILENCE

- Women expected to conform to a rigorous code of conduct → lack of agency
  - Chaste until marriage; dating forbidden until "looking for a husband"
    - Frequently includes arranged marriage & high level of parental involvement ("practice of matchmaking")
  - Any indication of struggle or mental health challenges = undesirable

TRADITIONAL GENDER ROLES

- Enormous pressure on young women to marry & immediately start a family
  - Restriction: may be a way of stalling adult responsibilities & slowing biological clock
  - Obesity: may be a way of being viewed as "undesirable" by potential suitors
- Required to be consummate homemakers & prepare elaborate Sabbath meals (large elaborate meals mandated by the weekly Sabbath)

(Rabin, 2011)

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CLINICAL BIAS

FAILURE TO TREAT RESPONSIBLY (Rabin, 2011)

- May not respect the observation of religious practices
  - Structured prayer times
  - Observation of the Sabbath
    - Cannot drive to be taken to participate in therapy, group meetings, etc.
  - Fasting on high holy days
  - Pathologizing an internal religious value system
    - *Shuckling*: ritual swaying during prayer (traditionally seen in men)
      - Assumed to be a compulsory behavior designed to burn calories
- Nutrition & Meal Planning
  - Kosher food rarely available at clinics (e.g., PB&J, bagels)
    - Further reinforces feeling of being ostracized
  - Accounting for consumption of wine/grape juice & challah
  - Understanding for the important role food plays in traditional Jewish culture

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www.ReliefHelp.org

Relief Resources is a non-profit organization that provides multiple services to individuals suffering from mental health conditions. Relief is geared specifically toward members of the Jewish community who are dealing with overwhelming issues.

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MONEY MATTERS

WORKING CLASS vs. MIDDLE CLASS

- Dichotomy between middle-class & working-class women:
  - Middle-class: capable of symbolic & abstract relationships through their actions
  - Working-class: assumed to relate to the world in literal & concrete ways
- Assumes working-class are exempt from developing an ED because they are incapable of developing a symbolic relationship with food.
- Women may develop an ED in response to the struggles associated with poverty, the stress of upward class mobility, etc.
  - Challenges the notion that ED's are somehow class bound.
  - Affirms that people of any class are quite capable of developing & sustaining complex, sophisticated, & symbolic relationships with food that go far beyond a biological need for sustenance.

(Thompson, 1994)

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AN AFFLICTION OF THE UPPER CLASS

PREVAILING STEREOTYPE: positive correlation between SES & individuals most likely to develop an ED

RESEARCH

- Very limited research available on the relationship between ED's and class!
  - Focus on gender-based research has been at the exclusion of other analytical categories that are relevant → can be both esteem & identity-related.
  - Data is inconsistent.
- Methodological Design Issues: (Gard & Freeman, 1996)
  - Sources of bias in clinical impression and referral procedures
  - Population differences: Tx setting vs. general population
    - Tx settings: more likely to include high SES, reinforcing stereotype
    - Community populations: more likely to identifying those that experience distress around food, weight, & body shape.
  - Failure to adequately separate anorexia and bulimia when identifying predisposing factors

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A BODY DOESN'T LOOK "*RIGHT*"

STIGMA

- De-legitimizes distress
- Can lead people to avoid seeking treatment out of fear of being dismissed by MD's
- MD's may make assumptions about whether treatment will be appropriate or helpful

POVERTY

- Anorexia → skipping meals may seem ideal (cognitive dissonance)
- Bulimia → added layer of guilt due to complex relationship with money & beliefs about food waste
- Limited access to quality & sustainable foods
- Intersection between saving money & counting calories
- Physiological consequences of ED (e.g. broken bones, dental work, expensive medical visits) reduces opportunities for upward mobility.

2020 POVERTY GUIDELINES vs. AVERAGE COST OF TREATMENT

- $26,200 for family of 4 (family of 1 = $12,760) (U.S. Department of Health & Human Services, 2020)
- $30,000/month on average (Parker-Pope, 2010)
  - Clients typically require 3+ months of treatment

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ACCESS TO INSURANCE ≠ ACCESS TO CARE

- ED'S are associated with some of the highest levels of medical and social disability of any psychiatric disorder. (Klump et al., 2009)
  - Yet, insurances provide limited (if any) coverage and fight against providing any long-term or supportive care.
- According to a survey of specialists (*n* = 109), representing nearly every inpatient eating disorder program in the U.S.: (Anonymous, 1999)
  - 1 in 5 ED specialists report they believe that insurance companies are indirectly responsible for the death of at least one of their patients.
  - 96.7% of ED specialists report they believe their patients w/ anorexia nervosa are put in life threatening situations because of health insurance companies' refusal to cover treatment.
- TRICARE provides healthcare coverage for over 9.5 million active duty service members & their families.
  - TRICARE restricts access to needed treatment, denying coverage for treatment at freestanding ED centers. (TRICARE, 2014)

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SEXUALITY AS A CONTINUUM

HISTORICAL CONTEXT

- STIGMA: LGBTQ identity associated w/ mental illness, social deviance, and psychopathology
  - Makes LGBTQ-identified individuals less likely to seek services.

SOCIAL CONSTRUCTION

- Assumption that LGBTQ-identified women have rejected traditional standards of beauty →
  - Not capable of being "attractive"
  - Don't place value on their appearance
- "Gay-Baiting"
- Assumption of heterosexuality
- Grooming girls to be heterosexual
  - Taught heterosexual is "natural" → means anything else is "unnatural"
- Internalized Homophobia: negative beliefs about oneself due to sexual orientation, non-conforming gender expressions, or transgender identity

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ENVIRONMENTAL FACTORS (Ray, 2007)

- May experience high levels of stress or fear about the potential consequences of being outed.
- Disproportionately exposed to violence & hate crimes (7x more likely), making them more vulnerable to PTSD.
  - LGBTQ-identified victims are more likely to be blamed for the traumatic event than their heterosexual peers.
- Of the estimated 1.6 million homeless American youth, between 20-40% identify as LGBT.
  - 33% of youth who are homeless or in the care of DCFS experienced assault when they came out. (Ray, 2007)
  - Homeless LGBT youth are at risk not only on the streets, but in the shelter system as well.
  - LGBT homeless youth are more likely to become **AND** stay homeless.
    - Largely due to family conflict associated with their sexual identity being a significant factor in their homelessness.

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MARGINALIZED VOICES

RESEARCH

- Research is limited & conflicting on ED's among lesbian & bisexual women. (Austin & Bryn, 2004)
  - Lesbian women experience less body dissatisfaction overall, but research shows that beginning as early as 12 yo, LGB teens may be at higher risk of binge-eating & purging.
  - Gay men disproportionately found to have body image disturbances and ED behavior.
    - Gay men are believed to represent approximately 5% of the total male population → among men who have ED's, 42% identified as gay.
  - Gay & bisexual boys reported being significantly more likely to have fasted, vomited, taken laxatives, or diet pills to control their weight.
  - Gay males 12x more likely to report purging than heterosexual males.
- LGBTQ Males w/ Eating Disorders (*n* = 135) → potential risk factor (Carlat et al., 1997)

ANOREXIA
- 22% males (aggregate)
- 58% identified as "asexual"

BULIMIA
- 46% males (aggregate)
- 42% identified as "homosexual" or "bisexual"

ED NOS
- 32% males (aggregate)
- data not reported

- A sense of connectedness to the gay community was found to be related to fewer current eating disorders → suggests a protective factor. (Ray, 2007)

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PREGNANCY – EATING FOR TWO?

- Under the best circumstances, it can be challenging for a woman to adjust to all the changes her body is going through—especially the change in one's body size.
- Not only is the amount of weight a woman is supposed to gain restricted, but someone is literally monitoring and commenting on your weight every couple of weeks.
- Recommendations of the Institute of Medicine suggest that women who are pregnant consume approximately 300 additional calories per day.
  - Roughly translates to 25-35 lb. weight gain over the course of a full-term pregnancy.

(Oster, 2018)

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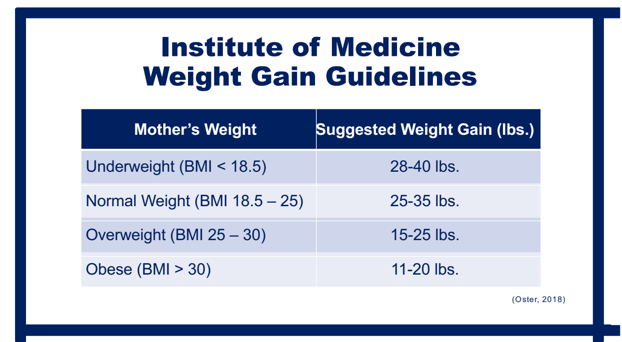

Institute of Medicine Weight Gain Guidelines

Mother's Weight	Suggested Weight Gain (lbs.)
Underweight (BMI < 18.5)	28-40 lbs.
Normal Weight (BMI 18.5 – 25)	25-35 lbs.
Overweight (BMI 25 – 30)	15-25 lbs.
Obese (BMI > 30)	11-20 lbs.

(Oster, 2018)

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WHAT ARE THE RISKS?

- Reality = more than half of women gain more weight than the recommended amount.
- Positive correlation between weight gain during pregnancy and baby's birth weight (relative to the timing of birth).

Small for Gestational Age (SGA)	Large for Gestational Age (LGA)
• breathing difficulties • difficulty regulating blood sugar • abnormal neurological signs	• difficulty during delivery resulting in an increased risk for C-section

*data relates only to full-term babies

(Oster, 2018)

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Where it Really Makes a Difference?

- Reality = more than half of women gain more weight than the recommended amount.
  - Unless weight gain/loss falls dangerously outside of normal limits, the focus on a pregnant woman's weight is, at best, an uninformed and dated practice.
  - The data suggests that being hyper-focused on "a few extra pounds" does far more damage than good!
- Consequences of placing so much emphasis on the mother's weight:
  - Increase in stress and cortisol secretion.
  - Increases shame.
  - Implicit messages of failure as a mother/woman; may induce feelings of guilt over potentially causing harm to unborn baby.
  - Increase in likelihood of relapse and/or increase in eating disordered behaviors.
  - May cause a woman to withhold information from her OB/GYN and/or stop seeking prenatal care altogether.

(Oster, 2018)

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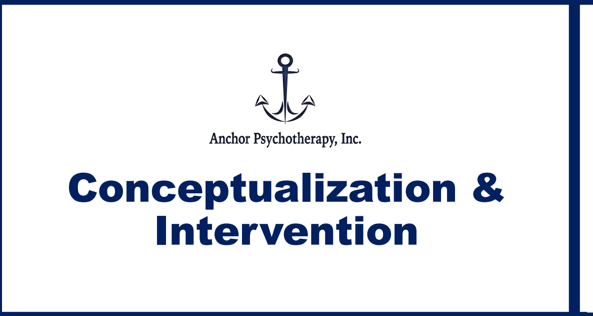

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"Regulation is the nervous system's ability to navigate the highs & lows of activation & return to calm."

-Patti Elledge

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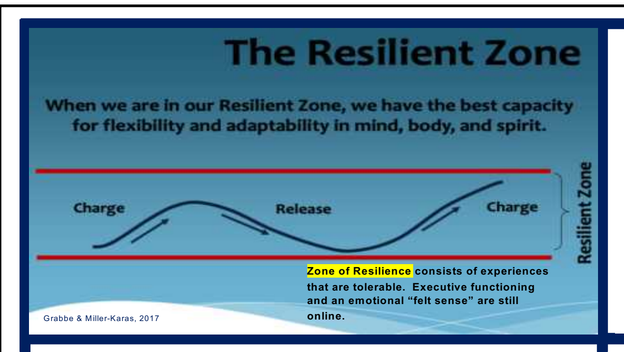

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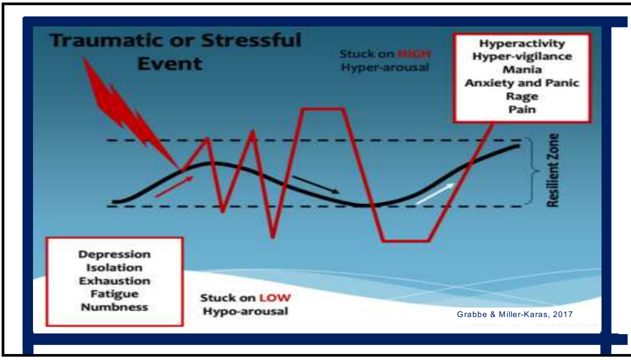

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RESTORING BALANCE TO THE NERVOUS SYSTEM

- Safety & Terror are **INCOMPATIBLE!**
- Engage the parasympathetic NS → Send a signal to the amygdala to turn off the body's alarm system.
- Trauma puts us in a chronic state of hypervigilance with the goal of preparing to defend against something.
  - Results in a struggle to perceive possibility.
  - Narrows ability to create new possibilities or perceive a bright future.

When you challenge the brain, you MOBILIZE it! You Change it!

- Coloring
- Puzzles
- Tracing Items

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SHAKE IT OFF!

ENGAGE IN MOVEMENT!

It is impossible to be immobilized if you are physically moving!

Examples:

- Yoga, Tai Chi, Walking

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WORKING WITH THE DISSOCIATION SPECTRUM
Engage the Senses

TOUCH

- Make contact with the body:
  - Placing hand over your heart and focus on heartbeat
  - Focus on the feeling feet on the ground
- Weighted blanket
- Worry Stones
- Polished River Rocks
- Kinetic Sand/Therapy Dough
- Japanese Raking Garden

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TASTE
- Use of a small food item that has a pleasant intense taste → ANCHOR
  - Breath mint
  - Lozenge
  - Piece of candy

SMELL
- Essential Oils
- Can be a small portable object to use as an anchor

HEARING
- Internal sounds (e.g., heartbeat, pulse)
- Soothing music (e.g., regulation playlist)
- Use of bilateral music

SIGHT
- Name (out loud) objects in surrounding environment
- Bring awareness to current time & space (e.g., mid-day, sunshine)

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Resources: 2 Types

DEFINITION: Anything that elicits a positive emotional experience and/or supports nervous system regulation.

INTERNAL RESOURCES:
- People, places, activities, skills, hobbies, and animals we know and love.
- Anchor Thoughts: a positive cognition so powerful, it pulls you out or your current mindset & into present moment

EXTERNAL RESOURCES:
- Values/beliefs that give us strength or a sense of peace/calmness.
- May include memories of important people or experiences.
- May include personal strengths (e.g., compassion, empathy, humor).
- May include body resources (e.g., physical strength).
- Container Exercise

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AF-EMDR RESOURCING

CALM/PEACEFUL PLACE OR PLACE OF COMFORT

- Sacred place/sanctuary
- Conflict-free space
- Evokes positive memories
- May use the heart as a safe refuge
- May use a safe place in the body
- May include images from nature
- Needs to include safety, comfort, shelter, and food (e.g., buffet)
- May include a healing body of water (e.g., "to wash off the yuck")
- May be real or imaginary
- Identify what the place is like using the 5 basic senses:
  - What do you see, hear, smell, feel, taste?

(Parnell, 2013)

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CONTAINER

- A container is a place you can temporarily store thoughts that pop up during a day when you are not willing or able to attend to them.
- The container can be defined by any space, as long as you can connect to the space, feel the space has the capacity to hold these thoughts/items, and is fully contained (e.g., lock on the door, lid for the container.)
- Can be helpful to include a trusted other that can protect the container.
  - Dual Purpose: protect the material & reinforce the container; protect the client from dipping into the box prematurely
- Examples: clinician's office, or the office of a prior trusted therapist/mentor, a special container you hand off to a trusted person or store in a safe place, mason jar, locked chest or drawer, your locked car, etc.

(Parnell, 2013; Photo Credit: iStock by Getty Images)

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HEALING BODY OF WATER

- Can be real or imaginary
- A place to wash off "the yuck"
- What color is the water?
- Where is the water located?
- What, if anything, surrounds the water?
- What time of day is it? (daytime/nighttime)
- The water **CANNOT** be contaminated by the "yuck" or other impurities

(Parnell, 2013)

ADULT/CURRENT SELF

- Connect with your innate qualities of empathy, compassion, confidence, courage, and strength.
- Form a mental picture of that part of yourself.
- Can you recall a time when you were nurturing, protective, and/or wise on behalf of another?
  - Can be caring for their own children, a relative, a friend, or even a pet.
- Bring to mind the positive traits you already have to be protective, courageous, strong, logical, confident, and grounded.

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NURTURING/COMFORTING FIGURES

- Figure may be real or imaginary and have a nurturing quality
- Someone or something that can comfort or care for you
- Spouse, partner, close friend, parent of a close friend, coach, caregiver, doctor
- Family members (must be non-conflictual)
- Figure from movies, books, TV
- Mentor, therapist, or someone of significant importance
- Spiritual figures and/or animals
- Internal allies
- May be your adult nurturing self

(Parnell, 2013)

PROMPTS

- Can you imagine a figure that has a nurturing quality?
- Can you imagine yourself as the nurturing figure providing nurturance to someone else?
- Can you imagine the nurturing figure nurturing you?
- Can you imagine viewing a scene in which one figure gives nurturance and the other receives it?

****You don't have to be able to imagine the figure nurturing you—what is important is that you can imagine someone/something that has a nurturing quality.*

100

PROTECTOR/BRAVE/POWERFUL FIGURES

- Internal allies that can be summoned to give you strength and to help provide you feel protected.
- Can be real or imaginary figures from the past or present.
- May be a character from a book, movie, etc.
- May be someone highly respected (e.g., public figure).
- May be an animal or pack of animals (e.g., dragon, pack of wolves).
- May be the same as the nurturing figure(s).
- Mentor, therapist, or someone of significant importance.

(Parnell, 2013)

- May be your protective adult self.
- Important you be able to ***feel*** the figures protective quality. You do not necessarily need to be able to imagine the figure protecting you.

WISE/PROBLEM-SOLVING FIGURES

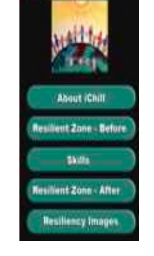
- Wise figures from family, ancestors, movies, books
- Spiritual figures (these figures are imbued with a power that feels numinous and superhuman)
- Historical figures
- Trusted other that is wise and compassionate
- Inner advisor or inner wise self

101

TRAUMA RESOURCE INSTITUTE

iChill Phone App

- Resilient Zone
  - SUDS rating before & after use of skills
- Skills
  - Can read or listen to audio
- Resiliency Images
  - Allows for uploading of images of resources.
  - Creates a virtual & easily accessible container of resources.



(Miller-Karas, 2015)

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A TRUE CALL TO ACTION

- Stop using samples of convenience.
- Challenge research that treats white heterosexual women as the standard, and re-examine the split and oppositional images of race, class, and sexuality.
- Not until we expand our conception of race, class, and sexuality—and begin to acknowledge and understand the interconnectedness of all three, will we be able to advance theory with any practical significance.

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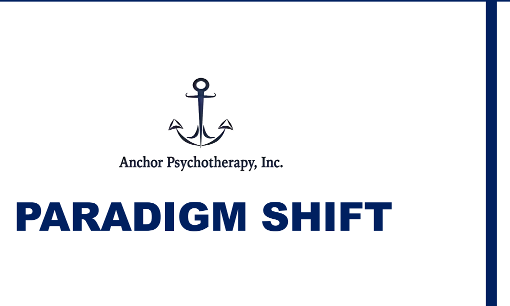

PARADIGM SHIFT

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PROBLEMS WITH THE CURRENT TREATMENT APPROACH

- Disempowering & Antagonistic
  - Professionals = Threat
- Operating Belief: If it's not painful, then you can't heal.
- Treating symptoms, not the underlying cause.
- Assumption is that the client can't know what is in his/her best interest.
  - Battle → Who's the expert?
- Limited/No resourcing
- Limited/No body-centered work
- Interventions are often poorly timed:
  - Not trauma-informed
  - Limited insight into transference
    - A triggered therapist is likely to intervene too quickly &/or too frequently

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CONCEPTUALIZATION

- Individual disorders → functional response to dysfunctional circumstances
  - Develop a life strategy in response to trauma.
- Understanding ED's develop largely as a product of trauma
- Response to physical & psychological distress:
  - Age & stage limitations
  - Often exposure to inescapable/chronic trauma
- When social injustices are directed at the body → makes sense that one may engage in efforts to escape the source of the pain = THE BODY!

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FIRST STEPS

STABILIZATION

- Any potentially life-threatening conditions resulting from a client being dangerously underweight/overweight (e.g., cardiac issues, rapid fluctuations in BP, suicidal ideation, severe substance abuse) and safety issues much be addressed first.

A COLLABORATIVE TREATMENT APPROACH

- Effective treatment requires a team of providers that are willing and able to work collaboratively in the best interest of the client.
- **ALL** treatment providers **MUST** be trauma-informed, understanding of the nuances of eating disordered clients, and be willing to work outside the box—we need to work **WITH** the client, not against them!

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A TRAUMA-INFORMED & RESILIENCY-FOCUSED MODEL

Trauma-Informed

- Identifies the signs, symptoms, and impact of social constructs contributing to trauma on an individual and systemic level.
- Reactive model → resources mobilized after a trauma has occurred.
- Educates and integrates knowledge, research, and practice into treatment.
- Resistant to future trauma.

Resiliency-Focused

- Inoculates the systemic culture from the effects of trauma.
- Operates proactively, instead of reactively.
- Supports the development of a shared trauma vocabulary.
- Understands we cannot prevent trauma from occurring, but we can ensure individuals and the community are as resilient as possible when trauma hits.

(Miller-Karas, 2015)

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PHARMACOLOGY

- Medication may play an important role in managing co-morbid conditions.
- Imperative that the psychiatrist be both trauma and eating disorder informed.
- Need to be mindful of medications that can cause weight gain/loss.

IMPORTANT CONSIDERATIONS:

- Use of medication should err on the side of being conservative:
  - Avoid numbing the client to the point where it becomes a barrier to the client engaging in trauma processing & treatment.
  - Encourage clients to learn to tolerate increasing levels of distress in an effort to increase their zone of resiliency.

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Understanding the Interweave Between Shame & Perfection

- Shame: *intensely painful feeling or experience of believing we are flawed &, therefore, unworthy of love & belonging.*
- Shame derives its power from being unspeakable.
  - Fueled by trauma → keeps us small, resentful, & afraid.
  - Greatest danger: Shame is silent and, therefore, unmeasurable!

(Brown, 2014)

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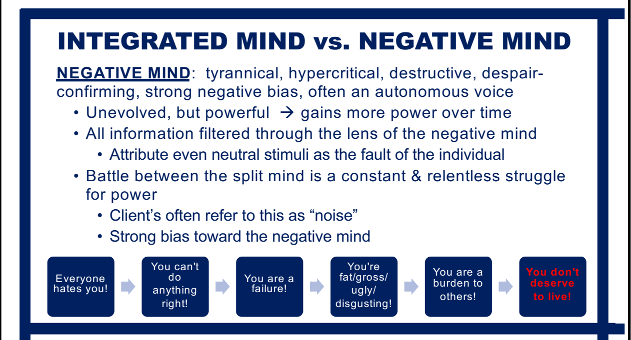

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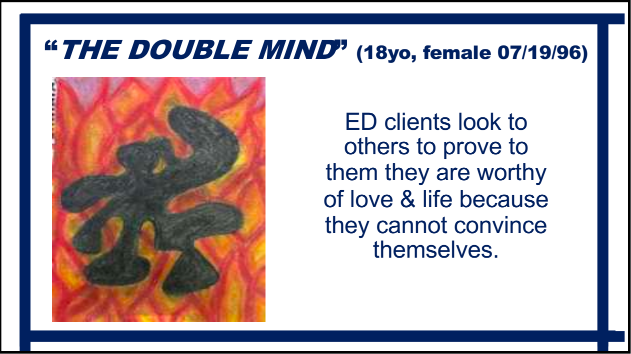

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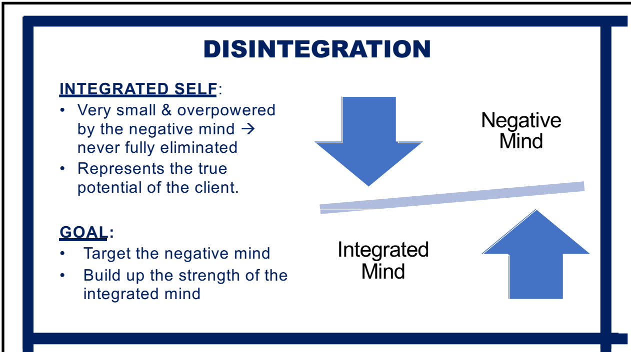

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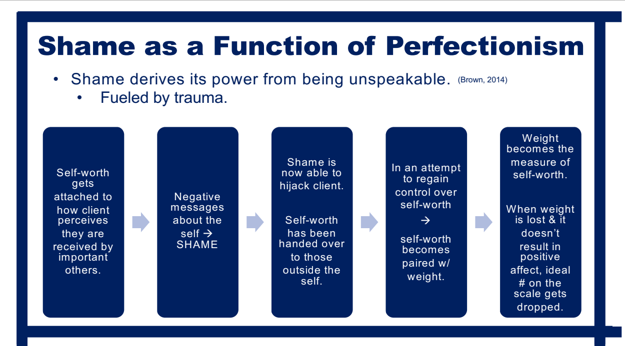

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QUIETING THE NOISE

- **NOISE**: a product of the activation of smaller parts desperately seeking to be seen and heard.
- **PART**: fractured part of self that holds all the pain associated with a traumatic experience/memory
- **TRIGGERS**: the efforts of an activated part to be seen & get needs met
- **INITIAL STEPS TO WORKING WITH PARTS:**
  - Identify younger parts
  - Build rapport with the parts (internal relational model)
  - Identify the basic unmet needs of the parts
  - Develop strategies for working with the parts (developing/increasing attunement)
- **GOAL**: an integrated and fully embodied self

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EGO STATES

Ego State Exercise (Shapiro, 2016)

WHAT DID WE JUST DO?

- We shifted your "state" by closing your eyes and going "inside."
- We accessed the adult functional part of yours—which includes the integrated adult self.
- We accessed a younger part & normalized some of its functions.
- We connected the younger part (past) to the integrated adult self (present).
- We put the integrated adult self in charge & got agreement that the adult self will take responsibility for caring for the younger part.
  - Identified what the responsibilities entail.
- Integrated the younger part back inside the current integrated adult self.

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Managing a Hijacked Brain
(NON-DISSOCIATIVE STATES)

POSITIVE RESOURCED INTEGRATED EGO STATES

- Adult integrated part (grounded)
- AF-EMDR resources
- High functioning part of self
- Can call on individual parts when needed to serve a certain function
  - e.g., therapist part, professional part, academic part, wise/knowledgeable/experienced part
- May be external to the client, but not client's experience
  - e.g., Anchor

PRE-EXISTING PROTECTIVE DYSFUNCTIONAL EGO STATES

- Disintegrated parts
- Trapped in the original trauma
- Often doesn't know they survived
- Functional response to dysfunctional circumstances
- May experience attachment-impairment
- Shame-based
- Fight/Flight/Collapse
  - Hyperalert
  - Terrified & ready to flee
  - Angry & ready to fight
  - Hopeless/helpless (collapse)

(Shapiro, 2016)

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UNDERSTANDING PARTS

YOUNGER PARTS
- Part of the self that experienced the original trauma
  - They hold all the pain, distress, & shame associated with the trauma
  - Trapped in time
  - They understand a before, & during → but no understanding of an "after"
- Unmet fundamental needs → some have never experienced compassion or love (esp. for the self)
- Age & stage limitations
- React from a place of fear

INTEGRATION
- ≠ absorbing, dissolving, merging, parts don't disappear
- = visibility, language, bear witness, show them the "after"
- Parts are **NOT** first responders!!!

(Shapiro, 2016)

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"My Internal World"

18 yo, female
07/20/96

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SHAME TAPES

- We all experience shame tapes that evoke feelings of self-doubt and self-criticism:
  - *"Real therapists don't struggle with _____!"*
- Shame typically begins as a 2-person experience → over time the messages are internalized and the 2nd person becomes obsolete. (Brown, 2014)

HOW DO WE COMBAT SHAME TAPES:
- Get curious
  - When we identify the source of the tapes, it creates a window for us to intervene on ourselves when the tapes begin to play.
- Identify the part that has internalized the tape.
- Identify source of the original message.
- Work to de-couple the part from the message → give it back to the original source.
- Grace & self-compassion toward the parts → integration

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Developing Shame Resilience

- We spend an inordinate amount of energy protecting ourselves (internally) and others (externally) from the parts of ourselves that feel intolerable, unacceptable, & material we believe makes us unlovable.
- Shame is suffocating & paralyzing!
  - Hard-wired to avoid disconnection & seek connection.
  - Shame is driven by a fear of disconnection.
    - FEAR: something about who we are, fundamentally at our core, makes us unlovable.
- We strip shame of its power by giving it language.
  - There is power in our story → but only if we tell our story!
- Language isn't just semantics:
  - Guilt = I did something bad → positive → facilitates change
  - Shame = I am bad → negative → reinforces the belief that we aren't capable of being or doing better

(Brown, 2014)

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THE INTEGRATED SELF

- Re-parenting:
  - Focus on attunement.
  - Gradual shifting of responsibility & control away from the negative mind & to the adult self.
- Establish rapport **with & between** the current self & the parts.
  - Negative mind won't relinquish control to the current self if the belief is that the current self is "a bad adult."
- Separate the condition from the client → identity.
- Counter the negative mind w/ unconditional positive regard → cannot co-sign the belief system of the negative mind.
- Challenge subjectivity.
- Brain/Body processing requires you simultaneously experience the self as BOTH a participant and as a witness → ability to **see & feel** the self.

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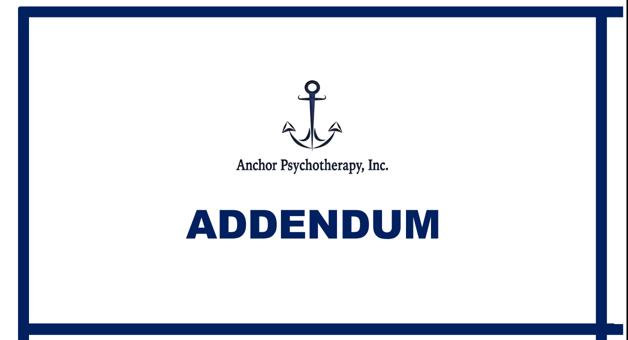

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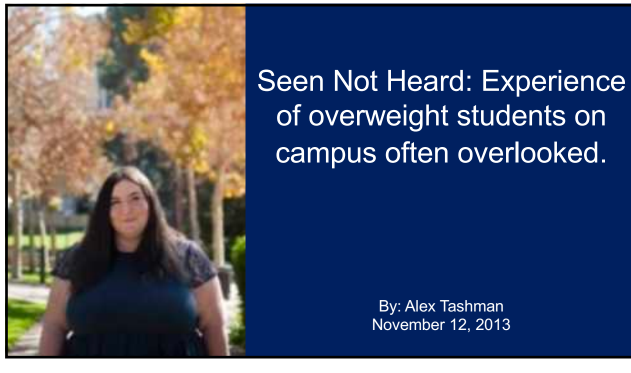

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