Eating Disorders, Trauma and Attachment: An Embodied Approach
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MAJOR CONCEPTS

• Eating Disorders- Functions & Contributing Factors
• Research for body based interventions in ED and Trauma
• Research related to attachment and the body
• 5 Treatment goals for body based work
• Body Based Interventions
Our own physical body possesses a wisdom which we who inhabit the body lack. We give it orders which make no sense.

~Henry Miller
TYPES OF EATING DISORDERS

ANOREXIA NERVOSA
Characterized by self-starvation and excessive weight loss.

BULIMIA NERVOSA
Cycles of binging and compensatory behaviors such as self-induced vomiting designed to undo or compensate for the effects of the binge eating.

BINGE EATING DISORDER
Characterized by recurrent binge eating without the regular use of compensatory measures to counter the binge eating.

OTHER SPECIFIED FEEDING OR EATING DISORDER
Any combination of the behaviors above, purging behaviors without binging, restricting without weight loss, etc.
## POSSIBLE FUNCTIONS OF AN EATING DISORDER

- Coping mechanism to deal with life
- A way to keep oneself from expressing distress to others
- Survival strategy
- A way to indirectly call out for help
- To keep from growing up typically accompanies a fear of responsibility
- A way of coping with unresolved trauma and/or deprivation
- A way to deal with/avoid emotions (numbing)
- A way to cope with a lack of autonomy (the one thing that isn’t controlled by others)
- A way to try and gain power and/or control
- Substitute for love, affection, attachment/intimacy or any unmet need
- Way to try and get needs met that aren’t be met internally or externally (i.e. comfort)
- A way to release emotions and cope with depression or distress
- Manifestation of unresolved family conflict
- A way to be out of control secretly
- A way to push others away
- Rebellion
CONTRIBUTING FACTORS

MEDIA

INTERPERSONAL & INTRAPERSONAL FACTORS

BIOCHEMICAL & BIOLOGICAL FACTORS

CULTURE

SOCIAL FACTORS

PSYCHOLOGICAL & PHYSICAL FACTORS
CONTRIBUTING FACTORS: INTERPERSONAL & INTRAPERSONAL

- Troubled family and personal relationships
- Difficulty expressing emotions and feelings
- History of emotional, physical, and/or sexual abuse (unresolved trauma)
- History of being bullied (more specifically around size or weight)
- Unfinished business within families
- Unresolved grief
- Insecure attachment to primary caregiver
- Instability in one’s life
- Lack of autonomy
- Lack of nurturance and/or acceptance
- Boundaries that are either too rigid or too lose
CONTRIBUTING FACTORS: SOCIAL

- Cultural pressures to glorify "thinness" and place value on obtaining the "perfect body" (unattainable)
- Defining beauty based on physical appearance versus inner qualities and strengths
- Overt and/or covert messages about food, weight, body, beauty, and self-worth
CONTRIBUTING FACTORS:
BIOCHEMICAL AND BIOLOGICAL

- Scientists are researching possible biochemical or biological causes of eating disorders.
- Some cases have shown that certain chemicals in the brain have been imbalanced related to:
  - Hunger
  - Appetite
  - Digestion

(The exact meaning and implications of these imbalances remains under investigation).

- Research indicates that eating disorders often run in families.
CONTRIBUTING FACTORS: PSYCHOLOGICAL & PHYSICAL

PSYCHOLOGICAL FACTORS

- Low self-esteem
- Feeling inadequate or a lack of control in one’s life
- Depression, anxiety, anger, or loneliness

PHYSICAL FACTORS

- Medical complications that arise
- Dietary restrictions such as different food allergies
Common co-occurring disorders are listed below, but not limited to the following:

- Obsessive-Compulsive Disorder
- Social Anxiety Disorder
- Major Depression
- Post-Traumatic Stress Disorder
- Addictions
- Bipolar Disorder or Mood Disorders
TREATMENT GOALS

- Assess for severity of eating disorder, body image, co-occurring disorders
- Stabilize ED behaviors, medical complications, and meal plan (TREATMENT TEAM)
- Gain insight into function of eating disorder and get these needs met in other ways
- Treat PTSD, Anxiety, Depression concurrently
- Develop alternative coping skills and relapse prevention
- Heal underlying issues (trauma, attachment trauma, family dynamics)
WHY ADDRESS THE BODY?

• Eating disorder and some PTSD symptoms further disconnect clients from their body or overemphasize body
• In eating disorder recovery, it is essential that there is a mind/body connection
• Distorted body perception can exacerbate ED, body image and trauma symptoms
• Body acceptance and body safety essential goals in ED & trauma recovery
• Body can be a resource for deepening the therapeutic process, deepening the emotional connection
WHAT DOES THE RESEARCH SAY ABOUT THE BODY?
Research shows that many patients with eating problems struggle with alexithymia, which is defined as difficulty in putting feelings and fantasies into words (Zerbe, 1995).

Many ED patients cannot put into words what happened to them. This stalemate occurs in part because their bodies have experienced trauma or because words have so little meaning to them due to alexithymia. (Zerbe, 1995)
• As many as two-thirds of clients with Eating Disorders have a co-occurring anxiety disorder (Kaye et al., 2004).
• Anxiety has a strong somatic-emotional component. (Beck & Emery, 1985)
• When addressing anxiety and PTSD, in addition to recognizing the importance of cognitive factors, body sensation and sensate experience is also important. (Levine, 1991)
Most of us have become deaf to our own bodies, which is why we are out of tune.

~Terri Guillemets
Trauma and Eating Disorders

- Rates of PTSD in ED samples range between 1-52%
- National Comorbidity Survey-Replication
  - Women:
    - AN (16.09%)
    - BN (39.81%)
    - BED (25.74%)
  - Men:
    - BN (66.19%);
    - BED (24.02%)

(Gleaves et al., 1998; Mitchell et al., 2012; Turnbull et al., 1997; Tortolani, 2014)
• Research aimed at understanding the causes and comorbidities of eating disorders (ED) identifies sexual trauma as one potential pathway to the development and maintenance of eating disorders.

• Although limited, recent evidence suggests that sexual trauma precedes and contributes to the development of ED.

• Existing literature indicates that the body perceptions pathway may impact ED through body dissatisfaction, shame, sexual dysfunction, and fear of future sexual trauma.

• The psychological difficulties pathway indicates a link between ED and the desire to cope with the failure of the average expected environment, psychological diagnoses, the need for control, and the regulation of emotions.

Trauma / PTSD lives in the body – Body is the enemy

• “In so many cases, it was patients’ bodies that had been grossly violated, and it was their bodies that had failed them — legs had not run quickly enough, arms had not pushed powerfully enough, voices had not screamed loudly enough to evade disaster. And it was their bodies that now crumpled under the slightest of stresses — that dove for cover with every car alarm or saw every stranger as an assailant in waiting. How could their minds possibly be healed if they found the bodies that encased those minds so intolerable?...The single most important issue for traumatized people is to find a sense of safety in their own bodies,” (Van der Kolk, 2014, New York Times Magazine)
MIND
- Flashbacks
- Depression
- Fears and phobias
- Nightmares
- Interpersonal problems

SOUL
- Loss of purpose
- Existential crisis
- Proxy self
- No self-worth

BODY
- Panic attacks
- Self-harm
- Sleep/eating problems
- Gynaecological problems
- Headaches
- High blood pressure
Flooding & Numbing symptoms all occur in the body and effect our capacity to communicate in words

• Traumatized individuals are vulnerable to react to sensory information with ... responses that are irrelevant, and often harmful, in the present.

• Reminders of traumatic experiences activate brain regions that support intense emotions, and decrease activation in the central nervous system (CNS)

• Regions involved in (a) the integration of sensory input with motor output, (b) the modulation of physiological arousal, and (c) the capacity to communicate experience in words. (Van der Kolk, 2006)
Research: Trauma and Body

- The sensations and actions that have become stuck in and after a traumatic event need to be integrated in the treatment process, so that the person can regain a sense of familiarity and efficacy in the body (Moore, 2006).
“Trauma is stored in somatic memory....in PTSD, failure of declarative memory may lead to organization of the trauma on a somatosensory level (as visual images or physical sensations) impervious to change”

-Bessel A. Van der Kolk, MD.
CBT- Necessary But Not Sufficient

• If we only address Cognitive and Behavioral issues:
  – Limited view of emotional responding
  – An inadequate consideration of interpersonal factors.
  – Insufficient attention to the therapist-client relationship.
  – Overemphasis on conscious controlled cognitive processing.
  – (Clark, 1995)

• CBT is enhanced by eliciting rather than managing or suppressing emotion. (Samoilov & Goldfried, 2000)

• According to numerous studies, CBT has only been shown to be effective with Bulimia Nervosa around 50% of the time, and CBT-E has been shown to be effective with BN and BED only around 60% of the time. Therefore, 40-50% of those with BN or BED that do not respond to CBT and additional treatment modalities should be considered
Attention to the human body brings healing and regeneration. Through awareness of the body we remember who we really are.

~Jack Kornfield
WHAT DOES THE RESEARCH SAY ABOUT ATTACHMENT?
Attachment

• The attachment in attachment theory refers to the infant’s innate human need for a sense of security and safety which manifests in relationships. (Bowlby)

• More recently there are revisions in the theory that describes patterns of attachment as strategies for identifying and protecting oneself from danger as opposed to seeking security. (Crittenden, 2012)

• With either, the more attuned and responsive the caretaker to the infant, the more secure the attachment. The reverse is then also true.
Attachment and Body

• Distress directs and motivates infants to seek out soothing physical contact with the attachment figure. Once activated ONLY physical attachment with the attachment figure will terminate the attachment behavioral system. (BOWLBY)
Attachment - first formed in the body

Psychological and physical boundaries develop early in life. Proper attunement and nurturing helps a child understand and distinguish between what is inside and outside of themselves.

A number of empirical studies have supported the idea that early attachment experiences are relevant to the development of numerous mental illness diagnoses.

(Fonagy, Steele & Steele, 1996; Ringer & Crittenden, 2006; Ward & Carlson, 1995)
Humans are born with a brain system that promotes safety by establishing an instinctive behavioral bond with their mothers (Siegel, 1999) and also produces “distress when a mother is absent, as well as a drive for the two to seek each other out when the child is frightened or in pain” (Lewis, Amini, & Lannon, 2000, p. 70). A child uses its attachment figure (usually a parent) as a secure base from which to venture out and explore, and a safe haven to return to in times of danger (Bowlby, 1988).
Types of Attachment

- Anxious/Preoccupied
- Avoidant/Dismissive
- Disorganized/Mixed
- Secure/Balanced

(Ainsworth)
How to identify attachment style?

- http://psychologytoday.tests.psychtests.com/take_test.php?idRegTest=3265
- http://www.web-research-design.net/cgi-bin/crq/crq.pl
- Adult Attachment Interview
Insecure Attachment

Insecure attachment does not directly cause later disturbance but it initiates a developmental pathway that, without corrective experience, increases the probability of psychopathology.

(Siegel)
Attachment Trauma

• “When faced with a threat, the amygdala triggers a fight-or-flight response, which includes the release of a flood of hormones. This response usually persists until the threat is vanquished. But if the threat isn’t vanquished — if we can’t fight or flee [AS IS THE CASE WITH ATTACHMENT TRAUMA]— the amygdala, which can be thought of as the body’s smoke detector, keeps sounding the alarm. We keep producing stress hormones, which in turn wreak havoc on the rest of our bodies.”

(Vanderkolk, New York Times Magazine, 2014)
Attachment Trauma

- For children who are exposed to the trauma of domestic violence, the protective qualities of comfort and safety present in the home environment are highly disturbed. (Devereaux, 2008)
Attachment and Development

Research indicates that attachment patterns have a global impact on a child’s functioning. In general, a child with secure attachment feels the security to explore the world, to focus, to experience open emotional expression, assert personal boundaries, make social overtures, and builds the capacity to self-soothe.

Conversely, insecurely attached children have poor self-regulation skills, develop a negative self-concept, make fewer social overtures, experience various types of cognitive impairment and display higher levels of aggression.
Characteristics of Secure Attachment:

<table>
<thead>
<tr>
<th>As Children</th>
<th>As Adults</th>
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<tr>
<td>1. Able to separate from parent</td>
<td>1. Have trusting lasting relationships</td>
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<td>2. Seek Comfort from parents with frightened</td>
<td>2. Tend to have good self-esteem</td>
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<td>3. Return of parents is met with positive emotions</td>
<td>3. Comfortable sharing feelings with friends and partners</td>
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<td>4. Prefers parents to strangers</td>
<td>4. Seeks out social support</td>
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Securely Attached Adult

- Value attachment and regard attachment experiences as influential
- Acknowledge need for others
- Freely explore thoughts and feelings
- Remember childhood events clearly
- At ease with their own imperfections
- Don’t idealize or have extreme anger
- And most likely have secure children

(J.Allen, 2001)
• Goal: Earned Secure Attachment
  – The older child’s or adult’s process of being able to revise attachment strategies to be more adaptive, to move into secure attachment.
  – Facilitation of an earned secure attachment is the underlying goal of treatment.
Attachment and Therapy

• Psycho-Education: Client and family understand attachment as necessary – not a fault or indulgence. (mismatch)
• Assess attachment styles
• Focus on multi-generational patterns can help neutralize shame and blame with families.
• A general implication of recent findings is that even with difficult past childhood experiences, the mind is capable of achieving an integrated perspective – one that is coherent and permits parenting behavior to be sensitive and empathetic.

(Siegel, 2012)
Attachment Therapy Goals

- Avoidant - learn more about emotions, recognize ebb and flow
- Anxious - learn to turn down own anxiety, self soothe
- Disorganized - resolve past experiences so that current events don’t trigger painful emotional memories from the past

(Daniel Sonkin)
Therapist’s Job with Attachment Trauma

- Transformations of the self through relationship
- Provide a secure base for exploration, development and change
- Provide attunement in helping client tolerate, modulate and communicate feelings
- Accessing disavowed or dissociated experiences to strengthen narrative competence
- Deconstruct attachment patterns of the past to construct new ones in the present
Targets for “Earned Secure Attachment”

• Turning to others for soothing and intimacy
• Minimizing idealization and family loyalties
• Resolution of significant losses in one’s life
• Establishing clarity with regards to self, and self in relations to significant others
• Meta-cognitional thinking in relation to family of origin
• Establishing a coherent narrative regarding one’s life
Mirror Neurons

• Mirror-neuron system allows our mind to read the intention of others through non verbal cues. (pre-frontal cortex)
• Neurological basis of empathy
• As parents and therapists, being sensitive to the non verbal cues of our children/clients
• Repair is important and necessary (for therapists too)
Mirroring Experiential
Mirroring

• Works with attachment system- being heard, seen
  – Attunement- matching tension
• Turning to others for soothing
• Others can understand me
• Understanding personal boundaries
• Noticing ebb and flow of emotions, body sensations
• What others?
Cultural, Gender & Religious Sensitivity

- Always assess body image with sensitivity and curiosity for clients' culture, gender, religious and ethnic background.
- Consider Culture, Gender, Religious and Ethnic background when utilizing movement and body based interventions.
Becoming Embodied - How do we get there?

5 Goals

1. CONNECTION - Create opportunities for connection to the body in a safe manner. Connection to and acceptance of all parts/ emotional states, connection to sense of Self

2. EXPRESSION - Create opportunities for safe and healthy expression through the body,

3. COGNITION - Correct cognitive distortions related to the body.

4. FUNCTION - Create increased ability to utilize self soothing and affect regulation skills

5. MINDFULNESS - Increased ability to be present in the here and now.
Goal 1: CONNECTION

- Create experiences in therapy and the outside world for safe and healthy connection
- “If I accept that my past happened to this current body, to me, to all of me, then it becomes real and I have to make meaning of it, I have to deal with why and what it means.”
- “My body makes my trauma real, it provides me experiential knowledge of my trauma. This means listening to my body, being present in it means listening to my truth.”
“I made my body the enemy because it was telling the truth. But that was because my perpetrators set the world up that way, they taught me to ignore my perceptions, my body’s perceptions that what was happening was not okay. The body took the blame because it said what they were doing was not okay.”
You cannot like, appreciate or tolerate something you are not connected to.
Goal 2: EXPRESSION

- Clients often view the body as something they have to carry around with them. A number on a scale, the thing that keeps them from being happy, the thing that makes them different
- Body as vehicle for healthy expression
- View the body as an ally
- View the Body as part of themselves
- Safe self expression
Goal 3: Correct Cognitive Distortions

- Must get at the underlying core beliefs or core schemas. >> Must come from client! Use Young Schema Inventory or Resik’s Cognitive processing model

- Common Trauma Based Body Distortions:
  - The bad things in my life are a result of my body.
  - My trauma is my body’s fault, my fault.
  - People reject me because of my body.
  - I cannot handle the emotions held in my body.
  - The reason my trauma no longer continues is because I have found a way to cover up the bad part of myself and my body.
  - If I have curves then I have to be sexual, people will expect this.
Goal 4: Function

• Teach clients that their body can function FOR THEM.

• Create experiential knowledge that body can:
  – Be effective
  – Set boundaries
  – Calm down / Self Sooth
  – Be strong / Be gentle
  – Have fun
Goal 5: Mindfulness

• Create opportunities for mindfulness-being in the present moment
• Use the body to experience the present moment
• Practice this in every session
• Set mindfulness goals outside of session
What are some interventions I can use?
Interventions with Clients: Psychoeducation- Why Connect?

- We experience feelings in our bodies.
- Clients must learn emotional regulation skills
- We cannot like or appreciate something we are not connected to.
- Connection creates accurate body image perception
- Helps with psychosomatic symptoms
Intervention with Clients: Why Connect?

– Trauma (including attachment trauma) causes disconnection and can cause re-enactment.

– Clients may ignore or dissociate from their natural early warning signs of danger.

– Connection helps clients make safe choices and gain insight into re-enactment dynamics.

– Full recovery from trauma requires body connection
Client’s Reasons To Not Connect

• Commonly Heard Reasons:
  – I cannot handle the emotions, I will fall apart.
  – I don’t know how, I just can’t
  – If I connect it will bring the past and present together.
  – The body combines what was aware with what was unaware.
  – I hate my body I don’t want to connect to it
Keep in Mind

• Meet the client where they are
• Work with the resistance
• Do not assign meaning
• Physical limitations & ED restrictions
• Emotional & safety implications
• ALWAYS focus on Attunement & Mirroring
Nature Walks

Nature walks that incorporate the following:

• reflection on surroundings
• pausing to take deep breaths
• notice the movement of the breath in the body
• moving the body in any way that feels refreshing and releases tension
• silent mindful walking mediation alone or in groups/pairs
• choosing an object in nature that represents how a client feels currently about their body and how they would like to feel in the future.
Movement Interventions

• Movement timeline
• Spontaneous, creative play
• Expanding movement repertoire- Trying on different affinities (light/strong; direct/indirect; quick/slow; bound/free)
• Modulating Energy
• Breath Work
Body Empowerment:

- Creating opportunities for experiential effectiveness: setting boundaries, saying no, recognize internal warning signs

- **Boundaries / Assertiveness work:**
  - Walking towards each other, learning to say stop when gets too close.
  - Role Play Situations

- **Mirroring / Shaping**
  - Works with attachment system: being heard, seen.

- **Healing Work**
  - What do you wish you could have done or said in this situation? Enact it
  - How did that feel in your body, what do you want to tell yourself now.

- **Strength work, pushing, powerful positions**
• Assessing Body Image:
  – Gather info on feelings, experiences, beliefs and perceptions of body
  – How does your family take care of their bodies?
  – What do you think your mom/dad feels about his/her body? How do you know?
  – What messages have you received about your body?
  – Have you had any enjoyable experiences in your body?
  – Have you had any not enjoyable experiences in your body?
Body Image Work

- Body Drawing- Statements, experiences, feelings
- Refocusing on functionality of body
- Positive Affirmations & Mirror Work
- Focus on connection, empowerment and enjoyment in the body
Anger Work

- Have client identify where they hold anger in their body. Work to connect to this part (s) of the body.
- Identify any anger towards the body and work to direct elsewhere.
- Can use pillow and bats, dance, jumping, hitting, slashing to express anger, release anger.
- Forgiveness of self
- Discuss cognitive distortions throughout.
Group Interventions:

- Group mirroring / weight sharing
- Group Unburdening - Fire and Water
- Group Sculptures/exploration of qualities of authentic self
- Moving in self and various parts (separating from parts)
Empowering the client - use Karpman’s triangle to have them move through victim, perpetrator, bystander / rescuer roles, and move out of the triangle into empowered stance. Help client to identify perceived & preferred roles, instances they embody these roles and ways to move out of the triangle entirely.
How do we invite our body and the client’s body into the therapeutic process?

• Maintain an awareness of your own body in sessions and groups. Attend to what you are experiencing in your body.

• Somatic counter-transference provides valuable information and assists with interventions.
How do we invite our body and the client’s body into the therapeutic process?

In order to be more fully embodied:

• Carefully attend to non-verbal communication

• If a client shifts her posture or takes a deep breath, gently mirror the behavior yourself, and/or simply verbalize what you notice.

• Mirroring is one of the most fundamental and powerful therapeutic interventions.
How do we invite our body and the client’s body into the therapeutic process?

Encourage simple and mindful ways to be embodied:
• Connection with nature
• Balanced and fun movement
• Yoga / Pilates
• Dance
• Martial arts
• Connect to 5 senses / Mindfulness activities
How do we invite our body and the client’s body into the therapeutic process?

Ask regularly about what clients are experiencing in their body during therapy. This integrates mind/body and dismantles the familiar “talking head” syndrome, in which client’s are cognitively and intellectually insightful but completely disconnected from their body. Trauma lives in the body. The only way out is through the body.

~ Deanna James
In Conclusion:

- Mind/body connection is essential to recovery from eating disorders, negative body image and PTSD.
- We must be embodied, bring the body into sessions, and address the body and body image.
- Create experiential knowledge through the body.
- Must address trauma based beliefs and internal schemas re: the body.
References

References


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