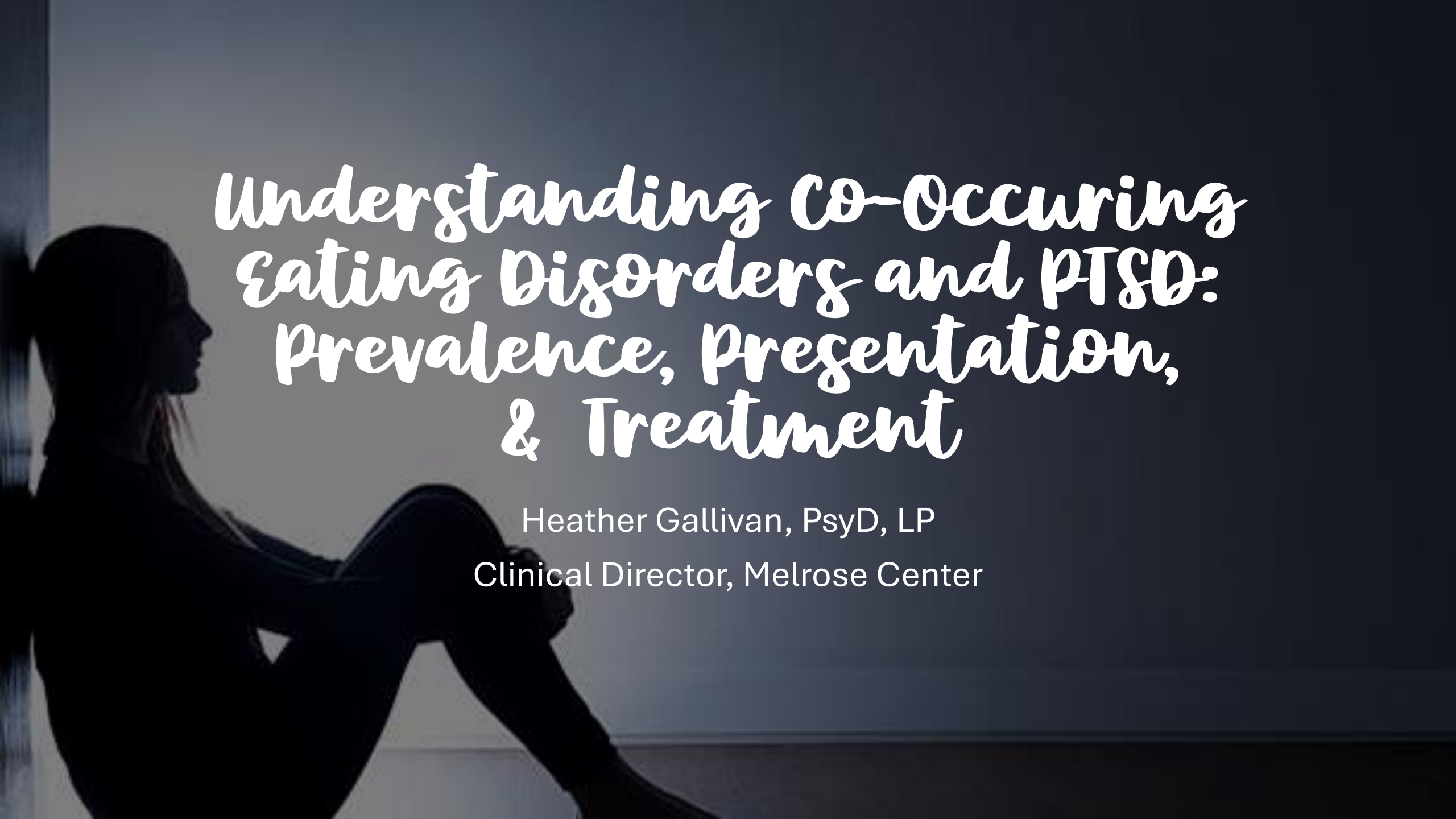

Understanding Co-Occuring Eating Disorders and PTSD: Prevalence, Presentation, & Treatment

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Learning Objectives

1. Define the issue and prevalence of co-occurring Eating Disorders, Trauma, and PTSD.
2. Describe the impact of co-occurring PTSD and Eating Disorders on treatment outcomes.
3. Describe the relationship between maintaining mechanisms for both eating disorders and PTSD
4. Summarize the evidence base for treatment interventions to treat PTSD within the context of ED treatment

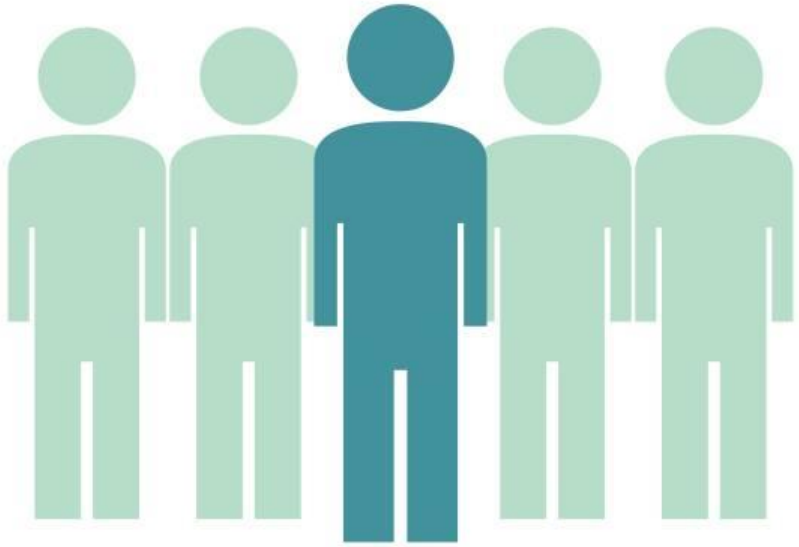
Why do HALF of people with EDs not fully recover after receiving treatment?


Eating Disorders are like Icebergs…

Eating Disorder Prevalence

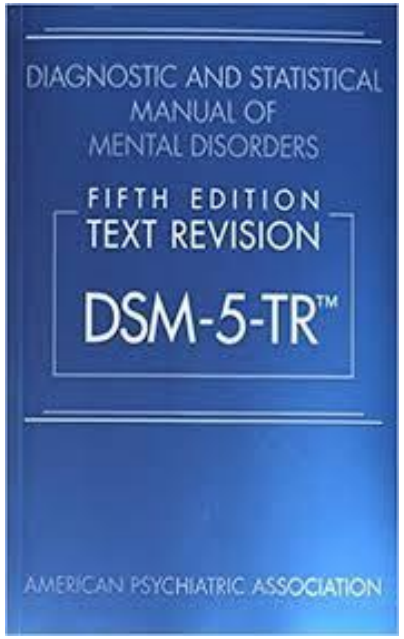
GLOBALLY INCREASED FROM 3.4% TO 7.8% IN THE PERIOD 2000-2018

IN THE US APPROXIMATELY 9% OF THE POPULATION WILL SUFFER FROM A CLINICALLY SIGNIFICANT ED IN THEIR LIFETIME



Only 1 in 5 will seek specialized eating disorder treatment

DSM-5 Eating Disorder Diagnoses



Anorexia Nervosa

Bulimia Nervosa

Binge Eating Disorder

Avoidant Restrictive Food Intake Disorder (ARFID)

Other Specified Feeding or Eating Disorder (OSFED)

Unspecified Feeding or Eating Disorder (UFED)

Psychiatric Comorbidities

56% AN, 94.5% BN, 78.9% BED Meet criteria for another mental health disorder

94% of those hospitalized with Eds have another mental health disorder

In children Anxiety disorders precede onset of ED

Adaptive Function of ED Behaviors

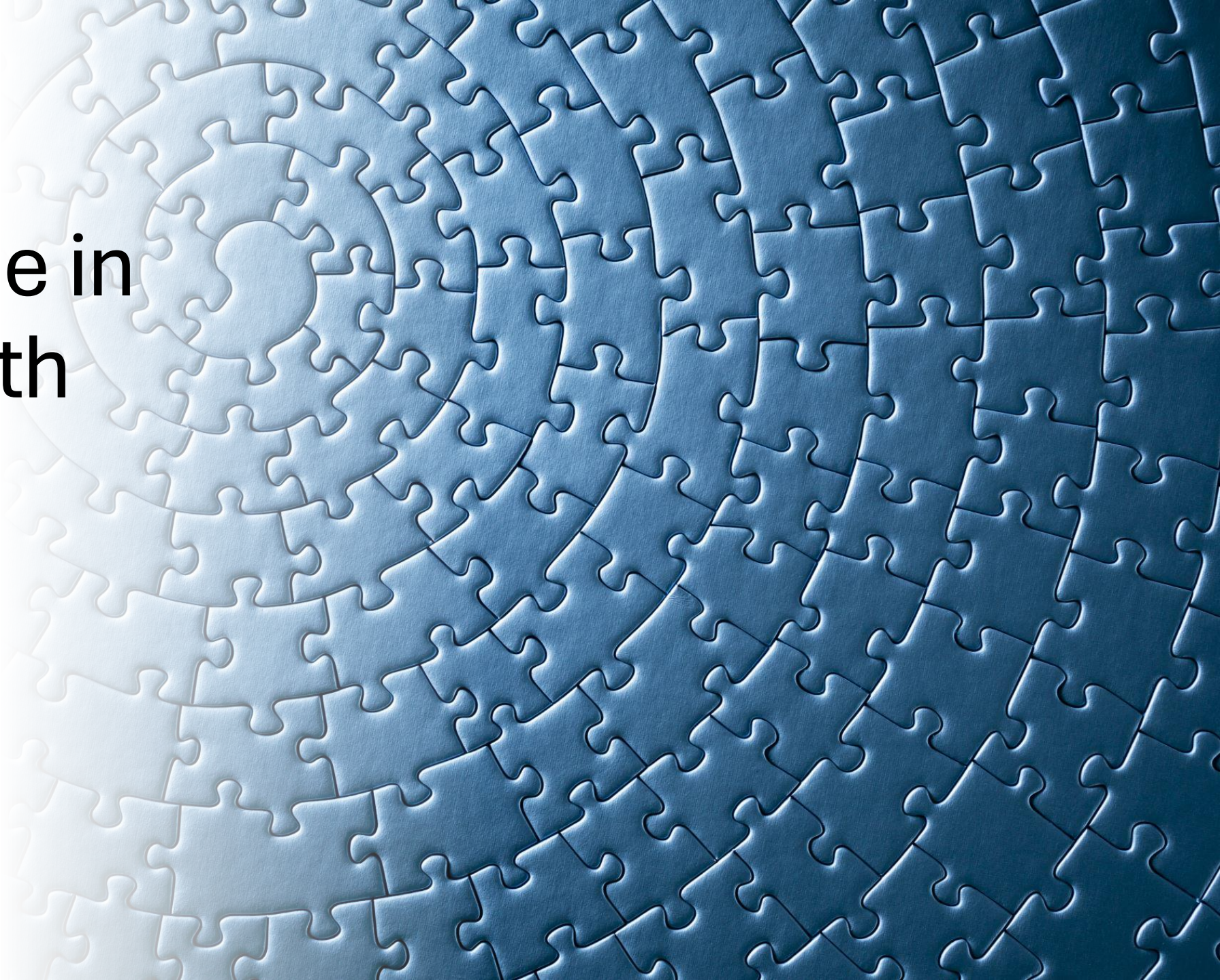
Shape, weight and eating concerns

Emotional Regulation

Self-Regulation

Interpersonal Regulation

Trauma Prevalence in people with EDs: 37-100%



Types of Trauma

- Sexual Interpersonal
- Other Interpersonal
- War/Combat
- Non-Interpersonal

Three “E’s” of Trauma

EVENT

EXPERIENCE

EFFECTS

Post Traumatic Stress Disorder

- Exposure to actual or threatened death, serious injury, sexual violence
- Presence of one or more intrusive symptoms associated with the traumatic event
- Persistent avoidance of Stimuli associated with the traumatic event
- Negative alterations in cognitions or mood associated with the traumatic event
- Marked alterations in arousal & reactivity associated with the traumatic event

PTSD Prevalence

- 6.8 % in the US general population
- 25% in people with Eating Disorders
  - Bulimia Nervosa 37-45%
  - Binge Eating Disorder 21-25%
  - Anorexia Nervosa 10-14%
- Eating Disorder residential settings up to 49%

Shared Common Risk Factors in ED-PTSD

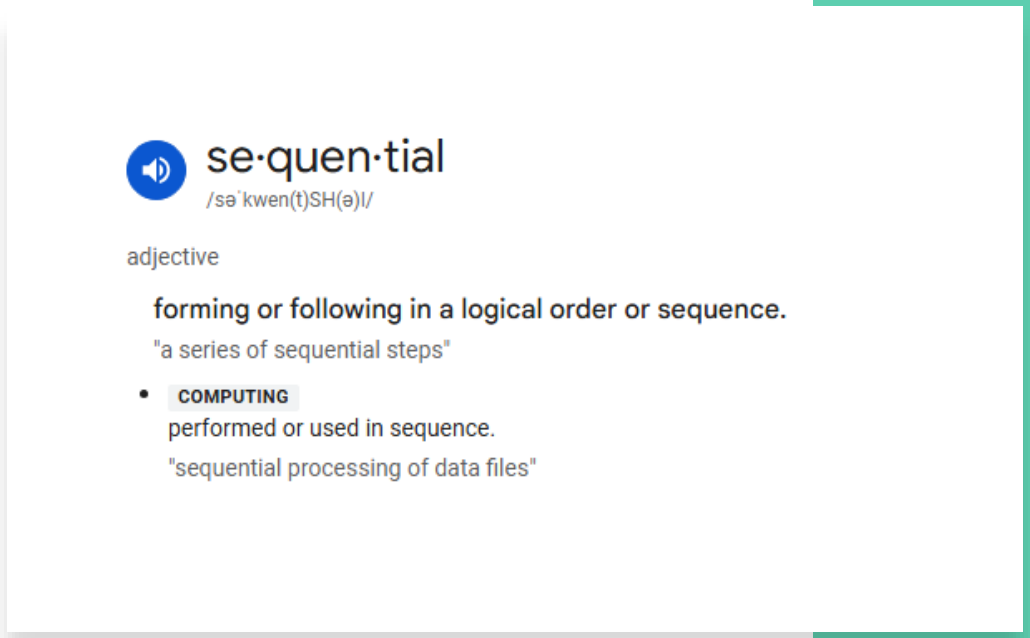
- Female
- Preexisting psychiatric disorders
- Personality traits & temperaments
- Positive family psychiatric history
- History of Child Maltreatment (or other trauma or adversity)
- Trauma dose/severity
- Lack of social supports

ED-PTSD

Patients are more likely to…

- Greater ED severity
- Greater general psychopathology
- Drop out of treatment prematurely
- Have poorer end of treatment outcomes
- Relapse following ED treatment

How can we approach this?



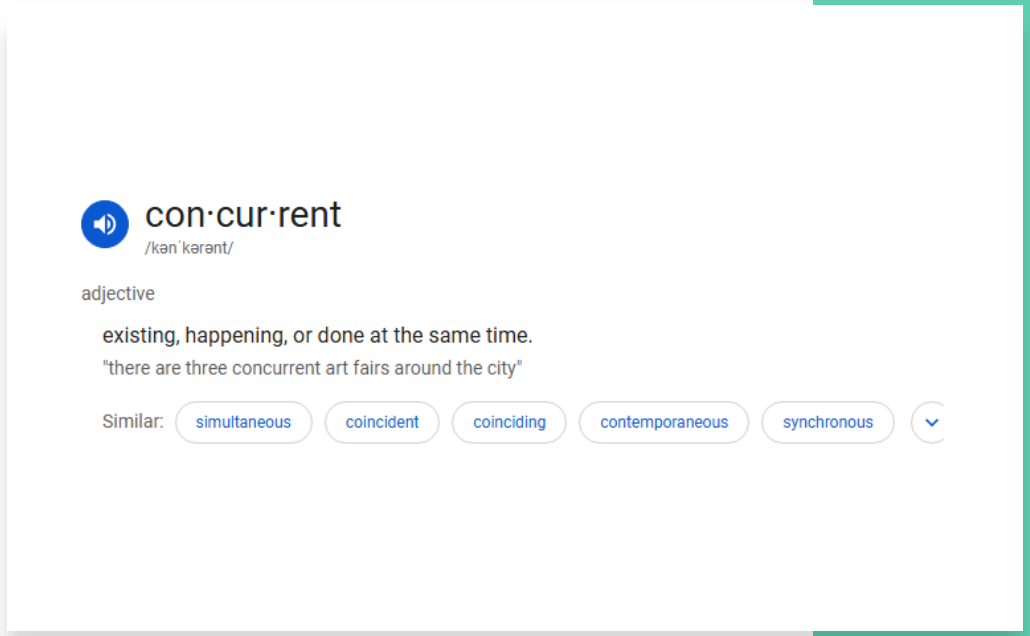
se·quen·tial
/sə'kwen(t)SH(ə)l/

adjective

forming or following in a logical order or sequence.

"a series of sequential steps"

- **COMPUTING**
  performed or used in sequence.
  "sequential processing of data files"



con·cur·rent
/kən'kərənt/

adjective

existing, happening, or done at the same time.

"there are three concurrent art fairs around the city"

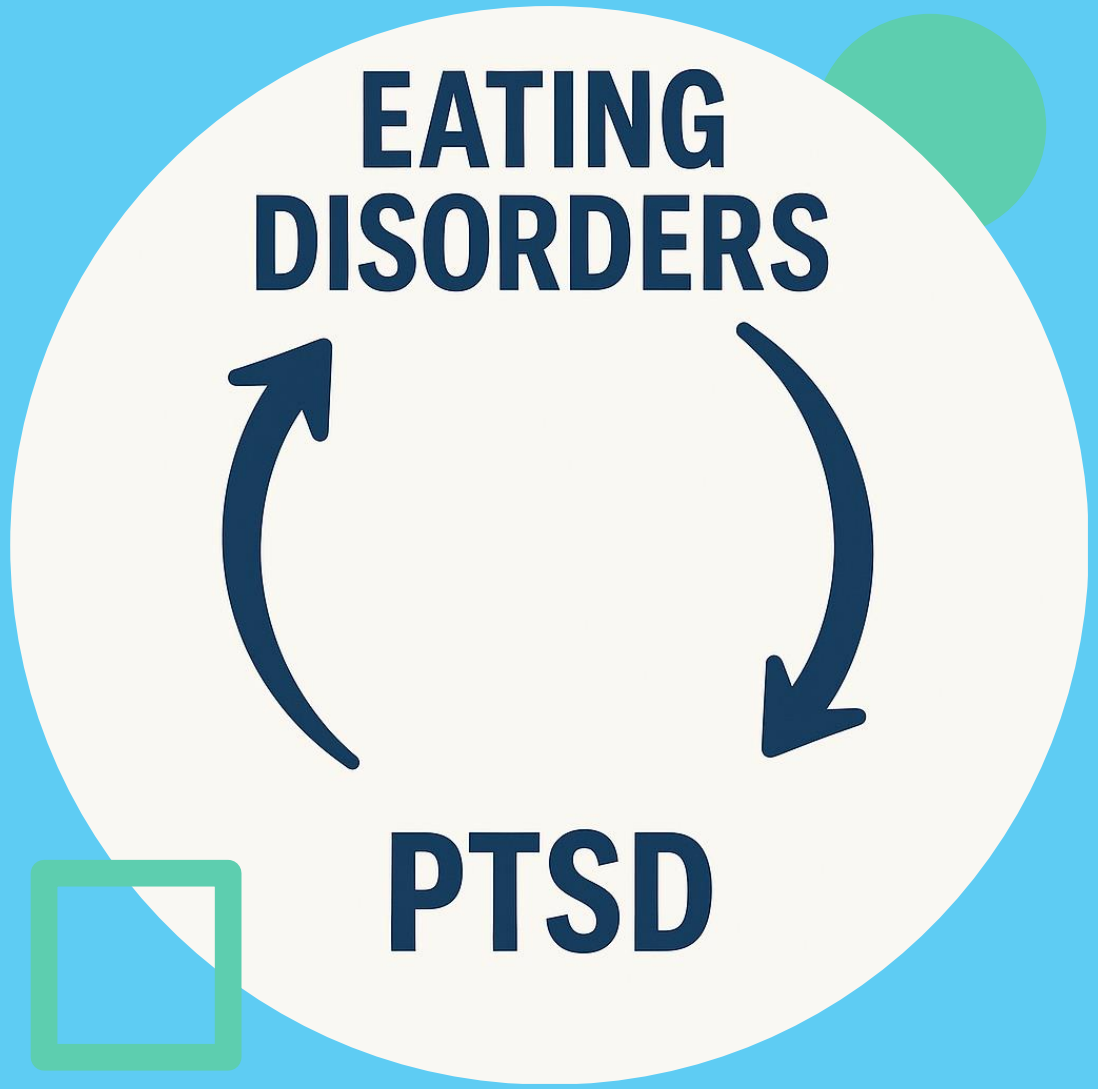
Similar: simultaneous coincident coinciding contemporaneous synchronous

Sequential treatment of ED-PTSD is often like a game of whack-a-mole

WHY?

- They are “not ready” for trauma-focused therapy
- It may lead to worsening ED
- It may lead to worsening PTSD
- It may lead to worsening depression, anxiety, etc
- Uncertainty about how to integrate trauma-focused therapy with ED treatment
- Preference for individually tailored treatments vs manualized approaches
- Lack of training in trauma-focused therapy amongst ED clinicians

Functional Relationship



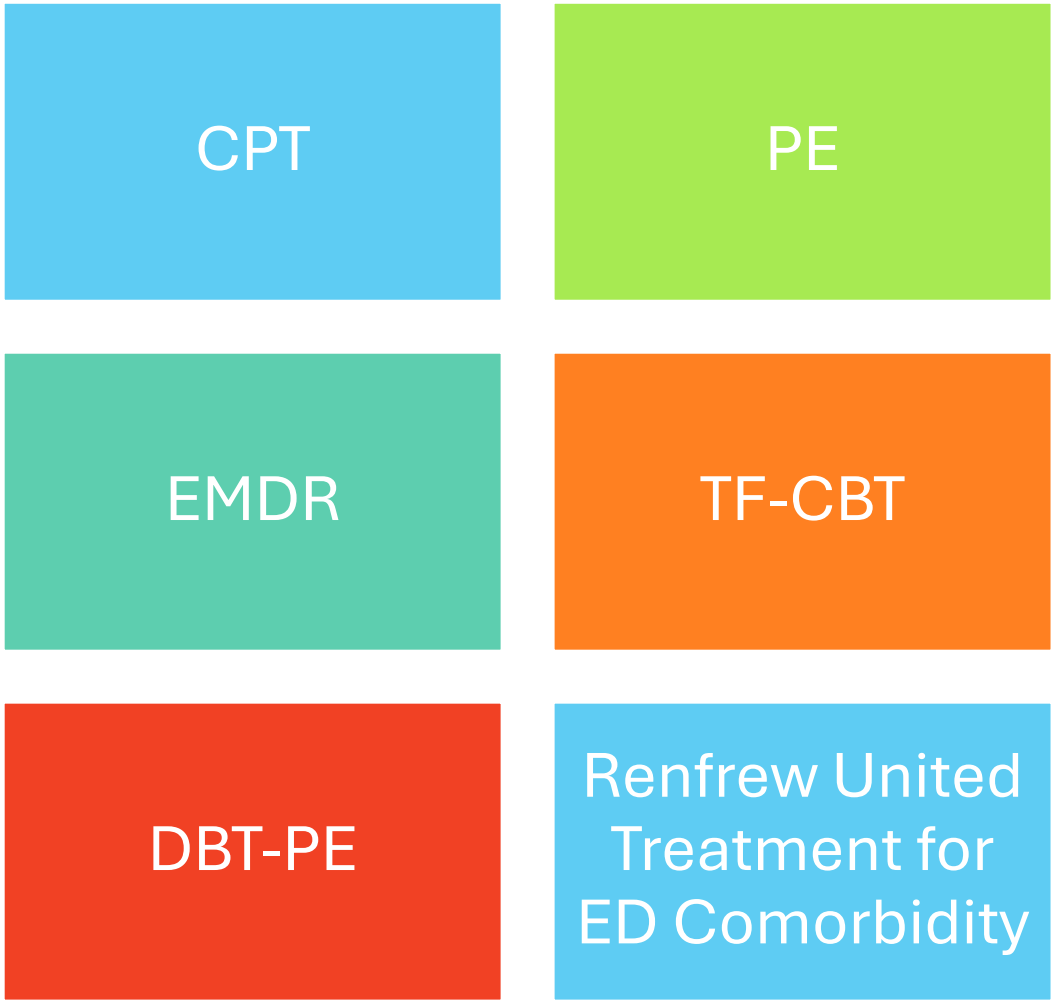
Why is this a problem

- Severe food restriction, binge eating, & purging have the strong potential to facilitate escape and avoidance of distressing trauma-related memories, thoughts and feelings as well as to decrease hyperarousal.
- Any degree of successful avoidance of trauma-related thoughts, feelings and memories is reinforcing and promotes maintenance of the ED.
- Individuals with ED-PTSD attempting to normalize their eating and interrupt ED symptoms may be faced with increased distress related to intrusive trauma-related symptoms as ED symptoms improve.
- This may be a significant obstacle to engaging in ED treatment interventions, treatment retention and ED treatment outcome.
- If PTSD is a maintaining factor of ED symptoms, then addressing PTSD in the context of ED treatment may improve treatment efficacy.

Adaptive Function of ED Behaviors related to trauma

- Binge Eating = self-soothe/emotion regulation
- ED Behaviors = Avoidance of memories
- Purging = soothing/emotion regulation
- Restriction = sense of structure, control, predictability, numbness
- Change in weight/body shape = give person a sense of safety
- ED behaviors = form of self-punishment

Treatment of Co-Occurring ED-PTSD



Cognitive Processing Therapy

- First Line PTSD treatment
- 12 sessions (50 min)
- Can be delivered individually or in groups

- Goals:
  - Improve understanding of PTSD
  - Reduce distress about memories of the trauma
  - Decrease emotional numbing & avoidance of trauma reminders
  - Reduce feelings of being tense or “on edge”
  - Decrease depression, anxiety, guilt and shame
  - Improve day to day living and functioning

CPT Key Interventions

- Psychoeducation
- Identifying and challenging maladaptive thoughts
- Writing impact statement
- Processing the trauma
- Developing new perspectives
- Increasing feelings of safety, trust and control

Integrated CBT for ED-PTSD

16 sessions

Combination of CBT-E for Eds & CPT for PTSD

Delivered over 14 weeks

- Sessions 1-8 twice weekly
- 9-16 weekly

Sessions 1-3 are 50 min & Focus on maintaining improvements made in ED behaviors

Sessions 4-14 were 90 min to include both CBT-E and CPT interventions

CBT-E does NOT involve formal cognitive restructuring.

CBT model of ED & PTSD

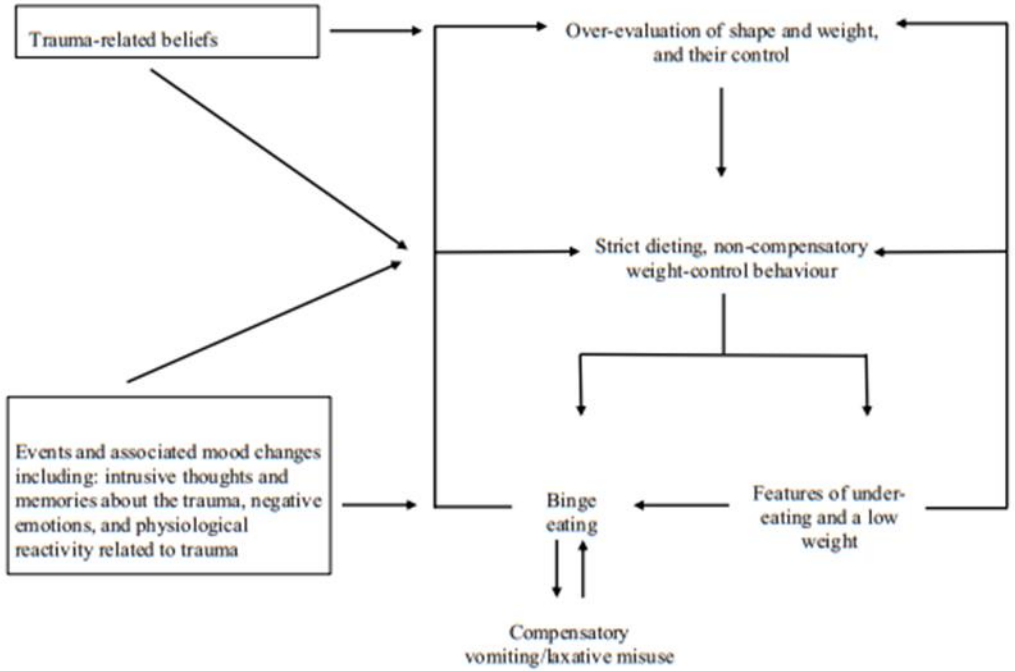


Figure 1. Cognitive-Behavioral formulation of co-occurring eating disorder and posttraumatic stress disorder. Adapted from Fairburn et al. (2008). In C.G. Fairburn (Ed). *Cognitive behavior therapy and eating disorders* (pp.47–196). The guilford press.

Personalized Formulation

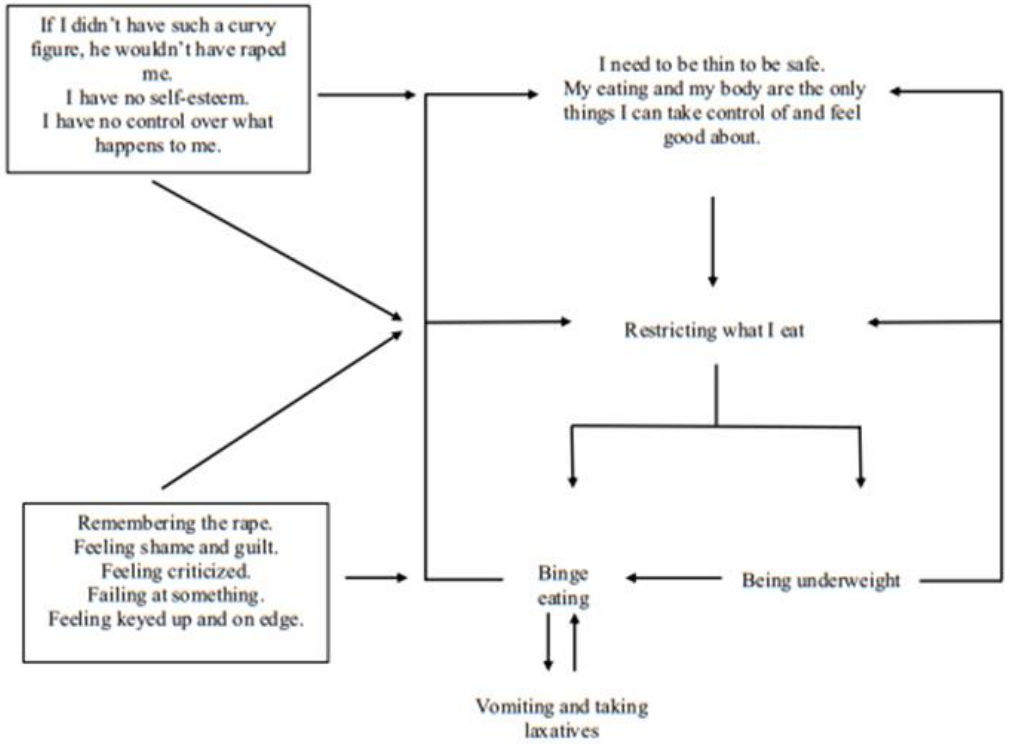


Figure 2. Personalized cognitive-behavioral formulation of co-occurring eating disorder and posttraumatic stress disorder. Adapted from Fairburn et al. (2008). In C. G. Fairburn (Ed). *Cognitive behavior therapy and eating disorders* (pp.47–196). The Guilford Press.

ED – PTSD
Stuck Points

Safety

Trust

Power/Control

Self-Esteem

Self-Intimacy

Integrated CBT Outcomes

- In a randomized control trial comparing integrated treatment with CBT-E, individuals in the integrated treatment had statistically significant improvement in PTSD than compared to CBT-E alone at EOT & 6-month FU.
- Another study found that 60% of participants achieved both ED and PTSD remission at EOT
- One study found that 80% of participants experienced significant PTSD improvements while also maintaining ED behavioral remission.
- Study of integrated CBT for ED-PTSD into residential treatment showed individuals demonstrated significant symptom improvement between admission and DC and remained statistically improved at 6 months FU compared to admission.

Unified Treatment Model

Focused on:

- Increasing emotional awareness
- Reduce emotional avoidance
- Improve emotion Regulation

3 Phases

- Motivation enhancement, nonjudgemental emotion awareness, psychoeducation about emotion, & self-monitoring
- Developing cognitive flexibility, reducing avoidance & emotion driven behaviors, and tolerating physical sensations of emotions
- Individualized exposure for food, body image and co-occurring emotional problems.

Guidelines for Starting Integrated Treatment of ED-PTSD

Establish chronology/sequence of events and provide psychoeducation on EDs and PTSD/trauma

Identify functional links between disorders

Address first the current level of danger, risk and or brain/body impairment

Establish patient's readiness to being trauma work

Establish that the patient is nourished and able to process information emotionally and cognitively

Patient's ED symptoms are relatively under control

Patient demonstrates an adequate level of distress tolerance

What can you do??

If you treat PTSD: Screen for Eds

If you treat Eds: Screen for PTSD

Screening Tools

Eating Disorder:

SCOFF

EDE-Q

Eating Disorder Screen for Primary Care

PTSD:

PCL-5

High Risk Eating and Activity Behaviors

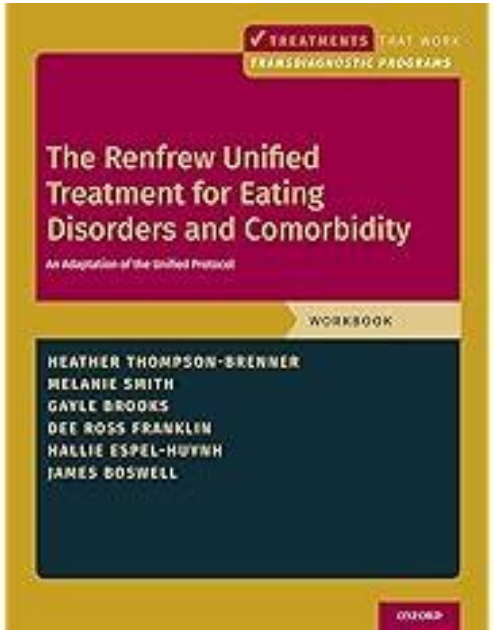
- Severe Dietary Restriction (<500-1000 kcal/day)
- Skipping meals to lose weight, cutting out entire food groups
- Prolonged periods of fasting
- Self-Induced Vomiting
- Regular use of diet pills, laxatives, or diuretics
- Compulsive or Excessive Exercise
- Additional red flags: Social isolation, irritability, fear of gaining weight, rigidity around foods and eating routines, body image distortion

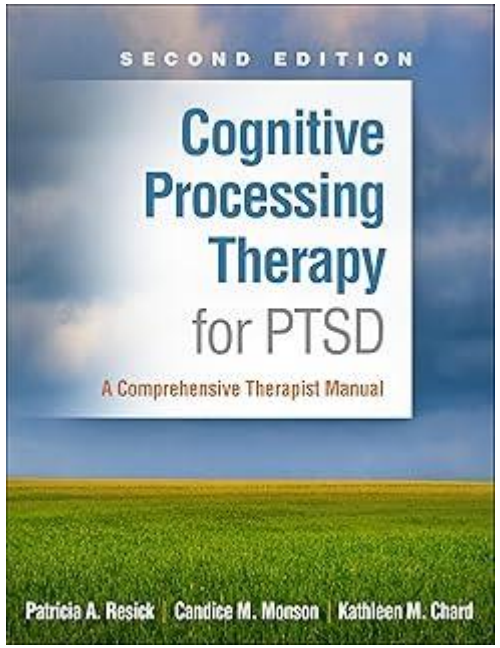
The best single question

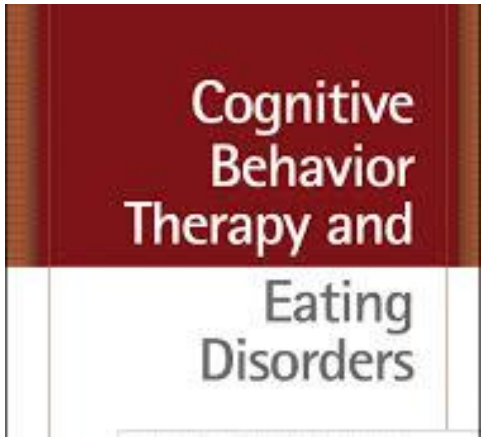
How much of your day is spent thinking about or being concerned about food, eating, your body, weight or shape?

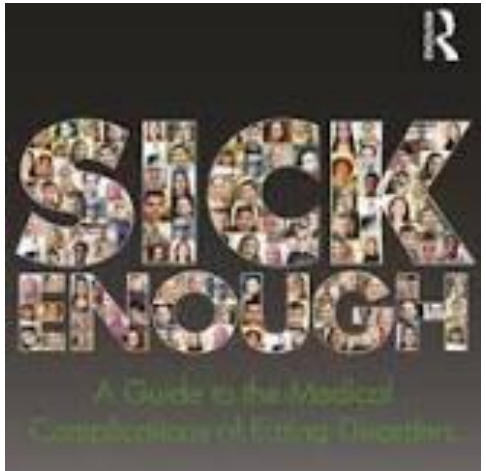
When to refer for a formal ED Assessment formal ED Assessment

Weight Loss	14lbs/3 months or 10% of body weight/2 months
Rapid Weight Gain	
Self-induced Vomiting ≥ 1 week	
Actively Engaging in ED Behaviors	
Medical Symptoms:	• Fainting/dizziness • Chest pains/shortness of breath • Feeling weak, fatigued • Feeling cold, blue extremities • Concentration difficulties • Swelling in extremities



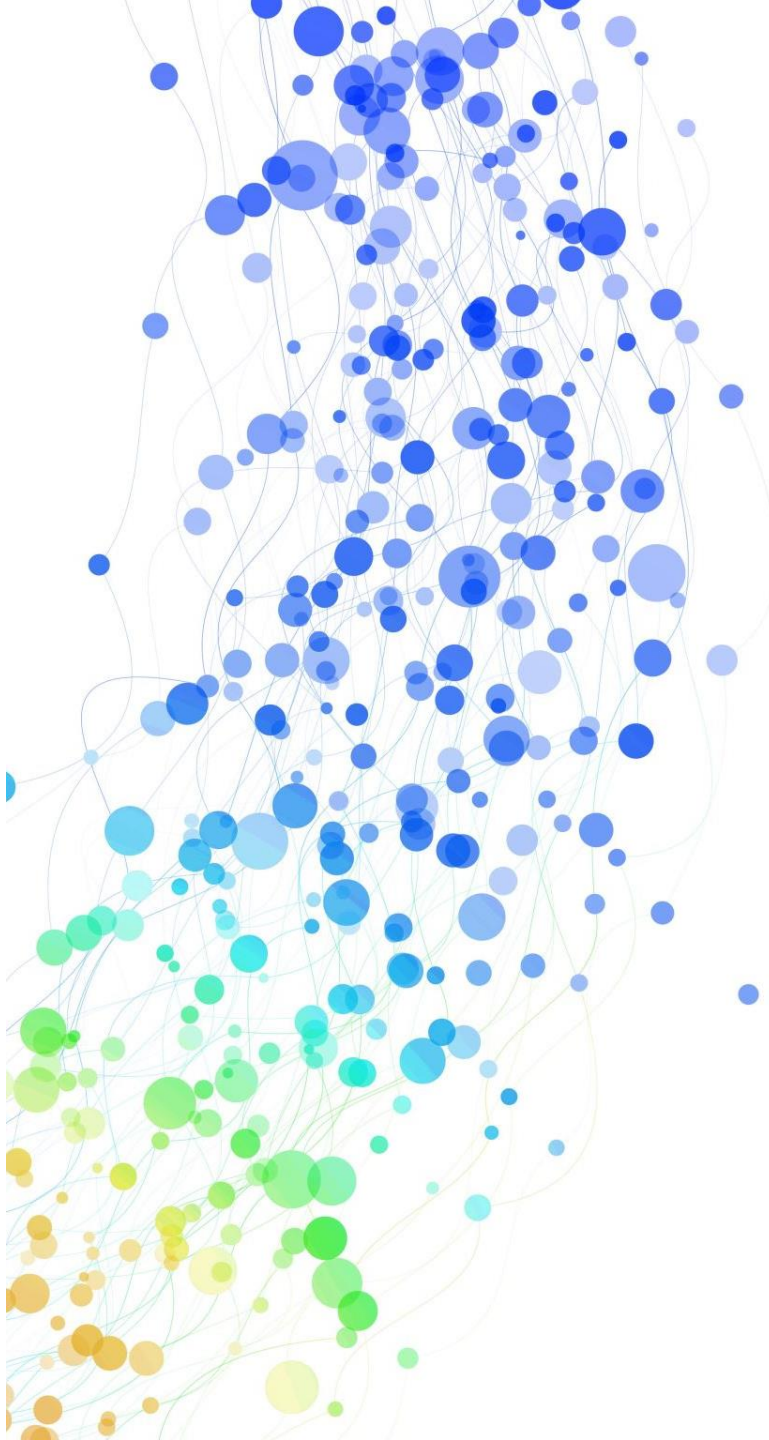






Resources

- Cognitive Behavior Therapy and EDs
  - Christopher Fairburn
- Sick Enough
  - Jennifer Gaudiani
- Melrose Heals Podcast
- National Eating Disorders Association: Home - National Eating Disorders Association



Questions?

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