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An Overview of Trauma-Informed Care and Practice for Eating Disorders

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ABSTRACT

This article reviews concepts and principles of trauma-informed care and trauma-informed practice for those with eating disorders (EDs). EDs are not universally recognized to be associated with traumatic events, despite substantial research evidence indicating that individuals with EDs report very high rates of childhood maltreatment, other lifetime traumatic events, as well as adverse consequences from trauma. Using national representative samples, higher prevalence rates of PTSD and other trauma-related comorbidities have been reported in those with EDs, particularly those with bulimic symptoms (binge eating and/or purging). Evidence suggests that those prone to develop EDs appear to be especially sensitive to the effects of stress/adversity and have high rates of premorbid anxiety disorders, personality traits, and neuropsychological features that predispose them to PTSD and its symptoms. This article also reviews some of the important principles for treating individuals with EDs comorbid for PTSD and other trauma-related disorders, including the necessity of moving beyond sequential treatment to the development of integrated treatment protocols. Integration of existing evidence-based treatments, including family therapy, cognitive behavioral therapy, dialectical behavior therapy, cognitive processing therapy, prolonged exposure, and eye movement desensitization reprocessing are recommended. Recent research suggests that ED clinicians view integrated treatment for individuals with ED and PTSD as a top priority, yet they have several concerns about administering such a treatment. As trauma-informed care is embraced by all clinicians and treatment programs that assess and treat eating and related disorders, better outcomes are anticipated.

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Introduction

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma is best defined by the “three E’s,” i.e., Event(s), Experience(s), and Effect(s) (SAMHSA, 2014a). SAMHSA rightly points out that adverse events are experienced differently by different people depending on a number of factors, including age, race, culture, prior experiences, genetic predispositions, and degree of social support. SAMHSA also notes that “trauma is an almost universal

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experience of people receiving treatment for mental and substance use disorders” (SUDs), and “the need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery” (SAMHSA, 2011). This emphasis has arisen out of the growing evidence documenting the ubiquity of traumatic events in the lives of individuals, especially those with mental and SUDs, as well as the underlying neurobiology that mediates the damaging effects of trauma. Although SAMSHA does not address eating disorders (EDs) in their otherwise comprehensive coverage of this topic, this review contends that trauma is characteristic of EDs and is often a necessary focus of assessment and treatment.

Posttraumatic stress disorder (PTSD) is the primary psychiatric disorder (effect) that directly results from experiencing traumatic events. However, many other serious sequelae have also been linked to trauma and PTSD, including most psychiatric disorders, e.g., SUDs, mood anxiety disorders, cluster B personality disorders, and many medical disorders that are leading causes of death, e.g., cardiovascular disease (Brady, Killeen, Brewerton, & Lucerini, 2000; Brown et al., 2009; Felitti et al., 1998). The EDs include anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), as well as other specified feeding and eating disorders and unspecified feeding and eating disorders (American Psychiatric Association, 2013). Much evidence has evolved over the last 20 years linking EDs with trauma and PTSD. The role of trauma, PTSD, and related factors in the predisposition, precipitation, and perpetuation of EDs will be reviewed, and the case for trauma-informed care (TIC) and a trauma-informed approach (TIA) is argued and integrated trauma-informed practice (TIP) will be emphasized.

Higher rates of traumatic events in EDs

A recent, comprehensive meta-analysis reviewed 13,059 individuals with EDs, 15,092 healthy controls, and 7736 psychiatric controls (Molendijk, Hoek, Brewerton, & Elzinga, 2017). Statistically significant associations were found between exposure to any type of childhood maltreatment (CM) (emotional, physical, sexual abuse) and the occurrence of all types of EDs and their defining features. The prevalence of CM was higher in each type of ED (prevalence: 21–52%) relative to both healthy controls (prevalence: 7–13%) and psychiatric controls (prevalence: 12–30%). ED subjects reporting CM were significantly more likely: (1) to be diagnosed with a comorbid psychiatric disorder, (2) to be suicidal, (3) to report an earlier age of ED onset, (4) to have a more severe form of the disorder, and (5) to have a greater frequency of bingeing and purging in comparison to ED individuals without any CM. The authors concluded that CM, irrespective of maltreatment type, is associated with (1) the

presence of all types of EDs and (2) with the severity parameters noted above that are predicted by cumulative trauma dose.

Of the many published studies on this topic, three studies in nationally representative samples deserve emphasis. All of these studies were based on nonclinical, nontreatment seeking samples randomly selected from across the United States, and all studies showed significantly higher prevalence rates of lifetime traumatic events in individuals with EDs compared to those without EDs (Afifi et al., 2017; Brewerton, 2015; Dansky, Brewerton, O'Neil, & Kilpatrick, 1997; Mitchell, Mazzeo, Schlesinger, Brewerton, & Smith, 2012). Interpersonal traumas were the most common type of trauma identified. In the National Woman's Study (NWS), any type of crime victimization experience, including rape, molestation, attempted sexual assault, and physical assault, was reported by the majority of women with BN (54%) versus 31% of women without an ED (Dansky et al., 1997). Furthermore, traumatic events were more likely to predate the onset of ED symptoms. The average age of first rape (14.7 ± 8.1 years old) was much younger than the average age of binge eating onset (23.6 ± 11.3 years). First rape occurred before the onset of BN in 78% of all women with both a history of rape and BN. When first rape occurred during adolescence (12–17 years old), it occurred before the first binge in 96% of cases. Likewise, when first rape occurred during childhood (<12 years old), the first binge came afterwards in 100% of cases (Brewerton, 2004). These findings provided important substantiation that victimization, especially during childhood and adolescence, is a causative albeit nonspecific risk factor for BN and perhaps other EDs, especially those with bulimic characteristics (bingeing and/or purging).

The National Comorbidity Survey Replication (NCSR) examined various types of traumas in both women and men with and without EDs. In women, any type of trauma was reported by 100% of those with AN and BN and by 90% of those with BED, as compared to 79% by the non-ED group (Mitchell et al., 2012). In men, any type of trauma was reported by 100% of those with BN and AN and 98% of those with BED as compared to 84% in those without EDs. In both sexes, any type of interpersonal trauma occurred in the majority of individuals with EDs compared to a minority in those without EDs (women: 46%; men: 42%). Unfortunately, the chronological relationship between trauma and ED was not able to be determined in this study.

In a more recent epidemiological study of over 36,000 adults in the United States using wave 3 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC-III), all CM types were associated with AN, BN, and BED (Afifi et al., 2017). The majority of individuals with an ED had histories of some type of CM (AN: 62.4%; BN: 65.6%; BED: 73.6%).

Higher prevalence of PTSD and PTSD symptoms in EDs

In addition to documenting higher rates of crime victimization experiences in EDs, results from the NWS documented significantly higher lifetime rates of PTSD in women with BN (37%) and BED (21%), as compared to women without ED (12%) (Dansky et al., 1997). To date the NWS endures as the most wide-ranging study of the relationship of trauma history and PTSD to EDs and psychiatric comorbidity in the United States.

The lifetime prevalence of PTSD was also found to be significantly higher in individuals with EDs in the NCSR (Hudson, Hiripi, Pope, & Kessler, 2007). In particular, individuals with BN and BED had significantly higher lifetime prevalence estimates of PTSD compared to non-ED individuals. When subthreshold or partial PTSD (pPTSD) is included, then the rates of pPTSD in both the NWS and the NCSR in ED individuals with bulimic symptoms increase even further (Brewerton, 2007; Mitchell et al., 2012).

PTSD and EDs share common risk factors

Several risk factors that predispose toward PTSD also predispose to the development of EDs and may contribute to their co-occurrence. These include female gender, positive personal and family psychiatric history, history of CM (emotional, physical, sexual, neglect) or another previous trauma or adversity, trauma dose/severity, as well as lack of social support (Breslau, Davis, & Andreski, 1995; Brewin, Andrews, & Valentine, 2000; Halligan & Yehuda, 2000; Nicholls & Viner, 2009; Stice, 2002). One pertinent finding is that the majority of individuals with AN and/or BN have been reported to have a preexisting or primary childhood-onset anxiety or mood disorder (Bulik, Sullivan, Fear, & Joyce, 1997; Deep, Nagy, Weltzin, Rao, & Kaye, 1995; Godart et al., 2003; Kaye, Bulik, Thornton, Barbarich, & Masters, 2004). Other psychiatric disorders, personality traits and temperaments have also been reported to be associated with both EDs and PTSD, including obsessive-compulsive and avoidant personality disorders, perfectionism, high harm avoidance, neuroticism, novelty seeking, negative emotionality, and behavioral inhibition (Afshar et al., 2011; Brewerton, Hand, & Bishop, 1993; Bulik et al., 2003; Byrne, Eichen, Fitzsimmons-Craft, Taylor, & Wilfley, 2016; Egan, Hattaway, & Kane, 2014; Flett, Besser, & Hewitt, 2014; Flett, Molnar, & Hewitt, 2016; Forbush, Heatherton, & Keel, 2007; Gudino, 2013; Halmi et al., 2012, 2000, 2005; Hewitt, Flett, & Ediger, 1996; Jaksic, Brajkovic, Ivezic, Topic, & Jakovljevic, 2012; Joyce, Watson, Egan, & Kane, 2012; Karwautz, Rabe-Hesketh, Collier, & Treasure, 2002; Lethbridge, Watson, Egan, Street, & Nathan, 2011; Lloyd, Yiend, Schmidt, & Tchanturia, 2014; Myers et al., 2012; Myers, Vanmeenen, & Servatius, 2012; Slof-Op 't Landt, Claes, & van Furth, 2016; Sutandar-Pinnock, Blake Woodside, Carter, Olmsted, & Kaplan, 2003).

Heightened perception of threat and reactivity to trauma in EDs

In addition to personality traits, other evidence suggests that individuals with EDs may have a heightened perception of threat and an enhanced reactivity to stress and trauma, including the subsequent development of PTSD or PTSD symptoms (Brewerton, 2015). There are a number of neuropsychological and neurobiological findings that may mediate this propensity. ED patients may manifest decreased distress tolerance as well as heightened disgust sensitivity, which makes maladaptive emotional reactivity and avoidance more likely (Aharoni & Hertz, 2012; Badour & Feldner, 2016; Corstorphine, Mountford, Tomlinson, Waller, & Meyer, 2007).

Other investigators have noted that individuals with EDs tend to be overly apprehensive about consequences and exhibit exaggerated inhibition (Kaye, Fudge, & Paulus, 2009; Oberndorfer, Kaye, Simmons, Strigo, & Matthews, 2011). In another study, those with disordered eating exhibited high levels of anxiety sensitivity, including fear of physical symptoms of anxiety, fear of publicly observable symptoms of anxiety, fear of cognitive dyscontrol, and experiential avoidance (Fulton et al., 2012).

ED-afflicted individuals can be especially sensitive to perceived punishment or criticism compared to controls (Harrison, O'Brien, Lopez, & Treasure, 2010; Harrison, Treasure, & Smillie, 2011; Jappe et al., 2011). In addition, they are reported to have difficulty adapting to change and to show weak central coherence, i.e., difficulty "seeing the big picture" and tendencies to "get stuck" on relatively trivial details (Frank et al., 2012; Lopez et al., 2008; Lopez, Tchanturia, Stahl, & Treasure, 2009; Roberts, Tchanturia, & Treasure, 2010).

Misperception of social cues has been recognized as an important characteristic of individuals with EDs, e.g., more likely to perceive hostile intent in human faces, to have greater emotional reactions to stress, and to exhibit greater avoidant coping strategies as compared to controls (McFillin et al., 2012). Patients with EDs make more facial emotion recognition errors often characterized by misinterpreting fear in others as anger (Ridout, Wallis, Autwal, & Sellis, 2012). Likewise, altered recognition of emotions has been reported in maltreated children and adults with PTSD (Masten et al., 2008; Poljac, Montagne, & de Haan, 2011). These features may act together to contribute to trauma vulnerability, reactivity, and impaired processing

Complex trauma and complex PTSD

"Complex PTSD" (C-PTSD) refers to a more complex condition characterized by prolonged and repeated interpersonal traumas, usually beginning in childhood and continuing through development (complex trauma), and characterized by a sense of disempowerment, lack of

control, and lack of effective escape (Cloitre et al., 2009; Herman, 1992). C-PTSD is also characterized by a pervasive insecurity and a disorganized type of attachment, aspects that are not mentioned in PTSD or dissociative disorder criteria. Three broad areas of disturbance are associated with C-PTSD, including: (1) a more complex, diffuse and tenacious symptom picture, (2) characteristic personality changes, i.e., deformations of relatedness and identity, and (3) the survivor's vulnerability to repeated harm (self-inflicted and by others) (Herman, 1992). Some trauma researchers have noted that EDs can be part of C-PTSD, along with a number of other clinical characteristics, including impairment of affect regulation, chronic destructive behavior, self-mutilation, drug abuse, amnesia and dissociation, somatization, alterations in relationship to self, distorted relations with others, and loss of sustaining beliefs (Courtois & Ford, 2009; Courtois, Ford, & Briere, 2015; Luxenberg, Spinazzola, Hidalgo, Hunt, & van der Kolk, 2001; Van der Kolk, 2002). In line with this concept of higher trauma dose, multiple episodes or types of abuses have been noted to significantly enhance the probability of developing an ED (Ackard & Neumark-Sztainer, 2003; Afifi et al., 2017; Brewerton, 2007; Leonard, Steiger, & Kao, 2003; Molendijk et al., 2017; Schoemaker, Smit, Bijl, & Vollebergh, 2002). Patients with EDs, especially the most severe and in need of higher levels of care, tend to be those who have been the most traumatized, to have the highest levels of comorbidity, to have been refractory to treatment, and to have a presumptive diagnosis of C-PTSD (Chou, 2012; Molendijk et al., 2017). Trauma histories, PTSD, and/or C-PTSD have been reported to predict poorer outcomes and/or dropout in those with and without EDs (Brewerton, 2015; Carter, Bewell, Blackmore, & Woodside, 2006; Ford & Kidd, 1998; Loneragan, 2014). One of the existing limitations in regards to diagnosing C-PTSD is the lack of a universally accepted measure of C-PTSD (Karatzias et al., 2016). Nevertheless, it is increasingly evident that systems of care that focus on the evaluation and treatment of EDs would do well to become proficient in TIC, as well as delivering trauma-specific treatments to patients with EDs, PTSD, and related comorbidity.

TIC and TIA

SAMHSA's public health approach to trauma focuses on several goals that are relevant to the optimal care of individuals with EDs: (1) increase awareness of the damaging short- and long-term effects of trauma experiences in children and adults; (2) develop and implement effective preventive, treatment and recovery and resiliency support services that reflect the needs of diverse populations; (3) build strong networks and partnerships to facilitate

knowledge exchange and systems development; (4) provide training and tools to aid systems' staff members to identify trauma and intervene early; and (5) inform public policy that supports and guides these efforts (SAMHSA, 2014a, 2014b). Ideally, TIC consists of a comprehensive approach at *individual, organizational, and systemic levels*. It utilizes respect and empathic consideration of trauma histories and vulnerabilities to generate safety and hope for all those afflicted with EDs. The foundations of TIC depend on an understanding of the *neurological, biological, psychological, and social impact* of trauma on the person as well as the heavy burden those effects often have on individuals, families, and communities. Truly effective TIC understands human susceptibility but nonetheless focuses on discovering and marshaling survivors' resources, strengths, and capacity for healing and recovery, i.e., hope (SAMHSA, 2014a, 2014b).

A TIA can be implemented in any type of service setting or organization and is indicated for those involved in the assessment and treatment of individuals with EDs. A trauma-informed organization, program, or system has specific characteristics: (a) realizes the pervasive impact of trauma and appreciates potential pathways toward recovery; (b) recognizes the symptoms/signs of trauma sequelae in patients, families, staff, and others involved with the system; (c) responds by wholly integrating trauma information into policies, procedures, and practices; and (d) seeks to vigorously resist any re-traumatization (SAMHSA, 2014a). There is ample evidence now to encourage all mental health organizations and practitioners involved in the assessment and clinical care of individuals with EDs to embrace TIC and a TIA. SAMHSA endorses adherence to six key TIA principles that readily apply to EDs, including: "1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice and choice and 6) cultural, historical, and gender issues" (SAMHSA, 2014a).

Opportunities to incorporate these principles for ED patients are diverse. For example, routine weighing of patients in professionals' offices without consideration of the intense anxiety surrounding numbers can erode safety and trust. Ideally, patients should be offered the choice of whether to be informed of their weights as well as the option of discussing what it means to them. Awareness of Western cultural beliefs, biases, and attitudes regarding body size/shape in staff are crucial. In another example, when force feeding, which can be lifesaving in AN, is done as part of medical rescue interventions that are perceived to be aggressive, non-collaborative, coercive, and/or intrusive, it can be highly traumatizing and undermine a patient's sense of safety, trust, collaboration, and empowerment (Starzomska & Smulczyk, 2011; Tan, Hope, Stewart, & Fitzpatrick, 2003). A vital consideration for trauma-informed providers of ED patients is to understand the effects of actions that may be perceived as abusive or traumatic. These examples are by no means exhaustive.

Trauma-specific treatment for EDs

There is a critical need for the development of integrated treatment approaches for ED patients with comorbid PTSD and associated disorders. One recent study surveyed a large group of frontline clinicians' perspectives on, and utilization of, "trauma-focused therapy" with ED patients (Trottier, Monson, Wonderlich, MacDonald, & Olmsted, 2016). These 184 ED clinicians were asked about their familiarity and comfort using each of four evidence-based, trauma-focused therapies for PTSD, including: (1) eye-movement desensitization and reprocessing (EMDR) (Shapiro, 2001; Shapiro & Maxfield, 2002); (2) cognitive processing therapy (CPT) (Resick, Nishith, Weaver, Astin, & Feuer, 2002); (3) Prolonged exposure (PE) (Foa, Hembree, & Rothbaum, 2007; Foa et al., 1999; Foa, McLean, Capaldi, & Rosenfield, 2013); and (4) trauma-focused cognitive-behavioral therapy (for children/adolescents) (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Deblinger, 2006). Overall, the authors found that ED clinicians' familiarity and comfort using these four interventions was relatively low. Community clinicians were more familiar and comfortable than hospital-based clinicians with EMDR and CPT, but this was still in a small minority of ED clinicians.

Conversely, there is evidence that non-ED clinicians often have negative reactions to patients with EDs, including feeling frustrated, hopeless, worry, and a lack of competence in treating this population (Satir, Thompson-Brenner, Boisseau, & Crisafulli, 2009; Thompson-Brenner, Satir, Franko, & Herzog, 2012). Most clinicians receive little training on EDs and are ill-equipped to manage these challenging, often life-threatening conditions (Girz, Robinson, & Tessier, 2014; Lafrance Robinson & Kosmerly, 2015; Robinson, Boachie, & Lafrance, 2012).

Although there are a number of evidence-based treatments for both EDs and PTSD separately, there are few published studies on integrated treatment approaches for this challenging but common comorbidity. Mitchell and colleagues studied the effects of CPT on Eating Disorder Inventory-2 scores in women with PTSD and found that several subscales improved (Mitchell, Wells, Mendes, & Resick, 2012). However, these women did not have diagnosed EDs. A more relevant study reported encouraging therapeutic effects from a pilot study of an integrated treatment approach in ED-PTSD patients using initial cognitive behavioral therapy for BN followed by CPT for PTSD (Trottier, Monson, Wonderlich, & Olmsted, 2017; Trottier, Wonderlich, Monson, Crosby, & Olmsted, 2016).

When it comes to the treatment of ED patients with C-PTSD, there is even less guidance available, although CPT, PE and TF-CBT have been reported to improve C-PTSD in controlled trials (Hendriks et al., 2017; Resick, Nishith, & Griffin, 2003). A survey of expert clinicians on best practices for C-PTSD

sheds further light on this area (Cloitre et al., 2011). These trauma experts recommended several first-line trauma approaches as being the “safest,” including education about trauma, anxiety/stress management, cognitive restructuring, emotion regulation interventions, and interpersonal/social skills training. The recommended “most effective” treatments were narration of trauma memory, emotion regulation interventions, cognitive restructuring, and education about trauma. These are likely essential skills for a successful integrated treatment for traumatized ED patients.

Integrated assessment and treatment

Good integrated treatment starts with accurate assessment and diagnosis. Preparation and planning are essential components in treating ED-PTSD patients. It is accepted standard practice for all mental health practitioners to initially perform a comprehensive psychological or psychiatric evaluation. According to Marsha Linehan, “99% of treatment failures are failures of assessment.” Although a comprehensive guide to the treatment of comorbidity is beyond the scope of this article, the basic principles of assessment and treatment have been outlined in detail elsewhere (Brewerton, 2004; Trim, Galovski, Wagner, & Brewerton, 2017). It is important to emphasize here the need to build a functional link between the ED and trauma/PTSD, which play significant roles in the predisposition toward, precipitation of, and perpetuation of an ED. The development of ED symptoms and behaviors may play a functional and adaptive role in terms of managing PTSD and other trauma-related symptoms, such as dissociation, depression, and other forms of anxiety (Brewerton, 2004; Brewerton, Dansky, Kilpatrick, & O’Neil, 1999; Brewerton & Dennis, 2015). For example, bingeing, purging, restricting, excessive exercising, and/or abusing substances may impair cognitive processing and facilitate avoidance of trauma-related memories, affects, behaviors, cognitions, and their cues (e.g., self-medication hypothesis) (Brewerton, 2011; Brewerton & Brady, 2014; Brewerton & Dennis, 2015).

There are several readily available assessment instruments for trauma exposure and PTSD symptoms (see www.ptsd.va.gov/professional/assessment), including the widely used self-report instrument, the Life Events Checklist for *DSM-5*, which can also be used as a structured interview. The PTSD Checklist for *DSM-5* can be scored to make a provisional *DSM-5* PTSD diagnosis. The Dissociative Experiences Scale is a good screening instrument for pathological dissociation. Other interview instruments include the Clinician Administered PTSD Scale (*DSM-5*), which is the gold standard used in PTSD clinical trials, the Dissociative Disorders Interview Schedule (*DSM-5*), the Structured Clinical Interview for *DSM-5*, and the Mini-International Neuropsychiatric Interview.

An integrated approach understands that several factors may interfere with the “processing” of traumatic material in the traumatized ED patient with PTSD and related comorbidity. The extreme nature of traumatic experiences at high doses interferes with attention and memory, and strong beliefs about predictability or control, which are common in ED patients, may hinder adaptive processing. Hence, the development of pathological fear and avoidance associated with PTSD and compounded by an ED leads to incomplete processing of traumatic material. This, in turn, leads to incorrect labeling of benign stimuli as dangerous, which is a result of mistaken associations and interpretations. This ongoing avoidance leads to a failure to learn corrective information and to a predisposition toward revictimization and treatment failure (Brewerton, 2004, 2007, 2015). ED treatment alone is not likely to be successful if patients are using ED behaviors to cope with trauma symptoms.

Although difficult to actualize, an ideal integrated model of ED-PTSD-comorbidity treatment dictates that all conditions are addressed concurrently by the same clinician(s) or program. An integrated model is driven by the hypothesis that EDs and related comorbidities are often, at least in part, a result of PTSD symptoms and/or that PTSD symptoms are highly relevant perpetuating factors (Brewerton, 2004, 2007; Brewerton & Dennis, 2015).

Guidelines for starting trauma treatment in ED patients

Recommendations regarding PTSD treatment in ED patients have been previously published and include these principles: (1) establish chronology/sequence of significant events, traumas, and symptom onsets (timeline); (2) educate patient/family members about all disorders, current and lifetime; (3) identify adaptive functional links between symptoms/disorders, e.g., binge eating, purging, and starvation may serve as possible strategies to facilitate avoidance and numbing, decrease hyperarousal, and regulate trauma-related states (“self-medication hypothesis”); (4) initially address the greatest danger, risk, and/or brain/body impairment; (5) establish that the patient is nourished/nourishing and able to begin processing information emotionally and cognitively; (6) patient’s ED symptoms are significantly improving/relatively under control; (7) patient demonstrates an adequate level of distress tolerance; and (8) the patient demonstrates a readiness/willingness to begin trauma work (Brewerton, 2004; Trim et al., 2017).

These principles overlap with the dialectical behavior therapy-PE guidelines for individuals with borderline personality disorder and PTSD as described by Harned, which inform this issue and include: (1) patient is not at imminent risk of suicide; (2) patient has not had any recent (past 2 months) life-threatening behavior (this may include ED behaviors); (3) patient has the ability to control life-threatening behaviors in the presence of cues for those behaviors; (4) there is no serious therapy-interfering behavior

(this may include ED behaviors); (5) PTSD is the highest priority target for the client and the client wants PTSD treatment now; (6) patient has the ability and willingness to experience intense emotions without escaping (Harned, 2014; Harned, Jackson, Comtois, & Linehan, 2010; Harned, Korslund, Foa, & Linehan, 2012; Harned, Tkachuck, & Youngberg, 2013). Taken together, these principles offer the clinician a map for successfully negotiating the journey of recovery for the ED-PTSD-comorbid patient, who often exhibit some of the features of BPD, such as impulsivity and emotional dysregulation.

Conclusions

TIC and practice for those with EDs is indicated but not always achieved in clinical practice. Substantial research evidence reveals that EDs are associated with high rates of CM, other lifetime traumatic events, lifetime PTSD, retraumatization, and other adverse consequences from trauma, which can act as predisposing, precipitating, and/or perpetuating factors. Evidence also suggests that those prone to develop EDs may be especially sensitive to the effects of stress/adversity and have high rates of premorbid anxiety disorders, personality traits, and neuropsychological features that predispose them to PTSD and its symptoms. Using an integrated TIA, important principles for treating individuals with EDs comorbid for PTSD and other trauma-related disorders are discussed and guidelines recommended. These guidelines include the need to move beyond sequential treatments to the development of integrated treatment protocols that understand and bridge the gap between trauma/PTSD and ED symptoms/behaviors. As TIC is embraced by clinicians and treatment programs that assess and treat EDs, better treatment adherence and outcomes are anticipated.

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