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The Weight of Shame and Trauma in Bariatric Patients

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Abstract

Past research has shown that Adverse Childhood Experiences (ACEs), including neglect and abuse, are correlated with obesity and other adverse outcomes in adulthood. Here it is proposed that childhood adversity follows a path to internalized shame, which then motivates a coping mechanism which can result in extreme obesity. Participants were gathered through a bariatric surgery program through support groups and as part of an amended intake process. They completed the ACEs as well as the Internalized Shame Scale (ISS). Data analysis attempted to find relationships between ACEs, the ISS, and each participant's highest BMI at any point in the bariatric program. Results confirmed ACEs correlated with high shame, as well as with high BMI. Shame/low self-esteem also correlated with high BMI. Stepwise regression analysis showed that ACEs and low self-esteem were the only significant predictors of BMI in the model which included measures of shame, anxiety, depression, and binge eating as well. The variance in BMI more than doubles when low self-esteem is added to the variance accounted for by participants' ACEs scores. This study indicates that other factors are at play (namely low self-

esteem) other than purely the childhood adversity. The adversity one experiences creates low self-esteem which needs to be coped with. When the coping mechanism is food, this coping behavior results in extreme obesity.

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Chapter 1

Introduction

Obesity is an increasingly serious problem in the United States. Current data from two surveys conducted by the Centers for Disease Control and Prevention (CDC) found that in adults aged 20 and older, 68.8% are considered to be overweight (BMI: 25-29.5), 35.7% are considered obese (BMI: 30+), and 6.3% have extreme obesity (BMI: 40+; Schiller, Lucas, Ward, & Peregoy, 2012). Since the early 1960s the prevalence of obesity has increased markedly from 13.4% to 35.7%, and extreme obesity has gone from describing only 1% of the adult population to 6.3% (Ogden, Carroll, Kit, & Flegal, 2012). While this trend could be considered by the layperson to be a consequence of increases in portion sizes, poorer nutrition, environmental toxins, genetically modified foods, low self-control, and/or sedentary lifestyles, the following will show that the extremely obese who seek out bariatric surgery often have other psychological factors contributing to their condition.

The Morbidly Obese

Results of a meta-analysis of studies correlating the presence of childhood maltreatment and obesity suggest that childhood trauma predicts obesity, regardless of the measures or definitions used to measure obesity or childhood maltreatment (Danese & Tan, 2014). Research on the bariatric population has also shown a higher prevalence of psychiatric disorders than the general population; particularly depression, PTSD, anxiety, and feeding/eating disorders (Kalarchian et al., 2007; Mauri et. al, 2008; Muhlhans, Horbach, & de Zwaan, 2009). Bariatric

patients have increased health concerns, mobility issues, and societal shaming, which are life stressors that could contribute to increases in risks for psychiatric disorders. Coupled with childhood trauma, the bariatric population is a perfect storm of risk factors for mental health issues (Muhlhans et al., 2009).

Although the medical community and insurance companies have made large strides in their psychological support of bariatric surgery candidates over the past few decades (requiring attendance of support groups, psychological evaluations, etc.), the mode and depth of psychological treatment could still be vastly improved (Ochner, Dambkowski, Yeomans, Teixeira, & Xavier Pi-Sunyer, 2012). The standards in place are requirements by insurance companies but beyond those standards, the consistency of care from program to program varies greatly (Ochner et al., 2012). Further, the practices in place have been shown to be relatively ineffective in facilitating pre-surgery weight loss, which is a factor in maintaining weight loss over time after surgery (Ochner et al., 2012).

If clinicians had a more well-informed theoretical approach with regard to this population, their outcomes both physically and psychologically could potentially be much more sustainable. What presents as a behavioral issue in need of behavioral treatment is often much more than that. Recent research shows that shame leads to depression, which leads to isolation (Bruk, 2014). In the morbidly obese population, this flow from shame to depression to isolation is theorized to be part of what contributes to a suicide rate twelve times that of the healthy-weight population (Bruk, 2014). In bariatric programs, rather than approaching patient care with compassion, shame is often an implicit form of treatment used by healthcare professionals (Bruk, 2014). In a population already susceptible to much higher levels of depression, feeling judged

and shamed by the very people meant to help them only compounds the psychological difficulties of these patients (Bruk, 2014). Further, feeling shame in an already extremely vulnerable situation may be a barrier to treatment or continuing with treatment (Bruk, 2014).

Adverse Childhood Experiences

Abuse of children is defined as "A repeated pattern of caregiver behavior or a serious incident that transmits to the child that s/he is worthless, flawed, unloved, unwanted, endangered or only of value in meeting another's needs" (Myers et al. as cited in Spinazzola et al., 2016, p. S19. In 1998, Felitti et al. used the *Adverse Childhood Experiences* (ACEs) questionnaire on a broad population with results demonstrating a strong relationship between the extent of exposure to abuse or household dysfunction during childhood and multiple risk factors for some of the leading causes of death in adulthood; one of which was extreme obesity. As a matter of fact, the idea for the ACEs study originated at a weight loss clinic where Felitti found most of the patients who had dropped out of the program had experienced childhood sexual abuse. Among other outcomes of child abuse are increased risks for drug addiction, alcoholism, depression, suicide attempt, sexually transmitted infection, liver disease, cancer, skeletal fractures, chronic lung disease, and ischemic heart disease (Felitti et al., 1998; Karr-Morse, 2012).

Although there is extensive research on the association between childhood trauma and eating disorders, historically the focus has been on Anorexia Nervosa and Bulimia Nervosa (Jaite et al., 2011; Lejonclou, Nilsson, & Holmqvist, 2014; Malecki, Rhodes, & Ussher, 2018; Schmidt, Tiller, Blanchard, Andrews, & Treasure, 1997). However, recent literature has focused on the links between childhood trauma and being overweight or obese. Findings suggest the presence of childhood trauma increases the likelihood of obesity, and further supports the ACEs

research (Fuemmeler, Dedert, McClemon, & Beckham, 2009; Gunstad et al., 2006; Gustafson & Sarwer, 2004; Johnson, Cohen, Kasen, & Brook, 2002; Rohde et al., 2008; Romans, Martin, Morris, & Herbison, 1999; Veldwijk, Proper, Hoeven-Mulder, & Bemelmans, 2012). Exposure to ACEs in childhood makes mechanisms for coping necessary to get through life. For the morbidly obese, eating and the weight itself are often the coping mechanisms (Perry, 2008).

Weight as a Coping Mechanism for ACEs

Trauma and neglect significantly impact neurodevelopment which likely contributes to brain abnormalities and psychopathology (Perry, 2008). When abuse and neglect happen during childhood while the brain is still being "wired," the abuse and neglect change the "wiring" of the brain in ways that produce troubling psychological consequences. The earlier the developmental trauma, the more devastating the impact (Perry, 2002; Perry, 2006). Vulnerability to attachment disorders, obesity, and the other health issues associated with ACEs increase the longer a child remains in a neglectful environment (O'Connor & Rutter 2000; Perry, 2006).

It has been suggested that maladaptive eating behavior leading to extreme obesity is a coping mechanism for one's trauma (Veldwijk et al., 2012). Two mechanisms have been theorized to explain the reasons for weight presenting as a symptom of coping with a history of abuse. First, it has been suggested that sexually abused individuals may use immature or maladaptive coping styles, such as problematic eating behavior, to cope with the abuse. The theory is that maturation of coping styles is likely arrested or compromised by the abuse (Romans et al., 1999; Springer, 2009 as cited in Veldwijk et al., 2012; Vaillant, 1971), and therefore common coping mechanisms that children use, continue into adulthood. The second theory is that the weight itself is the coping mechanism to attract less sexual attention, thereby

reducing the likelihood of repeated abuse (Gustafson & Sarwer, 2004; Rohde et al., 2008; Wiederman, Sansone, & Sansone, 1999 as cited in Veldwijk et al., 2012). For some patients, at a conscious level they are aware of the wish to make themselves sexually undesirable as a protective measure against predators. For others, this wish to be undesirable is wholly unconscious. For the unconscious subset, the underlying maintaining factors of their weight are unknown to them. Many extremely obese patients also resonate with the idea of putting on layers of flesh to feel protected, almost as a suit of armor (Cohen, 1995). If patients do not have adequate psychological care before and following surgery, losing weight rapidly may make them feel extraordinarily unsafe when their suit of armor goes away unless they are prepared for it. Patients and those providing care may think of receiving surgery as the solver of all problems, but the suicide rate post-surgery still far outweighs the normal population (Tindle et al., 2010). Further, if weight is the coping strategy for one's trauma, it stands to reason that accessing those coping strategies again after surgery has a high likelihood without follow up care and continued psychological support.

The Relationship Between ACEs and Shame

Research on shame has consistently acknowledged that it is one of the most damaging and harmful self-conscious emotions (Kaufman, 1996; Lewis, 1971; Tracy, Robbins, & Tangney, 2007). Shame is a socially engrossed, multilayered emotion, which blends with primary emotions (anger, anxiety, disgust, etc.) and involves affective, cognitive, behavioral, physiological, and social components (Matos, Pinto-Gouveia, & Duarte, 2012). Shame is about a sense of the self as inferior, defective, undesirable, or powerless as seen through one's own eyes, or by others (Gilbert 1998, 2003). Shame is "an intensely painful feeling or experience of

believing we are flawed and therefore unworthy of acceptance and belonging" (Brown, 2006, p. 45). It has been shown there is a correlation between trauma and level of shame. The more types of trauma one experiences, the higher the level of shame (Aakvaag et al., 2016).

Shame can be further understood by the evolutionary biopsychosocial model of shame (Gilbert, 2003; Gilbert & Miles, 2002). According to this model, humans are innately prone to be highly influenced by the quality of social relationships (Baumeister & Leary 1995; Cozolino 2014; Gerhardt 2004; Schore 1994). When theorizing with this in mind, it is plain to see how childhood abuse or maltreatment could be a major influence in a person's level of shame. If early attachment to parental figures (our first social relationships) is disorganized and disconnected, it stands to reason that it would set one up for shame feelings later in life (Charles, 2014; Fairbairn, 2013). If one feels left out and rejected by one's parents, the shame feeling of "I am bad" or "I am not worthy of love" is a way to make sense of the lack of connection or the abuse (Charles, 2014; Fairbairn, 2013). The famous Fairbairn (2013, p. 66-67) quote sums up the concept nicely, "It is better to be a sinner in a world ruled by God, than live in a world ruled by the devil." This feeling is carried on later in life. When one's attachment style is disorganized, and then the individual encounters Adverse Childhood Experiences later on, the impact is much greater because the shame is already ingrown. The individual expects to be treated poorly and can unconsciously engage in behaviors that encourage others to treat them that way. The abuse, trauma, or neglect then acts as a confirmation of the underlying shame feelings that already exist (Charles, 2014). For the extremely obese, one definite confirmation happens repeatedly in the form of societal shaming or individual bullying (Davis & Bowman, 2015).

When compared to other forms of shame, the most powerful correlate to early childhood abuse is bodily shame (Andrews & Hunter, 1997). If early childhood abuse is what produces shame, this would suggest that it is more of a cue for weight-related issues than other consequences of the abuse. Body-related shame and guilt mediate the relationship between weight status and self-esteem, which suggests that reducing body-related negative emotions will improve self-esteem in weight loss patients (Pila, Sabiston, Brunet, Castonguay, & O'Loughlin, 2015). Self-esteem is a significant statistical predictor of shame, and those with more severe eating pathologies, such as binge eating disorder, have lower self-esteem and therefore higher levels of shame (Albohn-Kühne & Rief, 2011). Further, body image focused shame experiences are associated with binge eating symptoms (Albohn-Kühne & Rief, 2011).

ACEs, low self-esteem, shame, and binge eating have each been shown to be common among those who are morbidly obese. Binge eating, a factor in obesity, is common among candidates for bariatric surgery. Treating binge eating symptoms is often a part of bariatric surgery preparation as well. Without addressing the shame component, practitioners could be missing a key piece. Abuse, shame, weight, and self-esteem may interact, with changes in any of these factors having effects on the others.

The Current Study

While it may be true that the morbidly obese experience a disproportionate amount of shame in American society (Davis & Bowman, 2015), we are interested in the possibility that shame is a predictor and maintaining factor for morbid obesity, rather than morbid obesity being a predictor and maintaining factor for shame. Research is limited in the area of shame as a correlate for obesity in the bariatric population. However, there is ample research showing the

link between ACEs and obesity (Felitti et al., 1998; Fuemmeler et al., 2009; Gunstad et al., 2006; Gustafson & Sarwer, 2004; Johnson et al., 2002; Rohde et al., 2008; Romans et al., 1999; Spinazzola, et al, 2014; Veldwijk et al., 2012). Only recently have researchers been exploring shame as a component related to ACEs and/or obesity. We are expecting to find that ACEs scores will correlate to high levels of shame, and in turn, high levels of shame will correlate to a high body mass index.

In the current study, we are seeking to establish that shame maintains eating and weight gaining behaviors, and therefore these three factors follow a path from ACEs, to internalized shame, to morbid obesity. We theorize the presence of developmental trauma/abuse changes one's developmental trajectory and how one thinks about one's self. This trauma leads to shame, and shame is what fuels and maintains the high acquisition of weight seen in morbidly obese bariatric patients.

Currently, psychological interventions in bariatric surgery programs follow a behavioral model. On the surface, this reasoning is sound since it is the behaviors that are contributing to and maintaining the obesity. However, if there are deep processes rooted in abuse and shame and those factors are not addressed, we theorize that the behavioral changes will be both more difficult to attain and less durable. While bariatric programs have taken steps in the right direction, ironically there is too much focus on weight loss. With this population being much more likely to have mental illness and to commit suicide, providing better psychological care while the patients are invested in their health and treatment could have positive implications for this population far beyond achieving and maintaining their weight loss. We aim to expand the

knowledge on the predicting and maintaining factors for obesity to better inform the communities that treat this population. We hypothesize the following:

Hypothesis 1: The participants' ACEs score will be positively correlated with their level of shame. The reasoning is that more adverse childhood experiences would lead to higher levels of shame in adulthood. If hypothesis A were confirmed, it would suggest that in the bariatric population, shame is present independent of morbid obesity as a theoretical result of childhood trauma. In other words, it would suggest that morbid obesity is a symptom of shame rather than shame being a symptom of morbid obesity.

Hypothesis 2: The participants' ACEs score will be correlated with their body mass index score. Although we believe it is shame that is the maintaining factor for morbid obesity, we theorize it is the adverse childhood experiences that prime the shame. Although there are more powerful indices available for weight and body fat, body mass index is used here because of its availability in archival data, as well as its common usage.

Hypothesis 3: The participants' level of shame will also be correlated with their body mass index score. The reasoning behind this hypothesis is the higher the level of shame a person has, the more they will engage in their maladaptive coping mechanisms to combat negative feelings associated with shame. With the bariatric population, those coping mechanisms are often food related.

Hypothesis 4: ACEs and shame are expected to predict body mass index individually, and we also propose that shame will have a moderating effect on ACEs such that adding shame will increase their combined prediction of body mass index.

If these hypotheses hold true, the results would have implications for treatment interventions and outcomes beyond what is currently practiced in bariatric surgery programs.

Chapter 2

Methods

Participants

Fifty-eight bariatric surgery candidates at a bariatric treatment center in the Pacific Northwest consented to participate in the study both directly within the context of bi-monthly support groups, and indirectly as part of an amended intake process. Patients engaged in the bariatric surgery program as much as one year prior to surgery and as much as one year into the postoperative phase were included in the sample. Patients were excluded if they were outside of this time frame. This sample will be described with respect to age, gender, and body mass index in the results section. Ethnicity was not able to be gathered for all participants due to the demographic questionnaire not being filled out for those participants gathered during the amended intake process, so is excluded from Table 1 (found in Chapter 3). However, for participants for which ethnicity was gathered ($n = 35$), the sample was overwhelmingly white (94%).

Instruments

The *ACEs Questionnaire* is a 10-item self-report questionnaire targeting three types of childhood abuse (psychological, physical, sexual), two types of neglect (physical, emotional), and five types of household dysfunction (substance use, mental illness, incarcerated relative, domestic violence, parental divorce). The yes/no format yields a total score ranging from 0 to 10. The questionnaire takes less than 5 minutes to administer and less than 5 minutes to score.

Bufford, Sizemore, and Blackburn (2017) found a .77 internal consistency (Cronbach's alpha). Dube, Williamson, Thompson, Felitti, and Anda (2004) found test-retest reliability for specific ACEs categories. Emotional abuse was .66, physical abuse was .55, and sexual abuse was .69.

The *Internalized Shame Scale (*ISS) (Cook, 2001), is a self-report measure of internal feelings of negative affect about the self and the extent that these negative response patterns become internalized in adolescents (over age 13) and adults. The ISS is composed of 30 items, 24 of which specifically target shame responses, and 6 that measure self-esteem. Administration takes approximately 10-15 minutes and 5 minutes to score. With regard to validity, the ISS shows modest positive correlations with other measures of guilt and shame. Many tests of convergent validity between the ISS and other measures of guilt, shame, suicide probability, depression, anxiety, anger and other correlates believed to be associated with shame have shown modest to high convergent validity (Cook, 2001). Del Rosario and White (2006) found internal consistency at .88 for shame subscale, and .96 for the self-esteem subscale, which they found to be consistent with results found by Rybak and Brown (1996). The test-retest correlations of items on the shame subscale was .84, and .69 for the self-esteem items. The mean item-total correlation was .73 (nonclinical) and .67 (clinical) (as cited in Cook, 2001).

The *Patient Health Questionnaire* (PHQ-9) (Kroenke & Spitzer, 2002), is a self-report measure of depression. The PHQ-9 consists of nine items, where the participant must recall over the past two weeks how often they experienced each symptom assessed, and then rate overall negative impact on their lives. It is primarily used as a short-form depression screener to assess overall depression severity over the past two weeks, and the need for potential further intervention. The measure takes approximately 2-5 minutes to administer and 1 minute to score.

In studies assessing two different patient populations, Kroenke, Spitzer and Williams (2001) found a .89 and .86 internal consistency respectfully. With regard to test-retest reliability, they had favorable results with .84 (Kroenke, Spitzer, & Williams, 2001).

The *Generalized Anxiety Disorder Scale-7* (Spitzer, Kroenke, Williams & Lowe, 2006) is a 7-item self-report scale developed as a screening tool to assess for the potential presence and severity of Generalized Anxiety Disorder. Items are rated on a 4-point Likert-type scale, with each item asking about a different symptom of GAD. The GAD-7 takes 2-5 minutes to administer and 1 minute to score. Lowe et al. (2008), found internal consistency of .89 across all subgroups they tested. With regard to test-retest reliability Mills et al. (2014) reported results of .83.

The *Binge Eating Scale* (Gormally, Black, Daston & Rardin 1982) is a 16-item self-report measure used to assess binge eating severity amongst obese persons. Each item has 3 to 4 numbered statements assessing for a specific behavior, feeling/cognition, or expectation for maintaining a diet. The scoring system differs by each question so a scoring key is used to obtain the total score. The BES takes approximately 3-7 minutes to administer and 3-5 minutes to score. The scale has a .89 internal consistency, as well as a two-week test-retest reliability of .87 (Gormally et al., 1982).

Participants whose information were gathered face-to-face (n = 27) were also given a questionnaire to obtain their demographic data as well as their pre/post-surgery timeline. File review took place to obtain the patients' maximum body mass index during their time in the bariatric program, and to gather age and gender demographics for patients who participated indirectly.

Procedures

Human Subjects Research Committee, e.g., Internal Review Board approval was obtained for this study. Participants who participated directly were asked to sign an informed consent form and then complete a demographic questionnaire. Participants were administered the ACEs questionnaire first, followed by the ISS. Administration took place before or following bi-monthly bariatric support groups.

Additional participants were gathered indirectly through the intake process into the bariatric program. The intake process was altered to include the ACEs and ISS questionnaires with other screeners that participants are required to complete (PHQ-9, GAD-7, and Binge Eating Scale). A check box and line for participants to initial was added into the informed consent document to include consent to participate in this study using the data gathered at intake. The administrator then conducted file review periodically as new participants entered the program.

Data Analysis

Prior to data analysis, data cleaning led to the replacement of one PHQ-9 score (1.8% of PHQ-9 scores), one GAD-7 score (1.8% of GAD-7 scores), and four Binge Eating Scale scores (7.4% of BES scores) by replacing with the means of each scale. A correlation matrix was used to investigate the relationships between internalized shame, ACEs, and BMI, as well as participant's PHQ-9 score, GAD-7 score, and Binge Eating Scale scores. A stepwise regression analysis was used to analyze internalized shame/self-esteem and ACEs scores in predicting participants' BMI's.

Chapter 3

Results

Data cleaning led to the elimination of one outlier. The participant was determined to be an outlier using Mahalanobis distance. Justification to use this method can be found in Zijlstra, van der Ark, and Sijtsma (2011). Assumptions were met for linearity, multicollinearity, and normality. Descriptive statistics are presented in Table 1.

Table 1

Means, Standard Deviations, and Number of Participants

	Mean	Std. Dev.	N
ACE Score	3.64	2.81	58
ISS-S	31.95	22.04	58
ISS-SE	16.07	5.63	58
BMI	48.76	10	58
PHQ9	7.71	5.97	58
GAD7	5.2	5.26	58
BES	14.19	8.32	58
Age	51.86	12.6	58
Gender	46 female/12 male	79% female/21% male	58

Note. ACEs = Adverse Childhood Experiences, ISS-S = Internalized Shame Scale: Shame, ISS-SE = Internalized Shame Scale: Self-Esteem, BMI = Body Mass Index, PHQ9 = Patient Health Questionnaire 9, GAD7 = Generalized Anxiety Disorder Scale 7, BES = Binge Eating Scale.

As seen in Table 2, correlation results indicate that ACEs correlates with both ISS-S and ISS-SE ($r = .37$; $p < .01$, $r = -.34$; $p < .01$) and BMI ($r = .35$; $p < .01$). Therefore, hypothesis A and B are confirmed. ISS-S and ISS-SE also correlate with BMI ($r = .34$; $p < .01$, $r = -.44$; $p < .01$). Therefore, hypothesis C is also confirmed. ISS-S was also shown to be significantly correlated with PHQ-9 ($r = .62$; $p < .01$), GAD-7 ($r = .54$; $p < .01$) and BES ($r = .56$; $p < .01$). ACEs was correlated with PHQ-9 ($r = .39$; $p < .01$) and GAD-7 ($r = .35$; $p < .01$) but not with BES ($r = .01$; $p > .05$).

Table 2

Correlation Matrix of All Independent Variables.

Variable	ACEs	ISS-S	ISS-SE	BMI	PHQ-9	GAD-7	BES	Gender	
ACEs	1								
ISS-S	.37**	1							
ISS-SE	-.34	-.77**	1						
BMI	.35**	.34**	-.44**	1					
PHQ-9	.39**	.62**	-.55**	.39**	1				
GAD-7	.35**	.54**	-.37**	0.24	.76**	1			
BES	.01	.56**	-.42**	.33*	.52**	.35**	1		
Gender	-.07	-.29	.24	-.01	-.11	-.13	-.15	1	
Age	-.28*	-.02	.12	-.29	-.07	-.25	.10	.09	1

Note. * = $p < 0.05$; ** = $p < 0.01$. Noted results are shown in bold. α shown on diagonal. ACEs = Adverse Childhood Experiences, ISS-S = Internalized Shame Scale: Shame, ISS-SE = Internalized Shame Scale: Self-Esteem, BMI = Body Mass Index, BES = Binge Eating Scale.

Standard and stepwise multiple regressions were conducted to determine how much of the variance in BMI can be accounted for by ISS (both shame and self-esteem subscales) and by ACEs. Additional variables were also analyzed to attempt to further account for variance in BMI (Age, Gender, PHQ9, GAD7, and BES).

Initially, a standard multiple regression entering all variables was used to indicate how much of the variance in BMI can be accounted for by the overall model. As presented in Table 3, results indicate the overall model significantly predicts BMI, $R^2 = .363$, $\Delta R^2 = .256$, $F(8, 48) = 3.41$, $p = .004$. This model accounts for 36.3% of the variance in body mass index within this population. A summary of regression coefficients as presented in Table 3 and Table 4 indicates that with the standard regression analysis, no single variable was shown to be a significant predictor of BMI.

Table 3

Standard Multiple Regression Using All Independent Variables

R^2	ΔR^2	F Change	df1	df2	Sig.
.363	.256	3.413	8	48	.004

To test hypothesis D, a stepwise multiple regression analysis was employed to specify which variables contribute most to the prediction of BMI in the model. In Step 1 age and gender were entered, then ACE score as Step 2, then ISS-Shame and ISS-SE in Step 3, and lastly PHQ9, GAD7, and BES as Step 4. The model summary of the stepwise multiple regression as shown in Table 5, indicates that ACEs and ISS-SE were significant predictors of BMI in this model, but no other variables were significant. Adding ISS-SE to ACEs significantly increased the variance

Table 4

Regression Coefficients for Standard Regression Analysis Using ENTER

	B	SE B	β	*t*	Sig.
Constant	58.82	9.47	-	6.21	<.001
ACE Score	.81	.50	.22	1.62	.11
ISS-S	-.07	.10	-.15	-.65	.52
ISS-SE	-.46	.36	-.26	-1.28	.20
Age	-.19	.10	-.24	-1.85	.07
Gender	2.07	3.02	.08	.68	.49
PHQ9	.44	.38	.25	1.14	.26
GAD7	-.30	.38	-.15	-.79	.43
BES	.32	.18	.26	1.71	.09

Note. ACEs = Adverse Childhood Experiences, ISS-S= Internalized Shame Scale: Shame, ISS-SE = Internalized Shame Scale: Self-Esteem, PHQ9 = Patient Health Questionnaire 9, GAD7 = Generalized Anxiety Disorder Scale 7, BES = Binge Eating Scale.

accounted for in predicting BMI. The ACEs accounted for 11% of the variance in BMI, ΔR^2 = .11, F(1, 49) = 7.02, p = .011. ISS-SE accounted for 13% of the variance in BMI, ΔR^2 = .13, F(1, 48) = 9.34, p = .004. Taken together, ACE score and ISS-SE account for about 24% of the variance in BMI. Being that the hypothesis was the ISS-S and not ISS-SE would be the significant predictor of BMI along with ACEs, hypothesis D is only partially confirmed.

Table 5

Stepwise Regression Model Summary Predicting BMI in Bariatric Sample

Model	R	R^2	Adj. R^2	Std. Err.	ΔR^2	ΔF	*df*1	*df*2
Step 1	.30	.09	.06	9.97	.09	2.5	2	50
Step 2	.45	.21	.16	9.42	**.11**	7.02	1	49
Step 3	.58	.33	.28	8.70	**.13**	9.34	1	48

Note. Noted results are shown in bold. Step 1 Predictors = Gender, Age; Step 2 Predictors = Gender, Age, ACEs; Step 3 Predictors = Gender, Age, ACEs, ISS-SE.

Table 6

Stepwise Regression Coefficients Predicting BMI in Bariatric Sample

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
Model	B	Std. Error	β		
Step 1					
Constant	60.88	5.65		10.76	<.001
Age	-.24	.11	-.30	-2.25	.03
Gender	1.20	3.52	.05	.34	.73
Step 2					
Constant	50.99	6.51		7.84	<.001
Age	-1.44	1.10	-1.8	-1.33	.19
Gender	1.78	3.33	.07	.54	.59
ACEs	1.33	.50	.36	2.65	.01
Step 3					
Constant	66.65	7.90		8.43	<.001
Age	-.18	.10	-.22	-1.76	.08
Gender	4.23	3.12	.16	1.33	1.9
ACEs	.62	.52	.17	1.19	.24
IS-SE	-.76	.25	-.42	-3.06	.004

Note. ACEs = Adverse Childhood Experiences, ISS-SE = Internalized Shame Scale: Self-Esteem

Chapter 4

Discussion

The purpose of this study was to determine the relationship between adverse childhood experiences and shame as predictors of body mass index. The assumption that childhood adversity would have a significant correlation with shame and its perceived opposite, self-esteem, was shown to hold true in the bariatric population sampled for this study. What this indicates is that the more adverse experiences someone has, the higher their level of shame and the lower their self-esteem. The opposite is also true, meaning the less adversity someone experiences in childhood, the lower their level of shame, and the higher their self-esteem.

The effect of childhood adversity is cumulative in that the more types of adversity one experiences, the more negative one's self-image is (Aakvaag et al., 2016). When a child experiences the various traumas that the ACEs questionnaire asks about, the child who is having that experience may make sense of the experience by feeling that they deserved it. In their minds, the type of child that would deserve those types of experiences would be a bad child (Charles, 2014; Fairbairn, 2013).

The more negative experiences individuals endure, the more they experience themselves as negative. Growing up with that image of one's self carries over into adulthood, where the adult unconsciously continues to try to make sense of the adversity they faced, even though intellectually they may know they did not deserve to have those experiences. Those messages of being "bad" were carved into their brains while the cement was still wet, but the beliefs

solidified over time as they interpreted further adversity growing up as confirmation of this negative self-image. For these adults, it is now a much more difficult task to chip away at those deep-seated beliefs that are now much less malleable.

Childhood adversity was also shown to be significantly correlated with participants' body mass index. This finding supports previous research that found similar results (Fuemmeler et al., 2009; Gunstad et al., 2006; Gustafson & Sarwer, 2004; Johnson et al., 2002; Rohde et al., 2008; Romans et al., 1999; Veldwijk et al., 2012). However, a discussion point that may have been missed in the previous studies is that similar to the effects adversity has on a person's level of shame or lack of self-esteem, the effects on BMI are also cumulative. Thus, within the bariatric population, it is not just that adversity causes obesity, it is that the more adversity a person has experienced in childhood, the more obese they tend to be. It is theorized that when adversity is experienced in childhood, it arrests the development of coping mechanisms in times of stress (Romans et al., 1999; Springer, 2009 as cited in Veldwijk et al. 2012; Vaillant, 1971).

With regard to coping strategies, a person becomes stuck at whatever developmental level they were at when the trauma occurred (Romans et al., 1999). Further, the more severe the trauma, the more immature the style of coping (Romans et al. 1999). When a traumatic event happens to a child, they must cope with it immediately following the event by soothing themselves in some way. In the bariatric population, the self-soothing was, at least in part, likely accomplished through food. When a coping mechanism works, it is likely that the person will return to that coping mechanism for soothing when they need to. The more adversity, the greater the need to cope, and the more use the coping mechanism gets. An anecdotal observation from providing psychological evaluations for this population is that food may have been the original

coping mechanism in childhood but was replaced to a greater or lesser degree by alcohol or drugs in adolescence. However, once drugs and alcohol became a problem that required abstinence, food was available to soothe once again.

As was theorized earlier, it is thought that adversity leads to shame, and that shame then is the ultimate cause of a high BMI. Shame is indeed correlated with BMI, so like the ACEs score, the higher the participant scored on the Internalized Shame Scale (or how low they scored on the self-esteem portion of the scale), the higher their BMI is likely to be. Shame was also correlated with higher levels of depression, anxiety, and participants' binge eating scores. Interestingly, the ACEs score also correlated with depression and anxiety but not with the binge eating score.

We theorize that it could be shame that is the key ingredient in the recipe of childhood adversity that exacerbates the maladaptive eating behavior to the point that it becomes binging. Research is limited on the role of shame in binge eating but Schulte (2016) found that emotional eating, body-related guilt, and body-related shame were high predictors of binging. While not all people receiving bariatric surgery have a binge eating disorder, not surprisingly those who do are usually heavier than those who do not. It is important to note that with correlational data there is a bit of a "chicken or the egg" argument, in that it could be argued that people who have a higher binge-eating scale score also have more shame because perhaps they are ashamed about their binge eating behavior or have a more negative body image than those who do not have BED (Albohn-Kühne & Rief, 2011; Legenbauer et al., 2011). It is plausible that someone experiences childhood adversity which makes them feel shameful, which they then cope with through maladaptive eating behaviors, which then causes them to become obese, and then the obesity

causes further shame. This may create a cycle of coping for the shame of obesity by further overeating.

Due to the difficulty in determining exactly what factors truly stand out when purely looking at correlational data, stepwise regression analysis was used. The regression revealed that only two factors measured in this study contributed unique variance as predictors of participants' BMI: ACEs score and the self-esteem portion of the Internalized Shame Scale. It is curious that only self-esteem was shown to be significant and shame was not. Because of how the Internalized Shame Scale is constructed, we are considering low self-esteem to be analogous with high-shame. Considering that the Internalized Shame Scale is a self-report measure, it could have been that participants' felt more comfortable endorsing low self-esteem than they did high-shame. The same participant may be more comfortable failing to endorse a question about how good they feel about themselves such as "On the whole, I am satisfied with myself," than they are endorsing a question confirming how bad they feel about themselves, such as, "I feel empty and unfulfilled". This theory is currently conjecture due to lack of research addressing this specific question. This is just one possible explanation for why the shame measure was not significant where self-esteem was.

The analysis indicates that binge eating, depression, and anxiety are partially the result of one experiencing childhood adversity and shame (low self-esteem) but were not unique predictors of weight. In other words, adversity and low self-esteem predict weight, depression, anxiety, and binge eating and not the other way around. Further, when looked at together, adversity and low-self-esteem account for almost double the variance in BMI than each did

alone. It is not just childhood adversity that sets one up for obesity, anxiety, depression, or binge-eating, as previous research would indicate (Felitti et al., 1998; Karr-Morse, 2012).

If a person had experienced childhood adversity but had high self-esteem, they would still be statistically more likely than others to be extremely obese than those without childhood adversity, however if they internalized low self-esteem as well, this research shows the two combined increases the likelihood greatly. In other words, it is not just having experienced childhood adversity, it is how adversity shapes the self-image.

If someone experiences adversity in a supportive, caring, and nurturing environment, they have a much better chance at developing the resilience needed to recover and thrive (Anthony, 1974; Garmezy, Masten, & Tellegren, 1984; McMillen, Zuravin, & Rideout, 1995; Shepherd, Reynolds, & Moran, 2010; Werner, 1984, as cited in Reyes, 2008). Specifically with children, if they are in an environment that teaches them to cope with the trauma of those events in healthy ways, their coping ability may not become arrested, and they may not have the need to make sense of those events in ways that promote shame or low self-esteem When one experiences adversity in an environment where a child feels powerless with limited support, they are on their own to make sense of the events in ways that are likely to promote the shame and low self-esteem, which then increases the likelihood of negative outcomes.

Implications

The morbidly obese population may be one of the last groups in our society that can be openly spoken about in disparaging ways without fear of being accused of being insensitive or bigoted. Society views this population as having had a choice in the matter, and when choice is involved, somehow that makes it acceptable to look down upon them or judge. This societal

shaming likely exacerbates the problems that have set this population up to be in the position they are in with their weight (Davis & Bowman, 2015). The layperson may believe that extremely obese people would have a higher likelihood of having low self-esteem, but their understanding is backwards. If ACEs research was common knowledge, it may give individuals in society pause to realize what this population is up against, and have been for most of their lives.

These bariatric participants are not people with a lack of self-control. These are people who are coping with trauma and low self-esteem/shame in the only way that has ever worked for them, and when the coping mechanism is taken away it is likely profoundly dysregulating. This dysregulation may trigger an urge to use the coping mechanism once again to quell whatever difficult feelings may come up. Sudden onset of PTSD symptoms after major weight loss in patients with sexual abuse histories have been reported, potentially for the above reasons (Collazo-Clavell, Clark, McAlpine, & Jensen, 2006, as cited in Grimaldi & Van Etten, 2010).

Within bariatric programs, this research further supports the need for better psychological care of patients and education of the medical providers. Despite great strides being made in both of these arenas, it is still largely looked at as a behavioral problem. With up to 50% of bariatric patients regaining weight following surgery, it seems more likely that psychological factors are at play (Liu & Irwin, 2017).

Once surgery takes place, psychological aftercare is limited at best. Aftercare is elective and not nearly as emphasized due to the lack of continued insurance company requirements. Even if aftercare is well provided, in the postoperative phase, patients often stop engaging (Grimaldi & Van Etten, 2010). If nothing else, patients' outcomes would likely be positively

impacted if they were educated on these findings and others that would shed light on what they are feeling and why they may backslide into old behaviors. Within bariatric programs, if this type of information was emphasized, it would hopefully compel the providers within the program to emphasize psychological care after surgery and provide psychoeducation on what patients may experience as they lose weight and how dysregulating it can be, especially if they have a trauma history.

Limitations

Some limitations of this study are within the population and how the data was gathered. This population was a mostly white, mostly female, mostly late middle aged sample, in a rural area of Oregon. To be able to generalize results with more confidence, future studies would need to be replicated in more varied locations with more varied participant demographics. Also, the data that was gathered through chart review was recorded in a way that rendered us unable to obtain coefficient alpha for each scale used with this sample.

Further, it is possible that more striking results would be present if a sample of extremely obese patients not pursuing bariatric surgery was sampled. Participants in this study are engaged in semi-regular therapy, had access to support groups, as well as individual support from their surgeon, nutritionist, and nurses, and are actively working on improving their lives during the time of data gathering. With this in mind, these participants may have already experienced improvements in shame or low self-esteem. Further, those completing the surveys following the support group may have been primed to endorse less shame and better self-esteem due to the environment and state of mind following the group meeting. A further limitation was the

inability to collect comprehensive demographic data for all participants. This limited our ability to look at potential other correlations based on cross sections of the population.

Future Directions

This study showed that a history of adversity in childhood and low self-esteem are predictive of BMI within this bariatric population. Also, high shame and low self-esteem correlated with adversity in childhood, and BMI correlated with all three. Future studies should be conducted with more nuanced measures for self-esteem and shame. The face validity of the ISS may have caused some underreporting as mentioned above. Also, replicating the study with a sample including more varied demographics, is needed for any generalization to be possible. Further, as mentioned, replication with extremely obese people who are not in a bariatric program may yield different or more striking results. A future study using the projective Thurston Cradock Test of Shame (TCTS; Thurston & Cradock, 2009) could potentially yield more marked results within shame/self-esteem without the difficulties associated with self-report measures. Also, it would have been beneficial to include a comprehensive interview to be able to get at each participants' level of support following whichever Adverse Childhood Experiences they experienced. This may prove to be a mitigating factor in whether or not ACEs result in shame/low self-esteem.

The effects of childhood adversity are cumulative. Each endorsement on the ACEs questionnaire is an event or series of events that may lead to having a negative view of one's self. The more traumatic events that accumulate, the larger the psychological burden and the more the trauma is internalized through negative beliefs (or lack of positive beliefs) about one's self. The earlier and more severe the traumas, the more immature the style of coping (Romans et

al., 1999). With this population that means coping through maladaptive eating behaviors and weight. It is likely that for these reasons, ACEs and low self-esteem are significant predictors of BMI. Diet and exercise are highlighted in bariatric programs for obvious reasons, but this population needs and deserves a more trauma informed treatment model that emphasizes psychological before and after care as an integral and necessary part of bariatric treatment.

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Appendix A

Internalized Shame Scale Protocol

by David R. Cook, Ed.D.

Name: _____ Gender: M F (please circle one)

Today's Date: ___/___/___ (mm dd yyyy) Age: _____ Date of Birth: ____/____/____ (mm dd yyyy)

Below is a list of statements describing feelings or experiences that you may have. Read each statement carefully and circle the number to the right of each item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. Try to be as honest as you can when responding. Please answer all of the items.

Never 0 Seldom 1 Sometimes 2 Often 3 Almost Always 4

		Never	Seldom	Sometimes	Often	Almost Always
1.	I feel like I am never quite good enough.	0	1	2	3	4
2.	I feel somehow left out.	0	1	2	3	4
3.	I think that people look down on me.	0	1	2	3	4
4.	All in all, I am inclined to feel that I am a success.	0	1	2	3	4
5.	I scold myself and put myself down.	0	1	2	3	4
6.	I feel insecure about othersí opinions of me.	0	1	2	3	4
7.	Compared to other people, I feel like I somehow never measure up.	0	1	2	3	4
8.	I see myself as being very small and insignificant.	0	1	2	3	4
9.	I feel I have much to be proud of.	0	1	2	3	4
10.	I feel intensely inadequate and full of self-doubt.	0	1	2	3	4
11.	I feel as if I am somehow defective as a person, like there is something basically wrong with me.	0	1	2	3	4
12.	When I compare myself to others, I am just not as important.	0	1	2	3	4
13.	I have an overpowering dread that my faults will be revealed in front of others.	0	1	2	3	4
14.	I feel I have a number of good qualities.	0	1	2	3	4
15.	I see myself striving for perfection only to continually fall short.	0	1	2	3	4
16.	I think others are able to see my defects.	0	1	2	3	4
17.	I could beat myself over the head with a club when I make a mistake.	0	1	2	3	4
18.	On the whole, I am satisfied with myself.	0	1	2	3	4
19.	I would like to shrink away when I make a mistake.	0	1	2	3	4
20.	I replay painful events over and over in my mind until I am overwhelmed.	0	1	2	3	4
21.	I feel I am a person of worth at least on an equal plane with others.	0	1	2	3	4
22.	At times I feel like I will break into a thousand pieces.	0	1	2	3	4
23.	I feel as if I have lost control over my body functions and my feelings.	0	1	2	3	4
24.	Sometimes I feel no bigger than a pea.	0	1	2	3	4
25.	At times I feel so exposed that I wish the earth would open up and swallow me.	0	1	2	3	4
26.	I have this painful gap within me that I have not been able to fill.	0	1	2	3	4
27.	I feel empty and unfulfilled.	0	1	2	3	4
28.	I take a positive attitude toward myself.	0	1	2	3	4
29.	My loneliness is more like emptiness.	0	1	2	3	4
30.	I feel like there is something missing.	0	1	2	3	4

Appendix B

Adverse Childhood Experience Questionnaire

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score rev bbr 10 24 06

While you were growing up, during your first **18** years of life:

1. Did a parent or other adult in the household often ...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often ...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you often feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you often feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Appendix C

Curriculum Vitae

EDUCATION

PsyD Graduate School of Clinical Psychology *Anticipated 2020*
George Fox University – APA Accredited
Dissertation: "The Weight of Shame and Trauma in Bariatric Surgery Patients"
Committee: Nancy Thurston, PsyD, ABPP/CL (Chair); Rodger Bufford, PhD; Kathleen Gathercoal, PhD

MA Graduate School of Clinical Psychology 2017
George Fox University – APA Accredited

BS Major Psychology, Minor Sociology, *magna cum laude* 2014
Grand Valley State University

AA Major Social Work 2012
Grand Rapids Community College

Certificate Guitar Performance 2005
Guitar Institute of Technology – Musicians Institute

SUPERVISED CLINICAL EXPERIENCE

Pre-Doctoral Psychology Intern Jun 2019-Jun 2020
Pine Rest Christian Mental Health Services/ Grand Rapids, MI
Psychological Consultation Center/Campus Clinic
Training Director: Brant VanOrman, Psy.D
Supervisors: Ryan Jaarsma, PsyD (Outpatient Clinic); Daniel Post, PsyD (Child Psychiatric Residential Services Rotation); Mark DeVries, Ph.D. (Neuropsychology); Sera Gruszka, PhD. (Underserved Rotation)
Settings: Community Mental Health (outpatient), Intensive Outpatient Substance Abuse, Residential Group Therapy, Inpatient and Residential Assessment, Neuropsychological Assessment
Outpatient Psychotherapy Rotation (16 hours/week, full year)

- Provided both short and long term outpatient individual psychotherapy for patients across the lifespan with a wide variety of presenting problems
- Maintained a caseload of 12-20 patients. Conducted initial evaluations and maintained documentation via electronic health record software (EPIC)
- Psychodynamic, ACT, Solution-focused, Motivational Interviewing, and family therapy techniques utilized

Child Psychiatric Residential Services Rotation (16 hours/week, 6 months)

- Provided weekly group therapy to a group of 4-8 adolescents on an unlocked residential unit
- Provided comprehensive LD/ADHD/cognitive/personality assessments for children and adolescents in locked and unlocked residential units
- Provided hospital based assessments on acute inpatient psychiatric units, most frequently to provide diagnostic clarity

Neuropsychology Rotation (16 hours/week, 6 months)
- Will participate in and lead clinical interviews and administer, score, and interpret neuropsychological batteries for 2-3 adult outpatient assessments per week
- Will address a variety of referrals including traumatic brain injury (TBI), dementia, substance use, psychiatric illness, and ADHD.
- Will participate in and lead feedback sessions with patients and families

Underserved Rotation (4 hours/week, full year)
- InterActions Residential Treatment Program (4 months).
  - Led a weekly psycho-educational group with 3-8 patients in a locked residential unit for adults with chronic and persistent mental illnesses.
- Substance Use Disorders Group (8 months).
  - Cofacilitated a 3-hour group therapy session for adults in detox, residential, and intensive outpatient substance abuse programs
  - Provided didactic training on topics related to mental health as part of the therapy group
  - Consulted and provided feedback on group participants' progress to case managers weekly

Didactic Training (4 hours/week, full year)
- Trainings include presentations from Pine Rest psychologists with varying areas of expertise, experts in the community, shared trainings with psychiatry residents, discussion of journal articles, diversity training, and spiritual integration training

Psychologist Trainee Jun 2018 – May 2019
Willamette Family Medical Center | Salem, OR
Supervisors: Ross Bartlett, PsyD; Karim Afzal, PhD
Settings: Community Mental Health and Integrated Primary Care
Population: Ethnically/racially diverse, underserved residents of rural communities

Mental Health Treatment
- Provided ongoing individual psychotherapy for patients presenting with trauma, anxiety, depression, relational concerns, and suicidality from an integrative perspective

Behavioral Health Consultation
- Provided short term behavioral health consultation through warm hand-offs from primary care physicians within medical pods in an integrated care setting for patients across the lifespan
- Addressed patient concerns, such as ADHD, mood disorders, suicidality, trauma, and personality disorders

- Gave presentations to medical staff on salient psychological issues that could impact their patients' medical treatment

Mental Health Crisis Consultant Dec 2016 – Present
Providence Newberg Medical Center | Newberg, OR
Willamette Valley Medical Center | McMinnville, OR
Supervisors: Mary Peterson, PhD; Luann Foster, PsyD; Bill Buhrow, PsyD; Joel Gregor, PsyD
Setting: Emergency Department/Hospital
Population: Individuals of all ages and diverse backgrounds presenting to the Emergency Department, ICU, and Med-Surg units for suicidal/homicidal ideation, suicide attempt, alcohol/drug intoxication, psychosis, substance induced psychiatric diagnoses, cognitive decline, and an inability to care for self

- Crisis Provided crisis consultantation, neurocognitive screening, and other risk assessment for two major medical centers, law enforcement, and mental health agencies in Yamhill County, Oregon
- Assessed for active suicidality, homicidality, mania, and psychosis
- Referred urgent-needs clients to inpatient psychiatric care facilities
- Collaborated with physicians and multidisciplinary team to provide patient stabilization and discharge plans
- Documented evaluations in electronic medical charts records (using the EPIC and Athena EMRs) and coordinated resources with county mental health employees

Doctoral Student Therapist Aug 2017 – May 2018
Linfield College | McMinnville, OR
Supervisors: Caitlin Wilpone-Jordan, PsyD;, Joel Gregor, PsyD;, Sally Goddard, M.D.
Setting: University Student Health, Wellness, and Counseling Center
Population: Ethnically/racially diverse undergraduate students, non-traditional students, and first generation students

- Provided individual psychotherapytherapy for students struggling with trauma, anxiety, depression, acculturation difficulties, and suicidality from an integrated perspective
- Administered comprehensive LD/ADHD/Personality/Neuro assessments to students to determine the learning support services they were eligible to receive

Behavioral Health Intern Jun 2016 – Jun 2017
Willamette Valley Medical Center | McMinnville, OR
Supervisor: Luann Foster, PsyD
Settings: Medical Clinic/Hospital and Geriatric Inpatient Psychiatric Hospital
Population: Rural population of extremely patients with extreme obesity preparing for bariatric surgery; and a geriatric population of patients with dementia, SI, depression, psychosis, anxiety, and an inability to care for self

<u>Bariatric Surgery Program</u>

- Provided individual psychotherapy in order to assist patients in overcoming psychological barriers for weight loss and behavior change; as well as to treat

depression, anxiety, binge-eating disorder, and trauma
- Facilitated group psychotherapy aimed toward at attenuating harmful eating behaviors, providing psychoeducation, and providing support throughout the weight loss surgery process
- Conducted psychological evaluations to determine candidacy for bariatric surgery; formulated diagnoses and treatment plans
- Provided psychological assessment, including depression, anxiety, binge-eating, shame, adverse childhood experiences, and dementia assessments
- Conceptualized and presented cases for individual and group supervision
- Collaborated with an interdisciplinary team in order to coordinate treatment plans

Senior Behavioral Health Unit (Inpatient Psychiatric Unit)
- Provided individual and group psychotherapy in an acute inpatient acute geriatric setting (cognitive stimulation, reminiscence therapy, CBT interventions, music therapy, etc.)
- Administered partial neuropsychological assessments to help inform diagnoses and treatment
- Collaborated with an interdisciplinary team with of psychiatrists, nursing managers, registered nurses, clinical social workers, and case managers to coordinate treatment plans

Clergy Assessment Testing Assistant May 2017
George Fox University | Newberg, OR
Supervisor: Nancy Thurston, PsyD, ABPP/CL
Setting: Private Assessment Practice
Population: Clergy candidates for archdiocese
- Conducted and scored personality assessments on clergy candidates in training
- Contributed clinical observations for the final report
- Shadowed Dr. Thurston, an ABPP/CL certified a psychoanalyst, in the intake interview process and synthesized the test findings

Pre-Practicum Therapist Jan – Apr 2016
George Fox University | Newberg OR
Supervisor: Glena Andrews, PhD
Setting: University
Population: Undergraduate college students
- Provided individual therapy to two students from a person-centered orientation
- Conducted intake assessments; formulated diagnoses and treatment plans
- Conceptualized and presented cases for individual and group supervision

RESEARCH EXPERIENCE

Dissertation Research, George Fox University Defended April 2019
Prelim Passed, May 2017
Dissertation Chair, Nancy Thurston, PsyD, ABPP/CL

- Title: *The Weight of Shame and Abuse Trauma in Bariatric Surgery Patients*
- A study on the effects of Adverse Childhood Experiences on shame and weight in a bariatric population

Research Vertical Team Member, George Fox University 2015 – Present
Supervisor, Nancy Thurston, PsyD, ABPP/CL

- Assisted team members with formulation of research projects
- Collaborated with other students on research projects
- Prepared for presentations of research projects and results

Research Assistant, Grand Valley State University Apr – Oct 2014
Supervisor, Mario Fific, PhD

- Administered tests to research subjects
- Compiled test results
- Researched literature on "Stopping Rules" and presented pertinent information to other group members

PROFESSIONAL PRESENTATIONS

Heather **Jordan Stricklen, MA.** (2019, December).
Relational Therapies: Attachment, Attunement, and Earning Secure Attachment at Psychiatry Joint Rounds, Pine Rest Christian Mental Health Services, Grand Rapids, MI.
Description: Case presentation on relational therapies presented for psychiatrists, psychiatry residents, and fellow interns at Pine Rest Christian Mental Health Services psychiatry joint rounds in Grand Rapids, MI.

POSTER PRESENTATIONS

Heather Harris, H, MA.,, Colleen Conklin, C., MA, Shaza Karam, S., MA & **Jordan Stricklen, MA.** (2018, August).
Speak Up! The Right to Refuse Abuse: A Pilot Study in Rural Oregon Schools at the American Psychological Association (APA) Conference, San Francisco, CA.
Description: Poster presented at the 2018 American Psychological Association (APA) Conference, San Francisco, CA.

Heather Harris, MA, Colleen Conklin, MA, Shaza Karam, MA & **Jordan Stricklen, MA** (2018, June).
Speak Up! The Right to Refuse Abuse at the 2nd Journal of Clinical Child and Adolescent Psychology (JCCAP) Future Directions Foorum, Washington, DC.

Description: Companion to the APA poster analyzing different data that was collected as part of the original study, presented at JCCAP Future Directions Forum, June 2018.

David Neal, MA, Rodger Bufford, PhD., **Jordan Stricklen, MA**, & Richard Nalbandian, M.A., Marilyn Charles, PhD., & Nancy Thurston, Psy.D., ABPP. (2017, April).

Metacognitive Outcomes of Psychodynamic Therapy for Severe and Persistent Mental Illness at the 37th Annual Spring APA Psychoanalysis Division 39 Conference, New York, NY.

Description: Poster presented at the 37th Annual Spring APA Psychoanalysis Division 39 Conference in New York, NY, April 2017.

TEACHING EXPERIENCE

Teaching Assistant Jan – Apr 2018

Graduate level course: Psychodynamic Psychotherapy
George Fox University Graduate Department of Clinical Psychology | Newberg, OR
Professor: Nancy Thurston, PsyD, ABPP/CL

- Assissted in the supervision of doctoral students in a group setting
- Contributed to psychodynamic case formulation, intervention, and elaboration of course material

Teaching Assistant Aug – Dec 2017

Graduate level course: Cognitive Assessment
George Fox University Graduate Department of Clinical Psychology | Newberg, OR
Professor: Celeste Jones, PsyD, ABPP

- Demonstrated and instructed doctoral students in the administration, scoring, and interpretation of cognitive assessment measures
- Evaluated students in standardized administrative practices and scoring accuracy
- Guest lectured on various topics related to cognitive assessment

Adjunct Professor Aug 2015 – Apr 2017

Music Department, George Fox University | Newberg, OR
Supervisor: Pat Vandehey, M.S.

Beginning Guitar Course

- Preparedring lesson plans and materials for students
- Leading Led an interactive class that taught students the fundamentals of guitar playing and music

Applied Guitar Course

- Teaching Taught students individually from beginner to advanced levels in a variety of styles
- Formally aAdviseding students on their academic progress in the program as well as prepared them for their jury and recital performances

OTHER WORK & ACADEMIC EXPERIENCE

Merchandise Associate/Assistant Buyer Jun 2014 – Jul 2015
Meijer Inc. | Walker, MI
- Chose images, wrote copy, planned, loaded, and proofed all department promotions
- Worked closely with buyer, vendors, promo teams, and other department teams to maintain and boost sales volume and profit margins

Housing Resource for Homeless Veterans Mar – Jun 2014
Community Rebuilders | Grand Rapids, MI
- Met and corresponded with homeless veterans to encourage and assist with their search for stability
- Searched for housing on behalf of homeless veterans

Undergraduate Practicum - Dr. Shelley Dennis, PhD, ABPP Jan – Apr 2014
Counseling Associates of West Michigan | Grand Rapids, MI
- Prepared tests and homework handouts for clients
- Researched inpatient treatment programs for various mental disorders
- Researched treatment modalities for various mental disorders

PROFESSIONAL/ACADEMIC AFFILIATIONS

Student Affiliate, APA: American Psychological Association
American Psychological Association of Graduate Students (APAGS)
Student Member, Division 39 Psychoanalysis, American Psychological Association

Member, George Fox University Psychoanalytic Reading Group
Member, George Fox University Psychodynamic Special Interest Group
Member, George Fox University Addiction Special Interest Group
Member, George Fox University Professional Development Special Interest Group

ASSESSMENT COMPETENCY

Personality/Broadband Assessment
16 Personality Factors (16PF)
Behavior Assessment System for Children, 3rd edition (BASC – III)
Millon Clinical Multiaxial Inventory, 3rd edition (MCMI – III)
Millon Adolescent Clinical Inventory (MACI)
Minnesota Multiphasic Personality Inventory-2/2-RF (MMPI-2/2-RF)
Personality Assessment Inventory (PAI)

Cognitive/Achievement Assessment
Wechsler Abbreviated Scale of Intelligence, 2nd edition (WASI – II)
Wechsler Adult Intelligence Scale, 4th edition (WAIS – IV)

Wechsler Individual Achievement Test – Third Edition (WIAT III)
Wechsler Intelligence Scale for Children, 5th edition (WISC – V)
Woodcock Johnson Test of Achievement, 4th edition (WJ-IV)

Neuropsychological Assessment

Booklet Categories Test
Boston Naming Test
California Verbal Learning Test, 2nd edition (CVLT – II)
Comprehensive Test of Nonverbal Intelligence, 2nd edition (C-TONI–II)
D-KEFS
Grooved Pegboard Test (GPT)
RBANS
Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
Rey Complex Figure Test and Recognition Trial (RCFT)
Tactual Performance Test
Test of Memory Malingering (TOMM)
Wechsler Memory Scale, 4th edition (WMS–IV)

Screening Tools

Alcohol Screening Questionnaire (AUDIT)
Beck Anxiety Inventory (BAI)
Beck Depression Inventory – Second Edition (BDI-II)
Collaborative Assessment and Management of Suicidality (CAMS)
Connors Continuous Performance Test, 3rd edition (CPT-3)
Conner's Adult ADHD Rating Scale – Self-Report: Long Version (CAARS- SR:L)
Conner's Adult ADHD Rating Scale – Observer: Long Version (CAARS – O:L)
Drug Screening Questionnaire (DAST)
Generalized Anxiety Disorder Screener (GAD-7)
Internalized Shame Scale (ISS)
Mini Mental Status Examination- Second Edition (MMSE-II)
Montreal Cognitive Assessment (MoCa)
Mood Disorder Questionnaire (MDQ)
Patient Health Questionnaire (PHQ-9)
Saint Louis University Mental Status Exam (SLUMS)
Screening, Brief Intervention, Referral to Treatment (SBIRT) Alcoholism Risk Screen

Projective Assessment

House-Tree-Person Figure Drawings
Rorschach Test (Exner and R-PAS Systems)
Rotter Incomplete Sentences Blank (RISB)
Thematic Apperceptive Test (TAT)
Thurston Cradock Test of Shame (TCTS)

VOLUNTEER EXPERIENCE

Serve Day Volunteer, George Fox University, Newberg, OR
9 September 9, 2015;, 14 September 14, 2016; , 13 September 13, 2017;, and 12 September 12, 2018

Student Mentor, George Fox University Graduate Department of Clinical Psychology, Newberg, OR
June 2016-April 2017

Assitant Group Counselor, Gilda's Club, Grand Rapids, MI
August 2013-January 2014

PRESENTATIONS AND TRAININGS ATTENDED

Marlow, D. (2019, March 20). *Foundations of Relationship Therapy- The Gottman Model.* Colloquium presentation at George Fox University, Newberg, OR.

Safi, D. & Millkey A., (2019, February 13). *Opportunities in Forensic Psychology.* Grand Rounds presentation at George Fox University, Newberg, OR.

Pengelly, S. (2018, October 10). *Old Pain in New Brains.* Grand Rounds presentation at George Fox University, Newberg, OR.

McMinn, L. and McMinn, M. (2018, September 26). *Spiritual Formation and the Life of a Psychologist: Looking Closer at Soul-Care.* Colloquium presentation at George Fox University, Newberg, OR.

Kuhnhausen, B. (2018, September 15, October 13, November 3). Gender & Sexuality [Certificate Graduate Course]. George Fox University, Newberg, OR.

Witkiewitz, K., Otto, M., Prasad, R., Dunn, K. (2018, August 10). *Clinical Responses to the Opioid Crisis: A Cross-Divisional Task Force.* Symposium presentation at the American Psychological Association Conference, San Francisco, CA.

Bushman, B. (2018, August 10). *Blood, Gore, and Video Games: Effects of Violent Content on Players.* Presentation at the American Psychological Association Conference, San Francisco, CA.

Bergman, B., DeLucia, C., Kelly, J. (2018, August 9). *Innovations in Substance Use Disorder Treatment for Adolescents and Merging Adults.* Symposium presentation at the American Psychological Association Conference, San Francisco, CA.

Whittingham, M., Yolom, I. (2018, August 9). *Celebrating a Lifetime of Distinguished Contributions to Group Therapy.* Presentation at the American Psychological Association Conference, San Francisco, CA.

Farley, F., Beck, A. (2018, August 9). *Aaron T. Beck at 97 in Conversation with Frank Farley.* Presentation at the American Psychological Association Conference, San Francisco, CA.

Vogel, M. (2018, March 14). *Integration and Ecclesia.* Colloquium presentation at George Fox University, Newberg, OR.

Taloyo, C. (2018, February 14). *The history and application of interpersonal psychotherapy*. Grand Rounds presentation at George Fox University, Newberg, OR.
"The History and Application of Interpersonal Psychotherapy." Grand Rounds presentation by Carlos Taloyo PhD at George Fox University. 14 February 2018

Luom, J., LeJeune, J. (2018, December 1). *Acceptance & Commitment Therapy – An Experiential and Practical Introduction.* ACT Bootcamp Workshop presented Oxford Suites, Portland, OR.

Sordahl, J. (2017, November 8). *Telehealth*. Colloquium presentation at George Fox University, Newberg, OR.
"Telehealth." Grand Rounds presentation by Jeff Sordahl, PsyD ABPP/CN at George Fox University. 8 November 2017.

Gil-Kashiwabara, E. (2017, October 11). *Using Community Based Participatory Research (CBPR) to Promote Mental Health in American Indian/Alaska Native (AI/AN) Children, Youth, and Families.* Colloquium presentation at George Fox University, Newberg, OR.

Seegobin, W., Peterson, M., McMinn, M., & Andrews, G. (2017, March 22). *Difficult dialogues.* Diversity Grand Rounds presentation at George Fox University, Newberg, OR.
"Difficult Dialogue." Grand Rounds presentation by Winston Seegobin, PsyD, Mary Peterson, PhD, ABPP, Mark McMinn, PhD, ABPP and Glena Andrews, PhD at George Fox University. 22 March 2017.

Warford, P., & Baltzell, T. (2017, March 1). *Domestic violence: A coordinated community response.* Grand Rounds presentation at George Fox University, Newberg, OR.
"Domestic Violence: A Coordinated Community Response." Colloquium presentation by Patricia Warford, PsyD and Sgt. Todd Baltzel at George Fox University. 1 March 2017.

Brown, S. (2017, February 8). *Native self-actualization: Its assessment and application in therapy*. Colloquium presentation at George Fox University, Newberg, OR. "Native Self Actualization: It's Assessment and Application in Therapy." Grand Rounds presentation by Sidney Brown, PsyD, at George Fox University. 8 February 2017.

Stark, M. (2017, January 21). *The Transformative Power of Optimal Stress.* Conference presentation given via videoconference.

Bourg, W. (2016, November 9). *Divorce: An attachment trauma*. Grand Rounds presentation at George Fox University, Newberg, OR. "Divorce: An Attachment Trauma." Grand Rounds presentation by Wendy Bourg, PhD, at George Fox University. 9 November 2016.

Kuhnhausen, B. (2016, October 12). *Sacredness, naming, and healing: Lanterns along the way.* Colloquium presentation at George Fox University, Newberg, OR. "Sacredness, Naming, and Healing: Lanterns along the Way." Colloquium presentation by Brooke Kuhnhausen, PhD, at George Fox University. 12 October 2016.

SBIRT (Screening, Brief Intervention, and Reference to Treatment) (2016, March 16). Training at George Fox University, Newberg, OR.

CAMS (Collaborative Assessment and Management of Suicidality) (2016, March 11). Training at George Fox University, Newberg, OR.

Jenkins, S. (2016, March 16). *Managing with diverse clients*. Diversity Grand Rounds presentation at George Fox University, Newberg, OR. "Managing with Diverse Clients." Grand Rounds presentation by Sandra Jenkins, PhD, at George Fox University. 16 March 2016.

Hall, T., & Janzen, D. (2016, February 17). *Neuropsychology: What do we know 15 years after the decade of the brain? and Okay, enough small talk. Let's get down to business!* Colloquium presentation at George Fox University, Newberg, OR. "Neuropsychology: What Do We Know 15 Years After the Decade of the Brain? and Okay,
Enough Small Talk. Let's Get Down to Business!" Colloquium presentation by Trevor Hall, PsyD, and Darren Janzen, PsyD, at George Fox University. 17 February 2016.

Mauldin, J. (2015, October 21). *Let's talk about sex: Sex and sexuality with clinical applications.* Grand Rounds presentation at George Fox University, Newberg, OR. "Let's Talk about Sex: Sex and Sexuality with Clinical Applications." Grand Rounds presentation by Joy Mauldin, PsyD, at George Fox University. 21 October 2015.

Hoffman, M. (2015, September 30). *Relational psychoanalysis and Christian faith: A heuristic faith*. Colloquium presentation at George Fox University, Newberg, OR.

"Relational Psychoanalysis and Christian Faith: A Heuristic Faith." Colloquium presentation by Marie Hoffman, PhD, at George Fox University. 30 September 201