The Relationship Between Eating Disorders and Trauma: A Reconceptualization of PTSD

Cathy Reto, PhD

PERSISTENT, DISORDERED EATING AS A GENDER SPECIFIC, POST-TRAUMATIC STRESS RESPONSE TO SEXUAL ASSAULT

MARIA P. P. ROOT

University of Washington

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So that explains it.

FEMALE BRAIN

SHOPPING LOBE

MUSICALS & SITCOMS

GOSSIP LOBE

BAD HAIR DAYS

MYSTERY MOODS & BEHAVIORS

FANTASY

MATERNAL URGES & WEDDINGS

CHOCOLATE

BINGES & CRAVINGS

MALE BRAIN

SEX

COMPUTER FIXATION LOBE

TO REMOTE CONTROL

JOB STUFF

LISTENING PARTICLE

LAME EXCUSES BEER LOBE

GETTING LOST & NOT ADMITTING IT

COMMITMENT NEURON

MOVIES WITH EXPLOSIONS & BABES

POWER TOOLS LOBE
Summary

- Trauma exposure is a non specific risk factor for EDs
- Many forms of trauma are now associated with EDs
- Trauma is more commonly associated with binge-purge symptoms.
- Findings of trauma and ED are now documented in children and adolescents as well as men and boys.
- Trauma is not necessarily associated with greater ED severity
• Trauma is associated with greater co-morbidity in ED’s
• PTSD emerges as an important mediator between trauma and the development of ED symptoms
• Subthreshold PTSD may also presents risks to ED
• Men with PTSD have higher rates of EDs than the general population
• Physiological arousal and social avoidance are strong mediators between PTSD and EDs
PTSD

- Criterion A: stressor
- Criterion B: intrusive recollection
  - recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
  - Acting or feeling as if the traumatic event were recurring (to internal or external cues that symbolize or resemble an aspect of the traumatic event
  - Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

• **Criterion C: avoidant/numbing**
  - Efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - Efforts to avoid activities, places, or people that arouse recollections of the trauma
  - Inability to recall an important aspect of the trauma
  - Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect (e.g., unable to have loving feelings)
- Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

• **Criterion D: hyper-arousal**
  - Difficulty falling or staying asleep
  - Irritability or outbursts of anger
  - Difficulty concentrating
  - Hyper-vigilance
  - Exaggerated startle response
Hallmarks of PTSD and EDs

- Emotion dysregulation may be part of the development of both disorders
- Both characterized by impulsivity.
- Hypothalamic-pituitary-adrenal axis (HPS) dysfunction seen in both disorders.
- Genetic variations in serotonin, dopamine may predispose to both disorders.
- High rates of dissociation and alexithymia are common to both disorders.
The Reconceptualization

• The idea that bulimia’s role in its relationship to abuse lies in its ability to facilitate and maintain a much needed post-traumatic dissociative response is different conceptualization.

• The idea that Bulimia choreographs or assumes the PTSD response
Role of Dissociation

There is good support that dissociation is co-morbid to PTSD and plays a mediating role in the Trauma-Ed relationship.
Bulimia and the Dissociative Response

- Bulimia may work to compartmentalize and organize perceptions, thoughts, feeling, and behaviors inn the easily accessible, easily understood terms of food weight and appearance
- Some report binge-eating almost like hypnotic induction, rhythmic, lulling, or trance-like in nature
- Others report a style that is frenzied and chaotic
• In relation to affect, some report a period of numbed or suspended affect in conjunction with binge eating.
• For those who do experience affect it is very narrowly directed and understood only at it relates to food, weight and appearance.
• Numbing experiences associated with vomiting.
• This relationship exists independently of trauma and are found in Bulimics with no abusive history.

• Hypnosis research provides evidence supporting a genetic or biological disposition to engage in dissociative activity.

• The suggestibility of ED women is well documented and may reflect a biological vulnerability
• In cases of abuse, heightened levels of dissociation may increase the likelihood of bulimic symptoms in those with a preexisting vulnerability.

• Isolation and Depersonalization subtypes were most frequent correlates of bulimic symptoms.

• These two subtypes also were most highly correlated with trauma.
Subfactors of Dissociation

Absorption
- Getting lost in thought
- Most common in general population
- Least powerful correlate of abuse

• Amnesia
- Significantly associated with all forms of abuse except self-defined physical abuse and rape
Depersonalization

- Out of body experience
- Foggy - time is slowed
- With Isolation yielded highest and most significant correlations with all forms of victimization

Isolation

- Partialing or compartmentalization of experience
- Disconnection of thoughts, feelings, memories
Bulimia as a Dissociative Response

- The level of dissociation one develops for the purposes of long-term coping may be of a different kind or subtype than that of an immediate or real-time response.
- Depersonalization may represent a real time or immediate response
- Isolation represents a partialing of experience more indicative of long term stylistic response
Dissociation as a long-term post-traumatic coping response

- One path is to engage and practice in increasingly more severe and frequent forms of dissociation.
- Another path is to engage in behaviors that somehow facilitate or involve and inherent or independent dissociative response such as bulimia, drugs, or alcohol.
• Bulimia Facilitated Dissociation

Abuse $\rightarrow$ Tension

Bulimia

Dissociation

• Bulimia increments over tension and abuse in prediction of dissociation accounting for 53% of the variance

• Dissociation increments over abuse in the prediction of bulimic symptoms -- 27% of variance
Bulimic Symptoms as a Post-traumatic Stress Response

- First introduced in 1989 by Root & Fallon
- Looks a bulimic symptoms as a model of functionalism.
- Bulimia, as a way of coping may actually take on PTSD responses and mange them under the exquisitely understandable umbrella of food weight and appearance.
The very nature of bulimia offers a psychological and behavioral abusive “fit”.

- Takes on physical and emotional reenactment in a way the bulimic now controls albeit out of consciousness awareness
- Allows the individual to reorganize, reattribute, and embrace her psychological and behavioral experiences once directly related to trauma in a tolerable way.
Intrusive thoughts now revolve around feelings of food, weight, and binge-eating with the same quality and intensity as the original set of trauma flashbacks without the prior connection to trauma.
Traumatic Responses and Bulimia

• Herman, 1992 *Trauma and Recovery*
  
  – An essential feature of a traumatic experience is the overwhelming and disorganization of the normal adaptive systems with subsequent alterations in perception, arousal, attention, and emotion.

  – Trauma responses “…tend to persist in an altered and exaggerated state (emphasis added) long after the actual danger is over
• These responses “….have a tendency to become disconnected from their source and to take on a life of their own (emphasis added)”

• Bulimia is a perfect fit.
Hyperarousal

• Reflects the physiological and psychological sequelae stemming from chronic arousal of the ANS and the constant expectation of danger.

• Chronic “fight or flight”
  - Increased sustained catecholamine response in PTSD
  - Increased levels of norepinephrine correlated with intrusive symptoms
• Corticosteroid systems that dampen these responses are also impaired in PTSD
• Decreased levels of serotonin linked to PTSD, depression, hostility, impulsivity
• Hyper vigilance, increased startle, sleep problems, and somatic complaints
• Bulimia *assumes* many of these symptoms and well as *counters* them
  – Bulimics have been shown to have lower levels of norepinephrine
  – Link between high carbohydrate meals and serotonin levels
  – B/P provides a level of physical exhaustion that may temporarily alleviate hyperarousal symptoms
  – Vomiting as form of systematic relaxation
  – Vomiting linked to ↑beta-endorphin
• Vomiting may pose a chronic physiologic stressor that works to stimulate an endogenous opiate response – may represent a form of self-induced analgesia.

• Vomiting severity is correlated to PTSD as well as substance use.

• May also induce the phenomenon of “stress induced eating”
Intrusion

• Invasive, repetitive, and mechanistic nature of thoughts, feeling, and behaviors associated with reliving the trauma

• Flashbacks, nightmares, reenactments.
• Feelings of fatness, ideas of food images of B/P episodes realized in similar way to flashback.

• B/P episodes experiences as involuntary, out of control, inescapable, and completely unfathomable.

• B/P episodes recreate sensations of unpredictability, powerlessness, and confusion tied to the original trauma.
• Bulimia also affords the individual a way of re-experiencing feelings of panic, and fear and shame in a controlled, understandable, and safe environment.

• Compensatory behaviors are obvious answers to identifiable problems and give rise to temporary feelings of mastery and competency
Constriction

• Herman describes as a complete overwhelming of the individuals biological and emotional defensive system resulting in surrender, shutdown, and escape.

• The process of detachment, disruption of self from situation, critical thinking, and sensation that constitutes dissociative mechanisms
• The redirecting and narrowing of thoughts, attention, and affect as well as numbing feelings and shutting out thoughts are hallmarks of the constrictive process.

• The narrowly defined world of food weight, and appearance offers the Bulimic a way to easily identify, understand, accept her feelings, direct her energies, and limit and control her environment.
“Dialectic of Trauma”

• Horowitz originally described as the cycling of symptoms.
• The continual flux between the two psychologically opposing states of intrusion and constriction.
• Constant vacillating between extreme arousal and numbing offers little opportunity for integration.
• The cyclic nature of bulimia offers the traumatized individual the perfect analog for understanding and experiencing these psychological shifts and allows her to reestablish the "dialectic of trauma" in a highly personalized way.
Statistical Support

- DSM-IV Bulimics with and without abusive/traumatic histories
  - Virtually no differences between the physically and sexually abused bulimics and those bulimics who were not abused on the variables comprising dissociation, PTSD or eating disorders
  - Bulimia may work to manage and suppress the PTSD symptoms
• Created an interaction variable of dissociation X bulimic symptoms
• To the extent that higher levels of both disordered eating and dissociation exist, they combine to significantly predict lower rates of overall PTSD symptoms for both sexual abuse ($\beta = -0.64$, $p < 0.05$) and physical abuse ($\beta = -0.71$, $p < 0.05$)
Food and Trauma

• Lots of good discussion about how food effects serotonin, dopamine, and opioid systems.

• High levels of hypervigilance, hyperarousal, and dissociative responses directly undermine individuals' ability to control and regulate her own physical functions and emotional responses.
– Internal bodily cues may be chronically misinterpreted, ignored, or suppressed.

• High incidence of family chaos at mealtimes.
  – Forced feeding of disliked or unwanted foods.
  – Eating beyond the point of satiety by “finish your plate”
  – High arousal directly impacts individual’s biological mechanisms of hunger and satiety and the physical process of digestion
– Over time, the continued pairing of food with psychological and physiological elements of arousal may become classically conditioned.

• Psychological domination
  – When to eat, what to eat, how much to eat.
  – Disparaging remarks around weight, hunger, appetite.

• Use of food to bribe, soothe or punish
Treatment

- Brewerton suggests treating the ED prior to treating the PTSD given that ED contributes to physical and emotional dysregulation.

- Fairburn suggests that comorbid disorders be treated prior to beginning CBT for ED

- Mitchell states that if eating is used to avoid intrusive memories - it may be more difficult to treat the ED without treating the PTSD first.
Given the relationship between Bulimia and PTSD we need to challenge some of the ways we approach treatment.

- You can’t separate the bulimia from the PTSD
- Abstinence models may, and do backfire.
- Rethink the “awfulness” of ED and think in terms of functionalism
• Direct interventions based on pt. readiness
• May start with encouragement to become curious.
• May start with delay of binge or purge to build mastery.
• Be careful not to collude with the “hatred” of the ED. And the pts. Verbalizations and urgings to make it stop now.
  • I have to do something now is the essence of and ED
• Bulimia choreographs every aspect of the patients life. The more you explore the more complex the dance.

• Start with where the client/patient is and start to make connections.

• Explore how Bulimia assumes the characteristics of PTSD.
  – If pt. is not ready make the connections indirectly.
  – At treatment progresses or pt. is ready address more directly.
Functions

Root & Fallon outline 9 functions specific to trauma

1. Bulimia is a way to anesthetize intense, negative feelings states in traumas that engender feelings of rage, pain, fear, and powerless
   - focus on food allows them to escape and redirect these feelings
   - Because its temporary it must be repeated
2) Vomiting can be a symbolic attempt to cleanse oneself of humiliating experience
   - They feel they can literally “get rid of it”
   - Mind you they are thinking they are compensating for binge – these connections come out via therapy

3) Bulimia can be an outlet for anger
   - Explore nature of binge
   - Fast and furious
   - Biting hard
   - Selecting hard or crunchy foods
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• 4) Bulimia justifies that she is worthless and deserves abuse
  – “Who would do such a thing”
  – Gives voice to her disgust
  – Proves she is weak and can’t control herself
  – She is undesirable
  – Justifies negative things she has been told about her
    • Bad girl
• 5) Bulimia is a way to establish psychological and physical space
  – It is something hidden and private
  – May use increase weight to keep others away
  – Bulimia keeps people from experiencing intimate relationships
    • They do great in abusive ones

• 6) Bulimia is an attempt to control her environment via her body
  – Bulimia narrows the focus of how you experience life
- Perfectly replicates experiences of feeling out of control with solutions that temporarily work

• 7) Bulimics body becomes object of hatred
  - Their body (versus their abuser) has betrayed them

• 8) Bulimia is a predictable experience
  - Helps victims put one foot in front of the other
  - No surprises in emotions – especially negative ones
  - You know exactly how you will
- But know you’ll know why – the Bulimia explains *everything*
- She can plan, follow through, and predict how she will feel and think

- **9) Bulimia is a way to cope and relieve tension**
  - Relieves tension both physically and psychologically
Thank-you

creto@forrestgeneral.com

www.pinegrovetreatment.com