

Trauma, Posttraumatic Stress Disorder and Eating Disorders

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Traumatic events are events that cause psychological, physical and/or emotional pain or harm.

Traumatic events, especially those involving violence between people, have been found to be significant risk factors for the development of a variety of psychiatric disorders, including eating disorders—particularly those involving bulimic symptoms, such as binge eating and purging.

Stress, Trauma and Coping

Stress is an unavoidable part of life, but sometimes when stress becomes overwhelming and overpowers our coping mechanisms (such as talking to a friend, meditating or journaling) it causes distress, disease and dysfunction. Generally, when stress reaches the point where it causes emotional and/or physical problems, then it becomes traumatic. What is “traumatic” to any given individual is best understood in light of the “three E’s,” i.e., Event, Experience, and Effects, an important point made by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014).

Some people are at increased risk of stress, trauma or negative events. This is determined by a combination of biological, psychological and social factors, such as being prone to anxiety and/or depression and/or having inherited the personality traits of high harm avoidance (shy, fearful, worrying behavior) and/or acting on an impulse. What may seem to be of little or no concern to one person can be very traumatic to another, particularly to one with, or predisposed to, an eating disorder.

How we cope with stress can play an important role in whether or not stressful experiences become traumatic. Individuals with an *avoidant coping style* will not fare as well as those with an *active coping style*.

- Avoidant coping: associated with self-punishing thoughts and beliefs, which can be self-defeating and result in a negative medical outcome.
- Active coping: problem-solving style associated with better medical results.

Eating Disorders and Predisposition to Stress

Available evidence suggests that eating disorder patients may be particularly sensitive or vulnerable to stress and its consequences (Brewerton, 2015):

- Individuals with anorexia nervosa (AN) and/or bulimia nervosa (BN) more often than not have a primary anxiety disorder, i.e., an anxiety disorder that began before the onset of their eating disorder.
- In addition, research indicates that individuals with eating disorders:
 - Are more likely to perceive threat or hostile intent from others
 - Exhibit high levels of anxiety sensitivity (a fear of behaviors or sensations associated with anxiety) characterized by fear of loss of control
 - Are often over concerned or preoccupied with negative consequences
 - Have exaggerated inhibition (self-restraint and the inability to act in a relaxed way) and anticipatory anxiety (tension over an expected negative outcome)
 - Are sensitive to punishment and have difficulty adapting to change
 - Weak central coherence: have difficulty “seeing the big picture,” but get hung up on the (often trivial) details

Posttraumatic Stress Disorder (PTSD)

One of the most important connections between having had traumatic or adverse experiences and the development of eating disorders and other related psychiatric problems is the presence of posttraumatic stress disorder (PTSD) or its symptoms. PTSD is a serious mental health condition that can develop when someone has been exposed to one or more traumatic events. PTSD symptoms include (American_Psychiatric_Association, 2013):

- Re-experiencing symptoms (e.g., flashbacks, nightmares, intrusive imagery)
- Hyperarousal symptoms (e.g., irritability or angry outbursts, exaggerated startle, problems concentrating, insomnia, being overly watchful and anxious)
- Avoidance symptoms (e.g., numbing, forgetting and avoiding trauma-related material)
- Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred (e.g., partial amnesia, negative beliefs about oneself, others, or the world, self-blame, constantly expecting the worst).

PTSD tends to be a chronic condition, especially when not adequately addressed and treated. For example, one of the findings from the National Comorbidity Survey was that over one-third of individuals with an index episode of PTSD still had the full syndrome 10 years later (Kessler, Sonnega,

Bromet, Hughes, & Nelson, 1995). Like many individuals with PTSD, it is not uncommon for eating disorder patients with PTSD, who tend to have more comorbidity and more complicated courses, to not get adequate assessment and treatment. Unresolved trauma and/or PTSD can be an important perpetuating factor in the maintenance of symptoms (Brewerton & Dennis, 2015).

Two major national representative studies have shown that individuals with bulimia nervosa, binge eating disorder or any binge eating have significantly higher rates of PTSD than individuals without an eating disorder. These include the National Women's Study (Dansky, Brewerton, O'Neil, & Kilpatrick, 1997) and the National Comorbidity Survey Replication (Hudson, Hiripi, Pope, & Kessler, 2007); the highest rates of lifetime PTSD were 38% and 44% respectively in the BN groups. When partial or subclinical forms of PTSD are considered, then well over half of individuals with bulimic symptoms have PTSD or significant PTSD symptoms (Brewerton, 2007; Mitchell, Mazzeo, Schlesinger, Brewerton, & Smith, 2012). In addition, traumatized people with eating disorders demonstrate high levels of dissociative symptoms, such as amnesia of traumatic material (being unable to remember the traumatic event), which are also factors that contribute to a negative medical outcome ((Brewerton, 2004; Brewerton, Dansky, Kilpatrick, & O'Neil, 1999)

Binge Eating, Purging and Trauma

In much the same way abuse of certain substances is used to self-medicate, binge eating and/or purging appear to be behaviors that facilitate:

- Reducing the hyperarousal or anxiety associated with trauma
- The numbing, avoidance and even forgetting of traumatic experiences

These behaviors are reinforcing, making it difficult to break the cycle. As a result, traumatic experiences and their destructive effects are not effectively processed and continue to cause problems (Brewerton, 2007, 2011). In this way, trauma, PTSD and eating disorders can be very much intertwined.

Treatment

Individuals with an eating disorder complicated by trauma and PTSD require treatment for both conditions using a trauma-informed, integrated approach (Brewerton, 2004; Brewerton, 2007; SAMHSA, 2014). If the trauma is not addressed during the treatment of an eating disorder, then it is likely that successful recovery will be thwarted. Important factors contributing to the success of treatment can include positive reactions by family members and close friends to disclosure about

traumatic events, as well as strong support from family and friends. Although the best approach to address PTSD in the context of an eating disorder remains elusive, work so far has focused primarily on cognitive processing therapy (CPT) integrated with traditional treatment for the eating disorder (Brewerton, 2004; Brewerton, 2007; Mitchell, Wells, Mendes, & Resick, 2012). Future research is likely to shed light on how best to treat this comorbid combination (Trottier, Wonderlich, Monson, Crosby, & Olmsted, 2016). A full discussion of treatment options for PTSD is beyond the scope of this article, but a wealth of information for both the public and professional sectors is on the National Center for PTSD website (<http://www.ptsd.va.gov/>).

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