CORRELATIONS BETWEEN PSYCHOTRAUMATIC EVENTS IN LIFE AND EATING BEHAVIOUR DISORDERS

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Abstract: *Psychotraumatic events in life (physical abuse, sexual abuse, rape, aggressions), especially during childhood and early adolescence, present a high risk of developing eating behaviour disorders. Nevertheless, as a result of a large number of studies carried out, their role in the etiopathogeny of eating behaviour disorders remains controversial, as there is no casual-linear link between sexual abuse in childhood and eating disorders during adulthood.*

Keywords: *anorexia nervosa, eating behaviour, sexual abuse*

Rezumat: *Evenimentele psihotraumatizante de viaţă (abuzul fizic, abuzul sexual, violul, agresiunile), în special în perioada copilăriei şi debutul adolescenţei prezintă un risc crescut de dezvoltare a unor tulburări de conduită alimentară. Cu toate acestea, în urma numeroaselor studii efectuate, rolul acestora în etiopatogenia tulburărilor de conduită alimentară rămâne controversat, neexistând o legătură causal–lineară între abuzul sexual din copilărie şi tulburările alimentare ale vârstei adulte.*

Cuvinte cheie: *anorexia nervoasă, comportament alimentar, abuz sexual*

During the last decades, special attention has been paid to the possible correlations between severe psychotraumatic experiences, especially sexual and physical abuse and the development of eating behaviour disorders. In the case of these patients, it is difficult to diagnose anorexia nervosa from bulimia nervosa, because there are often comorbidities, associated especially with impulse control disorders.

In order to understand the relationship between sexual abuse and eating control disorders, it is necessary to know: the functioning of the subject before the trauma (age and vulnerability of the child at the moment of the abuse); the family context and the educational level; the nature, the seriousness and the understanding of the trauma (physical, sexual abuse, one of them or a combination of the two); the immediate response of the trauma, as well as the child's ability to cope and the parents' reactions to the trauma; other factors including subsequent life events and self image (VANDERLINDEN and VANDEREYCKEN, 2000).

According to EDDY et al. (2008), severe sexual and/or physical abuse in childhood and early adolescence submits the individual to a special risk of developing a mental disorder, including eating behaviour disorders.

The victims of sexual and physical abuse often have low self-esteem. The feelings of guilt, despise, self-blame, self-devaluation, depreciation, inferiority, are present and accompany the deep feeling of being different from other people.

STEIGER and ZANKO (1990) compared the prevalence of sexual abuse in a group of 73 subjects suffering from eating behaviour disorders, with two control groups: 21 patients with various mental disorders and 24 women without psychiatric pathology. Approximately 30% of the group with eating behaviour disorders had a history of sexual abuse, versus 33% of the psychiatric control group and 9% of the normal control group. In the group with eating behaviour disorders, the patients with restrictive anorexia nervosa had a significantly lower percentage of abuse (6%) as compared to other subgroups of eating behaviour disorders.

Restrictive anorexia nervosa is defined according to D.S.M.–IV as the lack of a compulsive eating or purging (self-provoked vomiting or abuse of laxatives, diuretics or enemas) behaviour. The recurrent presence of a compulsive eating or purging behaviour during the episode of anorexia nervosa defines compulsive eating/purging anorexia nervosa.

In a study of 112 bulimic women with normal weight, hospitalised successively, LACEY (1993), found that only 8 patients (7%) had a history of sexual abuse involving a physical contact. 4 of them (3.6%) described incest, but this appeared during childhood in 2 cases only (1.8%). The author concluded that his therapeutic work confirmed the fact that incest and sexual abuse with children were found most often with multi-impulsive bulimics.

In another study carried out on 100 anorexic patients, WALLER (1993) discovered that 37% of the women were talking about unwanted sexual experiences. The results showed an association between the unwanted sexual experiences and the purging behaviour. The anorexic patients who had severe purgative behaviours had the highest percentage of sexual abuse.

The author is thinking about the influence of other factors which may be linked to sexual abuse during childhood

and the development of an eating pathology. His study of 1994 suggests that borderline personality disorders may be associated with sexual abuse and it may be the psychological factor that explains a small part of the causal link between sexual abuse and bulimic behaviour, especially the frequency of bulimic crises.

VANDERLINE et al. (1993) studied the relationship between traumatic experiences and dissociative phenomena in a group of 98 patients with eating control disorders. The frequency of traumas was of 28%; 20% of the patients mentioned sexual abuse during childhood, 8% mentioned the incest. Anorexic patients with bulimic attacks and/or purging behaviours, bulimics and patients suffering from atypical eating behaviours, had a significantly higher percentage of traumas (respectively 25%, 37% and 58%), as compared to restrictive anorexics (12%). Sexual abuses were less frequent with the latter group (3%), as compared to the other three subgroups of eating behaviour disorders (20%).

In conclusion, these data showed a relationship between the presence of a traumatic experience and the type of eating pathology. The group of traumatized subjects had significantly higher DIS–Q (Dissociation Questionnaire) scores than the group of non-traumatised subjects. The sexually abused subjects had higher scores especially for amnesia subscales. The lack of reaction or a hostile response may be less traumatic than the event itself.

The children, who are abused for the first time at a late moment in childhood, may lean more on cognitive strategies; they can blame the abuse on some people, they can rationalise, they can use more sophisticated defences as means of coping with the trauma. Some patients consume large amounts of food to get rid of a conscious state when they are confronted with unavoidable emotions or negative intrusive thoughts.

Many victims of childhood abuse have a high risk of revictimization for many patients, eating habit disorders start when the young adolescent is confronted with his or her own sexuality and more intimate contacts, even when these experiences are positive or not at all abusive. These situations may bring back the memories of the abuse, the feelings and thoughts of that abuse.

Eating pathology may function as a way of getting rid of these feelings or thoughts. The physical and sexual abuse of a child have an impact on the parents' relationships, being possible to lead to divorce and the increase of an economic stress (SIMON, 2007). Single parent families, especially women with their children are more vulnerable.

SCHAAF and McCANNE (1994) have not found elements to state that sexual or physical abuse during childhood is associated with the development of body image disorders in a sample of 670 college students, interviewed about the presence of sexual abuse during childhood. In addition, the results do not support the hypothesis according to which physical and sexual abuse during childhood could be in relation with a symptomathology of eating behaviour disorders. They suggest that the victims of sexual abuse during childhood present higher percentages of psychopathological disorders of different types, including eating behaviour disorders.

According to FLAMENT and JEAMMET (2000), bulimic men present a higher rate of homosexuality.

There is a relationship between the degree of the adult age psychopathology and the gravity of the sexual abuse (the abuse starting before the age of five, to which violence and physical abuse is added, abuse involving several aggressors close during childhood). The evaluation of the gravity encounters difficulties because it needs first of all the subjective experience of the victims.

RUTH et al. (2002) found a higher rate of sexual, physical abuses and discriminations in the patients suffering from bulimic, as compared to the other disorders of the eating behaviour. Regarding the white women, discriminations are predominant, while African-American women show a higher rate of sexual and physical abuse.

Studies on sexual abuse suggest the existence of several different factors in the development of eating behaviour disorders, such as the parents' lack of attention, inadequate parental control, physical abuse, the loss of a close person and psychological abuse.

Anorexic patients seem to be addicted to losing weight, and bulimic patients speak about the addiction to food. Many patients show difficulties in controlling the impulses and tendencies to alcohol and/or drug abuse. Alcohol consumption generally appears after the outbreak of the bulimic behaviour.

As a result of the study carried out by BAPT (2002), the use of tranquilizers with bulimics (23%) is more frequent than alcohol consumption.

BULIK et al. (2003) reveal the fact that bulimics have personal antecedents of ethylism and prescription drug addiction.

According to BIRT (2003), patients with eating behaviour disorders have imprecise frontiers with the other person's Ego, identity problems, an interpersonal ambivalence and relational difficulties, low self-esteem, imposing extremely rigid self-evaluation criteria.

GRECU and GRECU–GABOS (2006), found in the case of patients with eating behaviour disorders, post-traumatic stress disorders secondary to stressful life events (direct personal experiences concerning the death of people close to them, physical and/or sexual abuse, rape, death threats, painful feelings at a distance by the re-experiencing the event through images, thoughts, dreams, perceptions, neuro-vegetative hyperactivity similar to the one lived at the moment of the trauma).

Anorexics with a bulimic component evoke more conflicts and disorganisations, and less coherence in their families than restrictive anorexics (KESKI-RAHKONEN et al. 2007). It is justified to presume that such a family structure plays a mediating part between the childhood trauma and the psychological sequelae during adulthood.

As a consequence of several studies carried out,

the role of psychotraumatic events in life, especially during childhood and early adolescence, in the etiopathogeny of eating behaviour disorders remains controversial, further research being necessary in this sense.

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