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Treating eating disorders in the wake of trauma

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Eating disorders (eg, anorexia nervosa, bulimia nervosa, and binge-eating disorder) are serious psychiatric conditions, which are characterised by the over-consumption or underconsumption of food and are commonly accompanied by disturbances in body image. In addition to their impact on patients' quality of life, eating disorders are associated with substantial medical and psychiatric comorbidity and carry one of the highest mortality rates of any mental illness, in part due to the increased risk for suicide. Unfortunately, existing treatments for eating disorders often fail to achieve lasting remission or recovery, highlighting the need for improved intervention approaches to address identified risk and maintenance factors. Furthermore, as adolescence represents a key risk period for the development of these disorders, interventions that target or might be adapted for this age range are critically important.

Although eating disorder risk is undoubtedly multifactorial, experiencing traumatic forms of childhood maltreatment (ie, sexual, physical, or psychological abuse or neglect occurring before the age of 18 years) appears to increase risk for eating pathology. For example, studies conducted among individuals with eating disorders indicate elevated rates of childhood maltreatment relative to both healthy control groups and individuals with other psychiatric disorders,[1] with meta-analytic evidence indicating that the odds of having an eating disorder is 3·21 times higher among individuals who experienced childhood abuse compared with individuals who were not abused.[2] Although this body of literature primarily relies on cross-sectional or retrospective research designs in which individuals are asked to recall experiences from their childhood, existing longitudinal research supports a prospective relationship between childhood maltreatment and the emergence of eating pathology in adolescence and adulthood.[3] Overall, this work indicates that eating disorders are related to both sexual and physical maltreatment, but might be most strongly connected with emotional trauma.

Importantly, many children who are exposed to traumatic maltreatment do not develop eating disorders. Research indicates that the presence of post-traumatic stress disorder

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(PTSD) might especially increase susceptibility for eating pathology among young people who have been abused,[4] leading some researchers to suggest that difficulty coping with traumatic events (rather than the traumatic exposure itself) might function as the key precipitant of disordered eating.[5] PTSD might also promote continuation of eating disorder symptoms, with eating disorder behaviours (eg, binge eating) facilitating escape from unpleasant cognitive and affective states, including those associated with PTSD (eg, trauma-related thoughts and emotions).[6] Furthermore, PTSD appears to increase risk for comorbid psychopathology (eg, substance abuse, depression, borderline personality disorder, and self-harm behaviours) among individuals with eating disorders, resulting in a complex clinical picture that might negatively affect recovery rates and treatment response. Notably, some diagnostic systems delineate between PTSD (characterised by re-experiencing, avoidance, and heightened sense of threat) and complex PTSD (characterised by additional disturbances in emotion regulation, relationships, and self-concept). Although it is plausible that PTSD and complex PTSD might have differential relationships with eating disorders, there is currently a paucity of research examining this possibility. However, existing research does indicate that emotion dysregulation (ie, reduced ability to identify and adaptively respond to negative mood states), which is itself a feature of complex PTSD, explains the cross-sectional relationship between childhood abuse (in particular, emotional abuse) and eating pathology among adolescents.[5] These findings suggest that frequent abuse (especially verbal attacks on children's sense of wellbeing or self-worth, and criticism or minimisation of children's emotional experiences) might result in difficulties adaptatively responding to painful emotions, which might lead to eating disorder behaviours in an effort to alter or escape from these experiences.

Given this, treatment approaches that target symptoms of PTSD and emotion dysregulation in the context of eating pathology might hold promise for individuals with a history of abuse.[7] Recent work integrating empirically supported interventions for both eating disorders (enhanced cognitive behaviour therapy [CBT]) and PTSD (cognitive processing therapy) among adults suggests that integrated CBT might be more effective at reducing PTSD symptoms than eating disorder treatment alone while producing similar outcomes for eating disorder symptoms.[8] However, additional trials using larger samples are needed to confirm the efficacy of this approach and identify individuals for whom it might be most helpful. Furthermore, this treatment might need to be adapted for youth presenting with eating disorders and PTSD. Integrative cognitive-affective therapy (ICAT)[9] and dialectical behaviour therapy (DBT)[10] each target emotion dysregulation and appear to be effective at reducing both emotion dysregulation and eating disorder symptoms in adults. Limited data exploring DBT as a standalone or adjunct to family-based treatment for adolescents with eating disorders suggest that DBT might be a beneficial approach for this age group. Similarly, a small feasibility study (unpublished) examining a developmentally modified version of ICAT among adolescents with bulimia nervosa indicates strong acceptability and symptom improvement associated with this approach. However, the efficacy of DBT and ICAT among young people with eating pathology who have experienced trauma is currently unknown.

Given the apparent relevance of childhood trauma, PTSD, and emotion dysregulation to eating pathology in adolescents, eating disorder treatment providers should screen

for trauma history and consider addressing related factors (eg, PTSD and emotion dysregulation) as part of the treatment plan. Associated assessments such as the Childhood Trauma Questionnaire, Child PTSD Symptom Scale, and Difficulties in Emotion Regulation Scale are readily available. Integrated CBT for eating disorder and PTSD symptoms, as well as ICAT and DBT for elevated emotion dysregulation, appear to be useful tools in addressing eating pathology in the wake of trauma, but might need to be adapted for youth. Given the prevalence of childhood traumatic maltreatment among adolescents with eating disorders, greater attention to developing effective interventions for this population is critically needed.

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References

1. Molendijk ML, Hoek HW, Brewerton TD, Elzinga BM. Childhood maltreatment and eating disorder pathology: a systematic review and dose–response meta-analysis. Psychol Med 2017; 47: 1–15. [PubMed: 27624847]
2. Caslini M, Bartoli F, Crocamo C, Dakanalis A, Clerici M, Carrà G. Disentangling the association between child abuse and eating disorders: a systematic review and meta-analysis. Psychosom Med 2016; 78: 79–90. [PubMed: 26461853]
3. Johnson JG, Cohen P, Kasen S, Brook JS. Childhood adversities associated with risk for eating disorders or weight problems during adolescence or early adulthood. Am J Psychiatry 2002; 159: 394–400. [PubMed: 11870002]
4. Brewerton TD, Ralston ME, Dean M, Hand S, Hand L. Disordered eating attitudes and behaviors in maltreated children and adolescents receiving forensic assessment in a child advocacy center. J Child Sex Abuse 2020; 29: 769–87.
5. Trottier K, MacDonald DE. Update on psychological trauma, other severe adverse experiences and eating disorders: state of the research and future research directions. Curr Psychiatry Rep 2017; 19: 45. [PubMed: 28624866]
6. Trottier K, Wonderlich SA, Monson CM, Crosby RD, Olmsted MP. Investigating posttraumatic stress disorder as a psychological maintaining factor of eating disorders. Int J Eat Disord 2016; 49: 455–57. [PubMed: 26968858]
7. Brewerton TD, Trottier K, Trim J, Meyers T, Wonderlich SA. Integrating evidence-based treatments for eating disorder patients with comorbid PTSD and trauma-related disorders. In: Tortolani CC, Goldschmidt AB, Le Grange D, eds. Adapting evidence-based eating disorder treatments for novel populations and settings. New York, NY: Routledge, 2020, pp 216–37.
8. Trottier K, Monson CM, Wonderlich SA, Crosby RD. Results of the first randomized controlled trial of integrated cognitive-behavioral therapy for eating disorders and posttraumatic stress disorder. Psychol Med 2022; 52: 587–96. [PubMed: 34872625]
9. Wonderlich SA, Peterson CB, Smith TL, Klein MH, Mitchell JE, Crow SJ. Integrative cognitive-affective therapy for bulimia nervosa: a treatment manual. New York, NY: Guilford Press, 2015.
10. Safer DL, Telch CF, Chen EY. Dialectical behavior therapy for binge eating and bulimia. New York, NY: Guilford Press, 2017.