



THE RELATIONSHIP BETWEEN EATING DISORDERS AND TRAUMATIC EXPERIENCES IN ADOLESCENTS

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Abstract

The relationship between eating disorders and traumatic experiences is a complex and sensitive topic that has drawn the attention of the scientific community and mental health professionals over the years. This connection highlights how past traumas, such as abuse, neglect, or other painful experiences, can significantly impact an individual's relationship with food and their body, as well as their ability to regulate emotions.

Data obtained from research analysis indicate a statistically significant correlation between eating disorders and childhood traumatic experiences ($p = .001$; $p < .050$) and recent ones ($p = .040$; $p < .050$). A significant correlation was also found between traumatic experiences and emotional regulation capacity, both in terms of reappraisal and suppression. Individuals who have experienced trauma may struggle to reappraise their emotions and may tend to repress or ignore their feelings. This suggests that there is a link between a history of trauma and the development of eating disorders in adolescents and young adults. The interpretation of these findings indicates that childhood and recent traumatic experiences can significantly contribute to the development and manifestation of eating disorders in these age groups.

Keywords: *eating disorders, trauma, emotional regulation, recalculation, suppression.*

1. INTRODUCTION

Eating disorders are a major mental and physical health problem globally, affecting millions of people of all ages and genders. In particular, adolescence is a critical period when these disorders can appear and worsen, having significant consequences on the individual's physical and psychological development. At the same time, traumatic experiences in childhood and adolescence can have a profound impact on young people's mental and emotional health.

This paper aims to explore the relationship between eating disorders and traumatic experiences in adolescents, with the aim of gaining a deeper understanding of the risk and protective factors that contribute to the emergence

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and development of these disorders in this age group. By addressing this topic, we aim to contribute to increasing awareness and understanding in the scientific and medical community about the complexity and impact of these mental health issues.

Childhood abuse is a serious problem that can have profound and long-term consequences for an individual's emotional development. It can be defined as any form of abusive or negligent behavior by an adult or person in authority that causes physical, psychological or emotional harm to the child. Abuse can take many forms, including physical, sexual, emotional abuse or neglect.

Numerous studies (Groth et al., 2022; Anda et al., 2006; Felitti et al., 1998; Normal et al., 2012; Teciger & Samson, 2016) have highlighted the negative impact of childhood abuse on the emotional and psychological health of the individual in the long term. Among the effects of this phenomenon are: psychological trauma, emotional regulation difficulties, attachment problems, the cycle of abuse. Childhood abuse can affect a child's ability to regulate and manage emotions appropriately. These children may have difficulty expressing and managing their emotions, which can lead to self-destructive or dysfunctional behaviors later in life. Abuse can influence the development of a child's attachment patterns, affecting their ability to establish healthy and safe relationships in the future. Adolescents who were abused as children may be at increased risk of engaging in risky behaviors such as substance use, unsafe sex, or antisocial behaviors. There is a tendency for children who have been abused to become abusers in the future, thus perpetuating the cycle of abuse in later generations. Children who have been abused can develop profound psychological trauma, including post-traumatic stress disorder, anxiety, depression, and low self-esteem (Brewerton, 2009).

Parental verbal abuse, domestic violence, and sexual abuse appear to specifically target brain regions (auditory, visual, and somatosensory cortex) and pathways that process and transmit aversive experience. Maltreatment is associated with morphological changes in the anterior cingulate cortex, dorsal lateral and orbitofrontal cortex, corpus callosum, and adult hippocampus, and with enhanced amygdala response to emotional faces and diminished striatal response to anticipated rewards. Evidence suggests that these regions and interconnecting pathways have sensitive periods of exposure when they are most vulnerable. Early deprivation and later abuse may have opposite effects on amygdala volume. Structural and functional abnormalities initially attributed to mental illness may be a more direct consequence of abuse (Teicher & Samson, 2016).

The relationship between eating disorders and traumatic experiences is a complex and researched topic in psychology. Researchers have investigated several aspects of this relationship and developed theories that explain the connection between these two phenomena. One of the theoretical frameworks in this field is the theory of vulnerability (Brewerton et al., 2009). This theory suggests that people who have been through traumatic experiences may develop a vulnerability to eating disorders as a way to cope or control feelings of anxiety or discomfort. Trauma can affect the way a person perceives their own body and food, leading to the development of unhealthy eating habits.

In addition to vulnerability theory, self-regulation theory is also relevant (Brewerton et al., 2009). This theory suggests that people who have been through trauma may develop problems with emotional self-regulation. Eating disorders can become a way to regulate intense emotions or stress, providing a temporary sense of control and comfort.

There is also research that focuses on how eating disorders can serve as a form of self-victimization or self-punishment. People who have experienced trauma may develop feelings of guilt or self-deprecation and resort to dysfunctional eating behaviors as a way to punish or self-sabotage their own bodies (Hoek & Hoeken, 2003).

Contrary to the two mentioned theories, there is also research that emphasizes the fact that eating disorders and traumatic experiences can have a mutual impact (Brewerton, 2009). In other words, eating disorders may increase vulnerability to subsequent traumatic experiences, and trauma may exacerbate eating disorder symptoms.

People who develop eating disorders (EDs) experience a lack of control over their bodies and a lack of conviction to live their own lives. Childhood trauma and associated loss of control is considered a suspected underlying mechanism of TA, as TA symptoms are an attempt to regain control. However, some symptoms of TA involve criteria of a loss of control during binge and purging episodes. The meta-analysis by Smolak and Murnen (2002) identified similarities between lack of control present in traumatic experiences and TA symptoms. In addition, abuse victims have been found to lack perceived internal personal control and seek an external locus of control, which is related to TA symptomatology (Waller, 1998).

Kong and Bernstein (2009) named three broad traumatic experiences of loss of control as predictors of TA: emotional abuse, physical neglect, and sexual abuse. Emotional abuse appears to be the most prevalent traumatic experience among individuals with AD (Carretero-Garcia et al., 2012). However, emotional abuse typically accompanies other or multiple types of abuse. These traumatic experiences cause emotional distress and affective impairments, including depressed mood, low self-esteem, and generalized anxiety (Polivy & Herman, 2002), therefore emotional trauma that is frequently experienced with other types of trauma becomes important in the study of BP risk factors. The intense, overwhelming, loss of control, and sometimes intolerable emotions resulting from the types of trauma mentioned above have been found to influence disordered eating behaviors as coping mechanisms. Focusing on food disperses emotions from trauma to food and body shape. In addition, such individuals seek control over future traumatic events and associated emotions through food control. Thus, trauma, including neglect, physical abuse, and sexual abuse, is likely to be a risk factor for the development of AD (Polivy & Herman, 2002).

Childhood experiences of neglect (Dale, 2017) and sexual abuse (Wonderlich, 2001) are associated with emotional abuse and also related to disordered eating behaviors. Johnson et al. (2002) found that individuals who experienced physical neglect in childhood were more vulnerable to experiencing various types of eating and weight problems. Specifically, parental neglect due to insecure parent-child attachments has been shown to predict increased disordered eating behavior and

symptoms such as dietary restriction and concerns about eating, weight, body shape, and episodes of binge eating (Goossens et al., 2012). In addition, childhood sexual abuse (CSA) is linked to the development of TA (Wonderlich et al., 2007), which is understood because it is believed to affect identity and body image (Kearny-Cooke & Striegel-Moore, 1994). Thus, affected individuals have been shown to develop dissociative coping styles such as overeating (Perry et al., 1995) or seek to regain control by restricting food intake. Therefore, childhood sexual abuse and neglect have been identified as risk factors for BP.

To better understand this complex relationship, research continues to investigate the factors that contribute to the development and perpetuation of eating disorders in the context of traumatic experiences. Researchers have also explored intervention and treatment modalities that take into account the past trauma of patients with eating disorders.

2. OBJECTIVE AND HYPOTHESES

2.1. OBJECTIVE

From the desire to obtain more clarity regarding the relationship between eating disorders and traumatic experiences, in the present research, the aim was to identify the way in which traumatic experiences leave their mark both on eating behavior and on the capacity for emotional regulation.

2.2. HYPOTHESES

The hypotheses of the research were that there is a significant relationship between traumatic experiences and eating disorders, and that there is a relationship between traumatic experiences and the capacity for emotional regulation (recalculation and suppression).

3. METHOD

The assessment included, among other tools, techniques and methods used during the therapeutic process, the Eating Disorders Inventory-3 (EDI-3), the Childhood and Recent Traumatic Events Scale (ERQ).

The group of subjects was made up of 40 subjects, female patients, from the individual psychology clinic (aged between 14 and 18 years old), who presented with a specific symptomatology, showing dissatisfaction with their own body and their own eating behavior and which also presented a post-traumatic symptomatology.

4. RESULTS

Following the evaluation with the EDI-3, it was observed that most of the subjects obtained high scores for Desire to be thin (DS), Dissatisfaction with one's own body (NC), Low self-esteem (SSS), Emotional imbalance (DE) and Perfectionism (P).

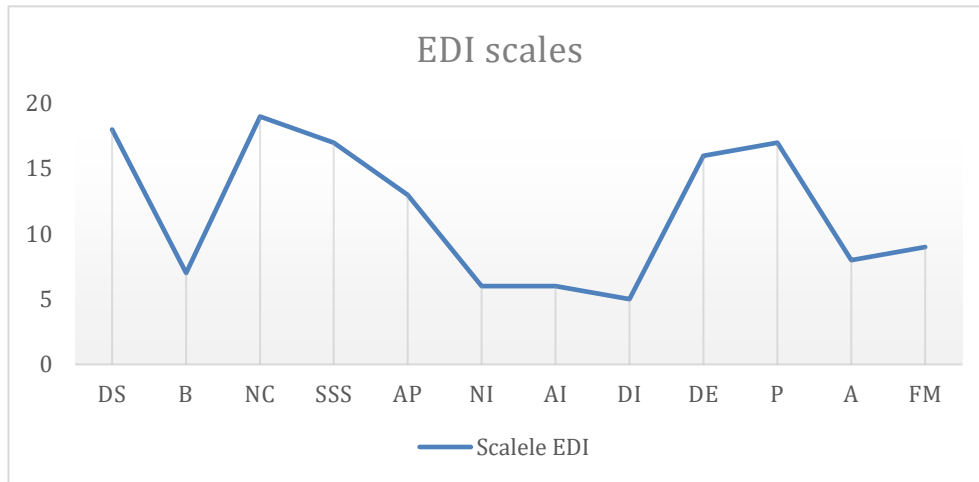


Figure 1. EDI scales for the entire research sample

The desire to be thin represents one of the basic characteristics of eating disorders and has been considered an essential diagnostic criterion, according to many classification systems. A high score on this scale indicates a strong desire to be thinner, preoccupation with diets, preoccupation with weight, and an intense fear of gaining weight. High scores on the body dissatisfaction scale indicate dissatisfaction with the shape and dimensions of some areas of the body, constituting a particular reason for concern for people with eating disorders. High scores for low self-esteem indicate feelings of insecurity, inadequacy, inefficiency, self-devaluation and the perception of the inability to reach one's own standards. High scores on perfectionism reflect rigorous personal standards of performance and demands for performance stemming from pressure exerted by parents and teachers during childhood. High scores on the emotional imbalance scale indicate a tendency towards mood instability, impulsivity, recklessness, anger and self-destructive behaviors.

Data analysis indicated a statistically significant relationship between two of the eating disorder specific scales, namely the desire to be thin and body dissatisfaction, and traumatic childhood experiences ($p = .001$; $p < .050$) and the recent ones ($p = .040$; $p < .050$).

Table 1. Relationship between eating disorders and traumatic experiences

Eating disorders	Traumatic experiences
<i>DS – desire to be thin</i>	$p = .001$
	$p < .050$
<i>NC – body dissatisfaction</i>	$p = .040$
	$p < .050$

The result of the analysis suggests a statistically significant relationship between two specific eating disorder scales, namely the desire to be thin (DS) and

body dissatisfaction (NC) and childhood and recent traumatic experiences. This means that there is a significant correlation between these variables. People who report higher levels of desire to be thin and dissatisfaction with their own body also have deeper traumatic experiences (from childhood or recent). In other words, there is a positive correlation between these dimensions of eating disorders and traumatic experiences.

Also, a significant relationship between traumatic experiences and emotional regulation capacity was reported. Traumatic experiences are significantly and negatively correlated with the recalculation dimension of emotional regulation, the correlation being equal to $-.534$, $p = .012$; $p < .050$, and their correlation with the suppression dimension of emotional regulation is significant and positive, being equal to $.632$, $p = .010$; $p < .050$. The results indicate a significant relationship between traumatic experiences and emotion regulation skills, with a focus on two aspects of emotion regulation: reappraisal and suppression.

Table 2. Relationship between emotion regulation capacity and traumatic experiences

Emotion regulation capacity	Traumatic experiences
<i>Recalculation</i>	Correl. Coeff. = $-.534$ $p = .012$ $p < .050$
<i>Suppression</i>	Correl. Coeff. = $.632$ $p = .010$ $p < .050$

Recalculation involves the ability to manage and change the dynamics of emotions in a healthy and adaptive way. The significant and negative correlation (-0.534 ; $p = .012$) with traumatic experiences suggests that individuals who have experienced trauma may have difficulty recalculating their emotions. In other words, these individuals may have trouble coping effectively and adaptively with intense or stressful emotions.

Suppression is another dimension of emotional regulation, but it involves inhibiting or ignoring emotions. The significant and positive result (0.632 , $p = .010$) suggests that people who have experienced trauma may use suppression as a strategy to cope with emotions. This means that these people may tend to repress or ignore their emotions, which is not always a healthy approach to managing emotions.

The data obtained from the analysis of the research data indicate a statistically significant correlation between eating disorders and traumatic experiences from childhood ($p = .001$; $p < .050$) and recent ones ($p = .040$; $p < .050$). A significant correlation was also found between traumatic experiences and the ability to regulate emotions, both in terms of recalculation and suppression.

People who have been through trauma may have difficulty recalculating their emotions and may tend to repress or ignore their emotions. This suggests that there is a link between trauma history and the development of eating disorders in adolescents and young adults. Interpretation of these findings suggests that

childhood and recent traumatic experiences may significantly contribute to the development and manifestation of eating disorders in these age groups.

The interpretation of these results could suggest that traumatic experiences can negatively influence emotional recalculation skills, that is, the ability to deal with emotions in a healthy way. At the same time, these traumatic experiences are associated with the use of suppression as a way of managing emotions, which can be unhealthy in the long term.

The results of the study suggest that the ability to regulate emotions is strongly influenced by traumatic experiences, which can lead to difficulties in managing and expressing emotions appropriately. This finding is consistent with the existing literature and emphasizes the importance of assessment and intervention in the management of emotional trauma in the treatment of eating disorders.

It is possible that the use of suppression as a coping mechanism for emotions is a common modality for individuals who have experienced trauma, and this may contribute to exacerbating eating disorder symptoms and impairing overall well-being. Identifying and appropriately addressing these behaviors can be essential in the management and treatment of eating disorders.

For the future, further research is needed to better understand the underlying mechanisms underlying the relationship between emotional trauma and eating disorders. Longitudinal studies could help clarify causal direction and identify protective and risk factors.

It is also important to develop and implement effective and tailored interventions for the management of emotional trauma and the treatment of eating disorders, including evidence-based therapies and primary prevention programs. A holistic and integrated approach could maximize the effectiveness of interventions and improve outcomes for individuals affected by these complex conditions.

5. CONCLUSIONS

Understanding the complex relationship between traumatic experiences and eating disorders is essential to the development and implementation of effective interventions in this area. A holistic and integrated approach is needed that addresses both the emotional trauma and the specific symptoms of eating disorders.

Early identification of trauma and implementation of healthy emotional regulation strategies can play a crucial role in the prevention and treatment of eating disorders. It is also important to provide adequate support and care for people with eating disorders, including access to specialist therapy and counseling services.

Future studies should further investigate the underlying mechanisms underlying the relationship between emotional trauma and eating disorders in order to develop tailored and effective interventions. Research should also explore innovative ways to treat and prevent eating disorders by integrating psychological, medical and social perspectives.

Raising awareness and educating the community about the impact of emotional trauma on mental and physical health is essential to promote

understanding and appropriate support for people affected by eating disorders and related trauma.

REFERENCES

1. Anda, R. F., Brown, D.W., Dube, S.R., Douglas Bremner, J., Felitti, V.J., Giles, W.H. (2006). Adverse childhood experiences and chronic obstructive pulmonary disease in adults. *American Journal of Preventive Medicine*, 34(5), 396-403.
2. Brewerton, T. D. (2009). Eating disorders, trauma, and comorbidity: Focus on PTSD. *Eating Disorders Journal*, 15(4), 285-304.
3. Carretero-Garcia, A., Planell, L.S., Doval, E., Rusinol Estragues, J., Raich Escursell, R.M., Vanderlinden, J. (2012). Repeated traumatic experiences in eating disorders and their association with eating symptoms. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity*, 17(4), e267-e273.
4. Dale, G. R. (2011). Eating disorders: Progress and challenges. *European Journal of Internal Medicine*, 22(2), 153-160.
5. Felitti, V. J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine*, 14(4), 245-258.
6. Goossens, L., Braet, C., van Durme, K., Decaluwe, V., Bosmans, G (2012). The parent-child relationship as predictor of eating pathology and weight gain in preadolescents. *Journal of Clinical Child & Adolescent Psychology*, 41(4), 445-457.
7. Groth, T., Hilsenroth, M., Boccio, D., Gold, J. (2020). Relationship between trauma history and eating disorders in adolescents. *Journal of Child & Adolescent Trauma*, 13(4), 443-453.
8. Hoek, H. W., & Hoeken, D. (2003). Review of the prevalence and incidence of eating disorders. *International Journal of Eating Disorders*, 34(4), 383-396.
9. Johnson, J. G., Cohen, P., Kasen, S., Brook, J.S. (2002). Childhood adversities associated with risk for eating disorders or weight problems during adolescence or early adulthood. *American Journal of Psychiatry*, 159(3), 394-400.
10. Kearny-Cooke, A., & Striegel-Moore, R. H. (1994). Treatment of childhood sexual abuse in anorexia nervosa and bulimia nervosa: A feminist psychodynamic approach. *International Journal of Eating Disorders*, 15(4), 305-319.
11. Kong, S., & Bernstein, K. (2009). Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders. *Journal of Clinical Nursing*, 18(13), 1897-1907.
12. Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis. *PLOS Medicine*, 9(11), e1001349.
13. Perry, B. D., Pollard, R.A., Blakley, T.L., Baker, W.L., Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and “use-dependent” development of the brain: How “states” become “traits”. *Infant Mental Health Journal*, 16(4), 271-291.
14. Polivy, J., & Herman, C. P. (2002). Causes of eating disorders. *Annual Review of Psychology*, 53(1), 187-213.
15. Smolak, L., & Murnen, S. K. (2002). A meta-analytic examination of the relationship between child sexual abuse and eating disorders. *International Journal of Eating Disorders*, 31(2), 136-150.
16. Sweetingham, R., & Waller, G. (2008). Childhood experiences of being bullied and teased in the eating disorders. *European Eating Disorders Review*, 16(5), 401-407.

17. Teicher, M. H., & Samson, J. A. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. *Journal of Child Psychology and Psychiatry*, 57(3), 241-266.
18. Waller, G. (1998). Perceived control in eating disorders: Relationship with reported sexual abuse. *International Journal of Eating Disorders*, 23(2), 213-216.
19. Wonderlich, S. A., Crosby, R.D., Mitchell, J.E., Thompson, K.M., Redlin, J., Demuth, G., Smyth, J., Haseltine, B. (2001). Eating disturbance and sexual trauma in childhood and adulthood. *International Journal of Eating Disorders*, 30(4), 401-412.
20. Wonderlich, S. A., Crosby, R.D., Engel, S.G., Mitchell, J.E., Smyth, J., Miltenberger, R. (2007). Personality-based clusters in bulimia nervosa: Differences in clinical variables and ecological momentary assessment. *Journal of Personality Disorders*, 21(3), 340-357.