Managing PTSD Symptoms Through Food (or No Food): Trauma, PTSD, and Eating Disorders

by Julie Trim, Ph.D.

Individuals with an eating disorder (ED) who report a history of trauma, or indeed, meet full criteria for post-traumatic stress disorder (PTSD), pose several challenges to the practitioner wishing to deliver evidence-based treatment. ED practitioners may have expertise in eating disorders, but few have strong training or experience with PTSD and associated comorbidities. Working with this subgroup requires specialized training in PTSD assessment and treatment. Diagnosing PTSD can be difficult in ED individuals because ED symptoms can "mask" or suppress PTSD symptoms, and PTSD symptoms can overlap with other psychiatric disorders such as major depressive disorder.

When an ED patient has PTSD, there are certain areas of sensitivity or conflict that arise in ED treatment and present additional barriers to success. The experience of a traumatic event can cause significant shifts in survivors' views of the world, self, and others. Disruptions in one's sense of safety, trust, power/control, intimacy, and self-esteem have been shown to be particularly salient in trauma survivors. Anecdotally, it is often these areas that pose additional challenges to treatment for the patient and the clinician alike. For example:

- Safety: In order to preserve a sense of safety, a person who experienced trauma may tell themselves that the trauma occurred due their body size or weight, and that being at a higher or lower weight will keep them safe from future traumas. ("If I hadn't looked a certain way, I wouldn't have been raped."). In fact, these types of self-blaming beliefs maintain or perpetuate PTSD.

- Trust: It is generally difficult for ED individuals to trust their treatment providers with regard to food, weight, and exercise recommendations. With an ED–PTSD patient, there are often additional barriers to trust given that interpersonal traumas (e.g., abuse or assault) often lead to a general distrust of others.

- Power/control: ED–PTSD patients often report feeling "in control" if they are able to make choices about their food and weight, and treatment typically involves letting go and allowing others (e.g., a dietitian) to influence these decisions. For ED–PTSD patients, this seems to trigger a strong pull to regain control and may lead these

patients to "dig their heels in" and refuse to follow their team's recommendations. Power/control issues may also emerge in intensive ED treatment settings, which are highly structured and supervised. The rules of the treatment center may lead ED–PTSD patients to feel extremely safe (i.e., one of the only safe places they have) or could be perceived as an unnecessary restriction of their rights, power, and control.

All of these sensitivities (i.e., safety, trust, and power/control) make sense given the patient's history. However, they can lead to a "bumpy road" in treatment and, in some cases, may result in dropout or premature termination from treatment.

ED-PTSD individuals can present with a range of diagnoses and behaviors. With respect to ED behaviors, binging and purging are typically more prominent than food restriction in this subpopulation. Researchers have speculated that overeating or binging becomes a self-soothing strategy for a traumatized individual, as these behaviors decrease emotional arousal and "numb" or suppress unpleasant feelings and memories. Purging serves a similar function, and can occur as a way to counteract an episode of binge eating. Outside of their ED diagnosis, ED patients with PTSD individuals tend to have significantly more comorbidities than those without PTSD; these include substance use disorders, mood disorders, impulse control disorders, and borderline personality disorder (BPD).

Formulating a treatment plan for a patient with an ED and PTSD is not easy, to say the least. ED practitioners are faced with complex questions: When to start PTSD treatment? What type of PTSD treatment to use? When to pause or stop PTSD treatment (if a problem arises)? Although research on the types of trauma experienced by individuals with EDs, comorbidity rates, and so forth is abundant, clear guidelines for treating ED-PTSD patients are lacking. ED clinicians are generally aware that trauma-related symptoms often represent a major obstacle to ED recovery, and yet clinicians are often fearful that starting PTSD treatment will trigger increased ED behaviors as well as other worrisome behaviors like self-harm, substance abuse, and suicidality. In a recent study by Kathryn Trottier, Ph.D. and colleagues, ED clinicians cited several barriers to providing PTSD treatment to their patients, including: (1) uncertainty about how to integrate trauma work with ED treatment, (2) lack of training in trauma-focused treatment, (3) institutional financial constraints, (4) not an institutional priority, (5) belief that trauma-focused treatment is a "long-term" endeavor, (6) preference for individualized treatment, (7) perceived readiness of the patient for trauma-focused work, and (8) concerns about psychiatric decompensation. Approximately half of participating clinicians anticipated at least four of these barriers, and 12% anticipated all eight.

Decisions about the treatment plan are fairly arbitrary given the limited research in this area. Possibly the least arbitrary—although still complex—is determining when the patient is ready for PTSD treatment. In some cases, other problems should be addressed prior to starting PTSD treatment (e.g., danger to self/others, safety concerns, and

psychological conditions that interfere with the patient's ability to receive or benefit from PTSD treatment), but PTSD treatment can be started as soon as these issues are resolved (Resick et al., 2014). Tim Brewerton, M.D., a prolific researcher in this area, argued that PTSD treatment should not begin until (1) the patient indicates a readiness to begin trauma work, (2) the patient is adequately nourished and able to process information emotionally and cognitively, (3) the patient's eating disorder symptoms are relatively under control, and (4) the patient has demonstrated an adequate level of distress tolerance.

Due to its clear structure in addressing multiple behaviors and treatment targets, Dialectical Behavior Therapy (DBT; Linehan, 1993) lends itself well to treatment with these patients. The DBT hierarchy monitors patient safety, minimizes behaviors that undermine or interfere with therapy, and provides a framework or "road map" for treatment. Melanie Harned, Ph.D., has developed a protocol for integrating Prolonged Exposure (PE; one of the four evidence-based treatments for PTSD) with DBT. The DBT PE protocol may not only enhance treatment effectiveness but also allow ED practitioners to feel less trepidatious delivering PTSD treatment to their patients. Furthermore, because many PTSD patients would like to be free of PTSD symptoms, making PTSD treatment contingent on elimination of higher treatment targets (i.e., life-threatening behavior and therapy-interfering behavior) can be a highly effective strategy for both reducing the severity of PTSD and meeting higher treatment targets.

To our knowledge, the Eating Disorders Center at UC San Diego is the only program in the country that provides evidence-based PTSD treatment for ED patients in a partial hospitalization program (PHP) or intensive outpatient program (IOP). In our Adult Program, patients can choose between Prolonged Exposure (PE) and another evidence-based PTSD treatment, Cognitive Processing Therapy (CPT). Post-treatment follow-up of patients who have participated in UC San Diego's ED+PTSD program have shown positive outcomes.