похудения) и личной выработки видения своего тела. И именно там происходит приписывание чрезмерно худым телам моделей и актрис положительных социальных, психологических и когнитивных характеристик. Таким образом, наблюдается прямая связь с общественными ожиданиями и правилами, а повышенное внимание женщин к их телам становится культурно и социально приемлемым. Это приводит к тому, что женщина вынуждена стремиться к определенным, порой труднодостижимым, стандартам красоты. Подобная неудовлетворенность может приводить к установлению нездорового пищевого поведения, а впоследствии перерасти в психические расстройства, в том числе и расстройства пищевого поведения и самоидентификации.

Психологические факторы расстройства пищевого поведения

Пациенты с расстройствами пищевого поведения часто демонстрируют социально-эмоциональные затруднения. Новые данные о социально-эмоциональных проблемах у людей с расстройствами пищевого поведения предполагают разработку дополнительных методов лечения, ориентированных на коррекцию этих трудностей, к ним относятся когнитивная ремедиация и тренинг эмоциональных навыков, а также модификация когнитивных предубеждений, а также интеграционная психотерапия, EMDR.

Люди с РПП сталкиваются со следующими психологическими трудностями: неспособностью самостоятельно принимать решения, сложностями с перенесением одиночества, ощущением опустошенности или беспомощности, чувство стыда, аутоагрессии, легкой ранимостью, подверженности малейшей критики или неодобрению со стороны. Как правило, случаи компульсивного переедания происходят в одиночестве, что приводит к последующим ощущениям отвращения к себе, вины, подавленности, так называемой "потери контроля". Это сказывается на психологическом состоянии: пациенты ощущают не самостоятельность, отсутствие воли, со-зависимым отношениям и схемам принятия жизненно-важных решений, выбора стратегии поведения. Когда же прием пищи оказывается в сжатых рамках, пациенты с РПП испытывают сильный дистресс, оборачивающийся мрачной раздражительностью, чувством неприязни к окружающим.

Наличие уже нескольких из этих факторов при клинической диагностике является поводом для оказания своевременной психологической помощи и поддержки пациенту, столкнувшемуся с данным расстройством.

Заключение

На сегодняшний день наблюдается недостаточное количество данных о патогенезе и развитии расстройств пищевого поведения. Исследование данных расстройств в областях генетики, эпигенетики, нейробиологии, эндокринологии, психологии и многих других областях могут помочь выявить механизмы, связанные с патофизиологией мозга, которые активно влияют на пищевое поведение данных пациентов. Появление новых данных и выявление все новых биологических маркеров будет активно способствовать более индивидуализированному, точному медицинскому и терапевтическому подходу в лечении расстройств пищевого поведения в будущем.

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No One is on My Side: The Role of Abuse in Eating Disorders

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Abstract

Eating disorders are considered some of the most difficult to treat and have the highest mortality rate of all mental disorders (Agras, 2001). Among them, anorexia nervosa is one of the psychiatric diagnoses with the highest mortality rate (Arcelus et al., 2011). In a longitudinal study conducted by Bulkin et al. (2007) from 1980 to 2005, it was found that

applying medication and working with behavior yielded inconclusive results (Openshaw, et al. 2004). If eating disorders were solely dependent on food, it would make sense that changing eating behaviors makes it easier to get out of the disorder. Unfortunately, however, this is often not the case. The clinical case presented here is a clear example of the relationship between eating disorders and trauma, particularly sexual, emotional, power, and physical abuse.

Keywords: eating disorder, anorexia nervosa, abuse, psychotherapy.

Socio-demographic data

In the United States, anorexia nervosa is now the third most common chronic disease among adolescent women, after obesity and asthma. In Spain, the latest studies coincide in pointing out a prevalence rate of cases of eating disorders in the adolescent population of around 4.1% - 4.5%.

The DSM-IV-TR (APA, 2000) established a lifetime prevalence of anorexia nervosa, for women at approximately 0.5% (DSM-IV-TR, 2000) and for men at approximately one tenth of that of women. The current DSM-5 (APA, 2013) reflects a 12-month prevalence of anorexia nervosa among young women of approximately 0.4% and specifies that it is less common in men than in women, maintaining the DSM-IV-TR (APA, 2000) ratio of 10:1.

The DSM-IV-TR (APA, 2000) indicates a prevalence of bulimia nervosa among adolescent and young adult women of approximately 1-3%, with a tenfold lower prevalence in men. This condition occurs mainly in industrialized countries and, within these countries, in females, with at least 90% of the cases constituting the DSM-IV-TR (APA, 2000) ratio of 10:1.

The DSM-5 (APA, 2013) indicates that the 12-month prevalence of binge eating disorder in adults (18 years and older) is 1.6% in women and 0.8% in men. Similarly, it indicates that the disorder is more prevalent in those who are seeking to lose weight than in the general population.

The lethality of eating disorders is the highest among those detected in psychiatric disorders. Specifically, anorexia is about 0.3%, bulimia is about 0.8% and non specified eating disorder is about 3.1% of the female population aged 12-21. If we consider the whole spectrum, taking into account the milder forms, the frequency estimate is much higher: between 11-16%.

Recent studies link posttraumatic stress disorder (PTSD) to eating disorders. They show results from approximately 75% of women in psychological treatment who suffered some form of trauma. Sexual and emotional abuse are the most common in these patients (Steiger et al., 2009; Chou et al., 2012; Burns, 2012; Grillo & Masheb, 2001). Identifying trauma and adverse life experiences in the biographies of these patients help to conceptualize the disorder and develop appropriate treatment for each case. In the treatment of eating disorders, attention continues to be paid to food behavior as a key part of treatment, however, with little effect. Usually, the reality of the problems with food lies in a patient's past, in the different traumatic events that force the person to survive around these problems. This case study shows how trauma and the different types of abuse that a patient suffers throughout their life are the basis of the severe disorder that they have suffered for years. Lack of attention by professionals to their traumatic history puts their lives at risk and, in turn, leads to abuse of power generated by the treatment itself. Through this case, it is expected to shed light on and improve the interventions with these patients, and to provide specialists with the ability to work with people suffering from these disorders to recognize the true origin of the problem.

This case study will show how trauma and abuse can be at the root of severe eating disorders. It will also demonstrate how a lack of attention on the part of professionals for a patient's traumatic past cannot only put a patient's life at risk but may also lead to power abuse

during treatment. It is hoped that this case will enable specialists to better recognize the true origin of eating disorders and to improve interventions.

Reason for consultation

A 29 years old patient requests a consultation to strengthen her social skills following recommendations from the eating disorder unit. She had been treated for 12 years of a severe anorexia nervosa. However, the problems with food continued, although the patient was already out of risk.

During the collection of history, the patient describes problems with food and her body since childhood; she tells how, in the first years of school, she was insulted referring to her weight. At the age of 13, she began to develop restrictive anorexia nervosa that lasted throughout adolescence and part of adulthood. Her medical history includes three suicide attempts for which she had to be admitted, and nine hospitalizations due to her underweight; she was fed by a probe because of her refusal to eat. Sexual abuse in childhood, emotional and physical abuse by the family and abuse of power appear in the different admissions where the patient describes the behaviour and treatment received from carers and professionals as traumatizing. The patient describes that during hospitalizations she was tied hand and foot to a bed facing the ceiling for a week as part of a treatment to get better. She describes how she was forced to eat food of inferior quality and how on one of her admissions her roommate fell to the floor and died instantly.

The first treatment was carried out in an eating-disorder unit during 12 years in which eating guidelines, behaviors, and medication were monitored; the family was consulted to ensure that the standards established by the professionals were met.

During the anamnesis something important happened which is worth mentioning since it is one of the keys to treatment: the patient's surprise reaction when asked if she had been sexually abused. She responded with surprise because she said it was the first time someone had asked her and that she was interested in knowing what had happened to her. Following this commentary, she was asked to describe, if possible, as much as she could about what had happened to her. She described sexual abuse in childhood from age 5 to 10 by a family friend. She says she tried to talk about the instances of abuse over the years. The first time she tries to count it was at age of 7 with her mother, but she excuses the abuser by associating his behaviors with his recent widowhood. She made a second attempt to tell about her abuse, this time to her therapist in the unit where she was treated. The response she got from her therapist was that the past was better left untouched because if she were to touch it, that would affect her behavior with food and nothing would change after that because the past is in the past.

From the second or third session, the belief that "no one is on my side", caused by accommodating the abuse as a result of years of helplessness in the face of unsuccessful attempts to ask for help, became clear. The syndrome of accommodation to child sexual abuse (SAASI) (Summit, 1983) describes a characteristic sequence of five phases: secrecy, helplessness, accommodation, late disclosure, and withdrawal, which is common in victims of chronic sexual abuse by close relatives.

The structure of submission and subjugation to life responds to accommodating the abuse and leaves a large imprint on one's inner experience of what the eating disorder is all about. The different types of abuse she suffered started early in life with bullying at school, sexual abuse, emotional abuse at home through guilt and emotional blackmail. She also tells of episodes of physical aggression in her family during her childhood, where on one occasion she asked for bread before eating and her mother, while making her feel responsible for her demanding attitude, put the crumb of bread in her mouth until she managed to make her vomit.

In the final stages of treatment, there was the abuse of power associated with the admission to the unit. She tells of episodes where she felt humiliated and disrespected., Experiencing great fear and confusion, without knowing what she had done to make them

take such aggressive measures. Once again she mentions to her family what it happens in the hospital with her but again "nobody took her side" and nobody did anything.

Objectives

The therapist and patient were able to formulate a number of treatment objectives as a guideline for the treatment plan:

- Encourage a secure therapeutic attachment relationship to promote trust.
- Stabilize and regulate on an emotional level as well as on a nutritional level.
- Cognitive, emotional and somatic resources for regulatory work.
- Promote healthy living habits; food, sleep, social skills, day-to-day activities.
- Process the different adverse situations and traumas resulting from the abuse suffered.
- Integrate the life circumstances associated to the belief; "nobody is on my side" and change for the belief; "I am by my side".

Intervention

The times in the hospital are a big piece of therapy work due to the aggressiveness of the patient's stays in hospital, the treatment she received there, and the complication of intravenous feeding due to her absolute refusal to eat.

In the beginning, the therapeutic treatment is focused on the therapeutic relationship in order to ensure that she can experience that someone is already on her side. Through bonding, all the work is reinforced. The importance of working with trust to start repairing the attachment and all the damaged by the traumas of betrayal, humiliation, and the fear of abandonment described throughout the collection of history as a result of experiences from the past.

As soon as the work in therapy starts, the abuse comes out very quickly, as the patient had been waiting for years. In the first moments, some stabilization work is done to calm down all the emotional pain that accompanies the abuse experiences she describes and the time in which they have been accumulated without the possibility to talk about it. Frustration and anger also arise from the disconnection from the pain, which the patient suppressed through the control of food and the various suicide attempts in order to stop the recurrent flashbacks she suffered over time, associated with situations that reminded her in one way or another of what she had experienced. The relationship of the eating disorder to the sexual abuse was obvious to the patient, she had always known it, but she had never been able to name it because she had never been given the opportunity to do so. This connected with a feeling of injustice and wasted time: years of a lifetime of illness that no one was going to give back to her because she had not been given the chance to be heard.

When the memories of the abuse started to pop up the family and the other professionals dismissed the therapy as invalid, alluding once again to the fact that it was not good for her to bring out all the traumatic experiences that she had inside.

The eating disorder, which was still there, her dissociated state, her attempts to suicide were not associated with the traumas she experienced in life and even she was not allowed to talk about them.

She continued in therapy and began the work of stabilization and regulation through resources like; safe place, learning to put limits, breathing, empowerment, grounding. She learnt self-regulation strategies and psychoeducation to identify the indicators of disconnection that may arise, somatic resource strategies that connect her to the present, and rooting. All of them are aimed at teaching her to use healthy strategies instead of resorting to food or food restriction as a way of regulating herself.

When stabilization is achieved, the work continued to focus on the behaviours with food. The disidentification of food as a safe haven was elaborated. The most phobic aspects of food associated with the food she was forced to eat for years because of her eating disorder are processed; the sensations, smells, textures, and situations associated with them, to which

she reacted, made her unable to eat and cook, complicating her eating habits and impacting her on a physical, family, and social level.

Being able to determine that she was in control of the sessions, that is, how far we could or could not go, was important to her as was the fact that she was able to locate an internal place where she could say, "I think it's been too much" or not. An attempt was made to expand her window of tolerance in working with trauma by respecting her own pace so that she would respect herself at all times in therapy. How far can she go and how far can she go before it gets too much and overwhelms her? Once the patient feels ready, work on all the traumatic events in her life can begin.

This intervention of elaboration of the trauma is conducted in three stages:

1. Sexual abuse: flashbacks, actual present triggers leading to abuse. The therapeutic bond as a reinforcement to feel the support of telling the trauma. Resources for calmness and awareness.

First, work began on sexual abuse because it is the most urgent; it constantly emerges through flashbacks and current life situations that trigger the trauma; situations, for example, in which she feels that people were not on her side connecting her with situations in which she wanted to tell what happened to her as a child, and her mother did not listen to her, and the abuse continued to happen. Just like when the abuser was abusing her in the living room while the mother was in the kitchen and didn't do anything to help her in that situation.

A trigger of the trauma was also that the therapist listened to her, which connected her with how unfairly she has been treated in her life. Once the work with this trauma began all the scenes of sexual abuse came to her. This part of the treatment was slow because it had to go very slowly in order not to exceed the window of tolerance.

2. Emotional abuse: guilt, attachment; the mother's blaming and denial.

An ambivalent mother who had difficulty showing emotions and maintains a cold relationship with the patient. Life situations in which the patient was blamed and in which guilt was used as a control strategy are processed as well as serious suicide attempts and associated guilt. When they wanted to control her in some way, they made her feel guilty. More importantly, guilt came much more often when she got sick because she was made solely and exclusively responsible for everything that happened to her.

The idea that she had broken her parents' lives is also addressed; messages she received and damaged her. The most complicated part was to see how all the complex trauma she suffered was neither seen nor understood as a child or as an adult. There were moments at the table with hours of dissociative experiences in front of a plate without being able to get up.

This part of the therapy associated with the emotional trauma was extremely important for the patient because a large part of the whole problem of social skills that was presented as a reason for consultation was related to the guilt experienced, with all the wounding of attachment: a denying mother who dedicated herself to never validating and to turning everything the patient did into guilt by not assuming responsibility of any kind, neither when she was wrong, nor validating when things were right.

3. Power. Abuse Very scary moments associated with being tied up in the unit, situations with the probe, disrespect, accusing her of lying and manipulation.

She had to work through all that she suffered in the unit when they tied her hands and feet, arguing that she was a dangerous person. She described how they kept her for a week experiencing extremely high levels of anxiety, staring up at the ceiling. These are painful situations for the patient because she describes how they were connected to the sexual abuse in which no one was on her side either.

This event represented another big moment of abuse and again her parents didn't do anything, didn't defend her with the hospital despite knowing that this unacceptable behavior was taking place.

The result of the treatment was most satisfactory. Once the complex traumas could be accessed and processed, the improvement was obvious. The patient was able to loosen control with food and the weight stabilized. The adjustment to the abuse that she was forced to endure throughout her life was repaired through trust and therapeutic bonding. The pattern of subjugation and submission that marked her lifeline as well as her relationship with others was repaired. Through therapy she learned to relate to others and to herself in a respectful way. Today she is a professional who is dedicated to the care of children with trauma and has created her own family. Her relationship with food is satisfactory although she continues to work on it.

Conclusion

This case example highlights the importance of abuse (physical, emotional, sexual, and power) in the development, maintenance, and treatment of eating disorders. During the clinical interview with this patient, specific questions should be asked about the different types of abuse. It needs to be established that they took place. Questions should also be included about uncomfortable glances or behaviors that may have been annoying, aggressive, or intimidating to patients. Addressing the abuse suffered is the cornerstone in the treatment of eating disorders. However, maintaining the window of emotional tolerance of the person that determines his or her ability to manage the work that has to be done in therapy with the different traumas associated with the abuse.

People who suffer from these disorders are often accused of lying and manipulation. This results in a negative view from health professionals to the patients. This negative view (for example; not trusting on the patient word, being irritable or with difficult attitude with the patient... prevent them from seeing the dissociative experience as a need to disconnect from everything inside them that they have not been able to express and that they have put into their food in their different diagnostic representations of eating disorders.

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