

Eating Disorders and Emotional Neglect: a Case Report

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ÖZET

Yeme bozuklukları ve duygusal istismar: Olgu sunumu

Yeme bozuklukları, yeme davranışlarında birçok sorunla seyreden, oluşumunda biyolojik, psikolojik, sosyal etkenlerin önemli olduğu psikiyatrik bozukluklardır. Kişilik özellikleri ve travmatik yaşantıların yeme bozukluklarının gelişiminde önemli rolü vardır. Psikiyatrik ek tanı ve travma öyküsü yeme bozukluğu hastalarında sık rastlanabilir, prognoz ve tedavi sürecini etkileyebilir. Travma öyküsüne bulimik hastalarda, bulimik olmayan hastalara göre daha sık rastlanmaktadır. Travma ile ilgili yapılan ilk çalışmalar cinsel kötüye kullanım üzerine yoğunlaşmış olsa da, daha sonraki çalışmalarda yeme bozukluklarında travma spektrumunun cinsel kötüye kullanımdan fiziksel ya da duygusal kötüye kullanım, ihmal ve ilgisizliğe kadar uzandığı anlaşılmıştır. Bu olgu sunumunda, gelişiminde psikolojik etmenler ve travmatik yaşantıların önemli olduğu anoreksiya nervoza (tıkının, çıkarıcı tip) tanısı alan genç kadın hasta aktarılacaktır.

Anahtar kelimeler: Yeme bozuklukları, travma, anoreksiya nervoza

ABSTRACT

Eating disorders and emotional neglect: a case report

Eating disorders are psychiatric disorders presenting various problems in eating behavior and have biological, psychological, social factors as important causes. Personality features and traumatic experiences have significant role in its development. Psychiatric comorbidity and trauma history are frequently seen among eating disorder patients and are important matters affecting prognosis and treatment course. Trauma history is more frequently encountered among bulimic patients than in non-bulimic patients. Although initial studies about trauma have focused on sexual abuse, later studies have demonstrated that trauma spectrum in eating disorders range from sexual abuse to physical and emotional abuse, neglect and indifference. In this case report, a young female patient diagnosed with anorexia nervosa (binge eating/purging) that psychological factors and traumatic experiences have significant role in its development, is presented.

Key words: Eating disorders, trauma, anorexia nervosa

DOI: 10.5350/DAJPN2010230207t

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Date of acceptance:
May 05, 2010

INTRODUCTION

Eating disorders are psychiatric disorders that involve a disruption in eating behaviors and are encountered more frequently among young women. Biological, psychological, social factors, personality traits and a history of trauma figure significantly in the development of eating disorders (1).

We know that an additional psychiatric diagnosis and a history of trauma are encountered frequently in patients with eating disorders and that these affect the prognosis and treatment process. Major depression, anxiety disorders, and personality disorders are the most common additional diagnoses (2,3). Moreover, the importance of trauma in the development of eating disorders has been emphasized and interest in the effect of post-traumatic stress disorder (PTSD) is

on the rise. Initial studies on trauma have focused on sexual abuse (4,5). In subsequent studies, the trauma spectrum in eating disorders has extended from sexual abuse to physical or emotional abuse, neglect, and indifference (6). In particular, domestic relationships, problems between parents, or trauma experienced by family members have been encountered frequently in the history (7) of eating disorder cases.

The relation between eating disorders and trauma can be summarized as follows (6):

- Sexual abuse is a non-specific risk factor for eating disorders.
- Many traumatic experiences, ranging from sexual abuse to emotional and physical neglect, are encountered in eating disorders.
- A history of trauma is encountered more often in bulimic patients than in non-bulimic patients.

d) Trauma frequency is also high in children and adolescents with an eating disorder.

e) Recurring trauma is linked to eating disorders.

f) Additional diagnosis is seen more frequently in eating disorder patients with a history of trauma.

g) Partial or subclinical PTSD may be a risk factor for eating disorders.

In this report, we present a patient whose follow-up care and treatment continues after a diagnosis of anorexia nervosa (binge eating/purging type) and in whom we consider emotional negligence and discord in family relations to have played a role in development of the disease. In this case, a traumatic experience in the family during puberty, negligence as a result of domestic conflicts, and rejection in a relationship with the opposite sex caused a decline in self-esteem, changes in body perception, and disruption in eating behaviors.

CASE

AA a 21-year-old female, born in Mersin, senior student at Istanbul University's Turkish Teaching Department, lives in Istanbul with her brother, their parents live in Mersin.

Her Complaints

The patient complained during admission that "The food I eat grows in my stomach. I eat and afterwards vomit uncontrollably. I want to vomit after every meal, this disease has surrounded my life like a spider web, I spend all my money on food." She stated that she had started to vomit after some meals about four years ago in order not to gain weight. She said that recently her complaints had increased significantly, that she spent all her money and time on eating and vomiting food, that she could not meet her friends for this reason, that her menstrual periods had been irregular for the last two years, and that she sometimes succumbed to pessimistic thoughts that she would never be able to recover from this disease.

Life story

AA is the second child of the family and has a

brother who is nine years older than her. After passing a university entrance exam, she came to Istanbul to live with her brother who also attends university there. When AA was born, her mother was 29 and her father was 34 years old and they both lived in Mersin. AA's mother and father met in secondary school, fell in love, and got married. Her mother and father are retired teachers. Her mother currently does not work, while her father is a classroom teacher in a private school.

Her mother does not have a history of pregnancy other than the two pregnancies. AA says that she was not conceived as a planned pregnancy, but was born willingly. She says that her mother and father do not have any problems and that there is no tension within the family. She said her father named her to match with her brother's name.

Her father was born in Mersin as the third of seven siblings. He is a high school graduate and works as a classroom teacher. AA says that her father grew up in a village, that he's a 'peasant'. Her paternal grandfather was one of the village leaders; since both her paternal grandmother and grandfather fell ill and passed away when her father was a baby, she never knew them. She described her father as 'stern and authoritarian'. Her mother always told her father that he is very selfish.

Her mother was born in Mersin. She was the second of five siblings. Her mother did not grow up with all her siblings: her youngest siblings, twin sisters, were born when she was eight years old. The twin sisters were given to AA's mother's aunt since the aunt did not have children; this decision was taken while AA's grandmother was still pregnant with the twins, who were then raised by the aunt. One of the twins calls both her biological mother and her aunt 'mother', while the other twin calls only her biological mother 'aunt'; this sister is not in good terms with her other siblings. AA's mother does not have any problems in her relationship with her own family. AA and her family live near her grandmother and get together with them very often. AA describes her mother as a person who "does not show her feelings much, but is self-sacrificing".

Infancy and childhood (ages 0 to 6)

AA was born mature in a normal birth in a hospital. According to her, her neuromotor development was normal. Her mother worked and therefore could only look after AA for forty days, after which she started to work in the school part-time. AA's grandfather looked after her and her brother until she started primary school. She said that she had a happy childhood without any problems. She remembers playing games outside with her friends from the neighborhood outside during her childhood. But she says she never played any games with her brother and that she has no memories of her brother.

School Age (ages 6 to 13)

She started school at the school where her mother worked, in her mother's class. The patient's brother went to science high school as a boarding student in the year she started primary school. AA learnt to read and write at the normal age. She said "My mother did not differentiate, at school she was my teacher. I sometimes also called her 'teacher' at home." She spent a happy time during primary school. The year she started secondary school, when her brother was in third year in medical school, he was investigated for about six months on the grounds that he was a member of an illegal organization. In that year, the police came to their house in Mersin to look for her brother and search the house. In the same year, her brother was caught and sent to prison. She says that troubles in her family began at this time, that her mother was in a 'mourning' process, so to speak. Her mother went nowhere except work, did not get together with her friends or go to meetings or weddings, never put on any make-up, and isolated herself from her surroundings, even from her family. AA said that her mother pushed her into the background and almost never cared for her during this period, and that her relationship with her mother ruptured after this period. AA became angry with and blamed her brother for putting her in such a situation. Her mother and father visited her brother frequently, but did not take AA with them in order for her not to be affected.

Adolescence (ages 13 to 21)

AA was not taken to visit her brother while he was in prison, but she exchanged letters with her brother often. Her brother wrote her about which books to read and what she must do to develop herself. She said "Even though my brother was in prison, he did a better job of raising himself, than I did raising myself." When AA was 15 years old, in high school preparatory class, her brother and his friends in prison began a hunger strike. They continued the hunger strike for 310 days. Some of her brother's friends died. Her brother did not accept treatment. AA said that her mother and father accepted that her brother would die and for this reason they took her to visit her brother for the first time. She stated that she was quite overweight at that time, while her brother was about to die, very thin and almost unable to speak. When her brother saw her, he told her that she had put on too much weight, and she joked that she wanted to establish the weight balance in the family. She described that period as the most overweight period in her life, she was 55 kilograms at the time and she said she could not stand being at that weight.

For summer vacation in that period, AA went to visit her aunt-in-law who had a stomach condition and vomited the food she ate voluntarily. Then AA also started voluntarily vomiting up the food that she ate during that summer vacation to avoid gaining more weight. She said that she vomited only to stop gaining more weight, rather than to lose weight. But after a while, she needed to vomit after eating and felt uncomfortable when she could not vomit. At this time, she entered her first year in high school and started to flirt with a boy from the same year in school. About three months later, her boyfriend wanted to break up with her for no reason, and a few days later she found out that her former boyfriend had flirted with her closest female friend. She described the girl as a 'slim, tall and beautiful girl'. She said that she felt very bad during this period, that she distanced herself from her school and all of her friends, and that her teachers noticed what was happening. A short time later, her unstoppable eating habit began and she drank about

one litre of water after every meal to be able to vomit easily. During this period she was at her slimmest (38 kg). Her mother did not know about her vomiting habit and the distance between her and her mother grew even larger, but her father cared very much for his daughter; AA said she and her father had a very good relationship. When AA was 16 years old, in the first year of high school, her brother gave up the hunger strike, accepted treatment, and her mother stayed in the hospital with her brother for a long time. Her brother got out of prison, took the university entrance exams and was admitted to the Faculty of Economics when she was in second year at high school. According to AA's statement, her mother moved out of her mourning process and started to meet people, go out, and put on make-up. AA was preparing to do the university entrance exam in the same period, and her family took very good care of her; she attributed this to the fact that her brother had gotten out of prison and that she was preparing for the exam. When AA was admitted to the Faculty of Letters, she moved in with her brother who was studying in Istanbul. She lived in the same house as her brother and his girlfriend, who used to be his lawyer when he was in prison. AA said "my brother and I could not tear down the wall that was between us". They did not talk at all in the house and ignored each other. She stated "we were like two strangers living in the same house." Her brother found out about her vomiting habit when she moved in with him and wrote a letter to her about it and left it in her room. In the letter, he said that he knew she blamed her brother for this disease, but that he was not the one to blame, that she must come to her senses and seek treatment.

Social Life

AA said that she had many friends, but none of them knew about her disease – she claimed she could not trust anyone enough to tell them about it. She said that she got along well with her friends, that people always noticed her and her friends considered her a very funny and witty person. But she avoided her friends and others around her when eating. Outside of

school, she spent all her time eating and vomiting at home and lay down after vomiting since she felt very weak. She could vomit quietly, her habit of vomiting was accepted by her brother and his girlfriend, with whom she lived.

Her first relationship was at 15 years old with a boy of the same age. Their relationship lasted about three months and was ended by her boyfriend. Her second relationship was with someone she knew from her hometown. This relationship lasted about six months and was also ended by her boyfriend. She said "I do not understand what is going on, but it may be that I cannot make time for my boyfriends because of my disease." AA did not have sexual intercourse during these relationships.

Personal History

She has her first menstruation when she was 14. AA first learned about menstrual periods from her friends. She said she was not scared when she had her first menstruation, that she knew the things she needed things and shared these with her mother. She has not menstruated for the last two years, and she said her menstruation was irregular before that.

Family History

No significant information.

Treatment Attempts

She sought psychiatric support for the first time when she was in her second year at high school, she was started on fluoxetine with some behavioral tasks; the dose was quickly increased to 60 mg/day. The patient continued treatment for a short time and then stopped treatment. When the patient first requested treatment, she had been using 40 mg/day fluoxetine. She had started by herself about three months earlier.

Psychiatric Examination

AA was 1.63 m tall, weighed 43 kg, took care of

herself, was slim-looking and her face was plumper than her body. She is willing to communicate and respectful, she makes eye contact and is cooperative, her amount and rate of speech was normal. Her affect was mildly depressive, her attention and concentration were adequate, her reality testing was intact, but her perception about her own body was distorted toward thinking that her body may be considered normal. No delusions or hallucinations were detected. Excessive preoccupation about eating and vomiting was present in her thought content.

In her thought distortions, there were selective abstractions such as 'No one likes me'; overgeneralizations such as 'I can't do anything right'; arbitrary inferences such as 'my relationship with my brother is bad because of my disease'; labels such as 'I am weak-minded'; and intermediate beliefs such as 'I must be the centre of attention among my friends', 'No one will ever like me if I exceed a certain weight'.

Laboratory Tests

RBC: 4,42x10⁶/mm³, WBC: 6000/mm³, Glucose: 75 mg/dl, Urea: 10 mg/dl, Iron: 32 µg/dl, Total iron chelation capacity: 450 µg/dl, TSH: 1.13 µIU/dl, FT4: 0.77 ng/dl, B12: 684 pg/ml, Folate: 5.3 pg/ml, Potassium: 4.66 mmol/L, Sodium: 140 mmol/L, Chlorine: 109 mmol/L were detected.

EEG was within normal limits.

Psychometric Examinations

MMPI: Medium depression, perfectionist personality traits, and sensitivity in interpersonal relations are the main characteristics of her profile.

RORSCHACH: Isolation in interpersonal relations and an insecure, fragile and self-effacing behavior are at the forefront. The person develops mature and close relationships and has difficulty sustaining them. Efforts to identify with the woman figure and conflicts experienced in this area are seen to be the dominant themes of the individual's inner world. A desire for co-dependency with the mother figure focuses the anger towards the mother, and she has great difficulty

separating, individualizing and forming an adult female identity. We observed that her relationships with the opposite sex are extremely limited and narcissistic thoughts about the body are quite intense. However, sexuality causes intense concern in the person; she has difficulty in dealing with this concern and uses her isolation mechanism.

Consequently, she was profiled as experiencing intense difficulties in separating from the mother, individualizing and developing a female sexual identity, exhibiting a quite negative self-perception and problems with impulse control.

She got 49 points (cut-off point is 26) on the Eating Behavior Test (8).

DIAGNOSIS

All these symptoms and findings were evaluated as anorexia nervosa (binge eating/purging type) according to DSM IV-TR diagnosis criteria. Her brother's hunger strike, her boyfriend's flirting with her closest female friend, and rejecting the mother's behavior were evaluated as the patient's psychosocial stressor sources (9).

DIFFERENTIAL DIAGNOSIS

As a result of the internal examination and laboratory tests, no disease connected to the general medical condition that would cause weight loss was detected. Bulimia nervosa of the binge eating/purging type was excluded on the grounds that the patient's weight was too low. A different diagnosis than weight loss due to depressive disorders was made because of the intense fear she felt about gaining weight, the accompaniment of amenorrhea, and lack of other depressive symptoms. Obsessive compulsive disorder was excluded on the grounds that the patient has no other obsessions or compulsions other than thoughts and behaviors about eating or food, the fear of gaining weight and feeling fat even though she is very thin. Although avoidance of eating is present within society, the diagnosis of social phobia was excluded since it does not necessarily entail low weight and does not include an intense fear

of gaining weight. Disruption of the body image in body dysmorphic disorder was excluded, since it is frequently related to a fallacy towards a specific part of the body (9).

DISCUSSION

The patient reported in this case had dependent personality traits and the perfectionist personality trait in the parents, especially the mother, was remarkable. The father figure was not as dominant as the mother, and the brother was a more influential male figure and who was obeyed at home. Personality traits and disorders are important in the formation of eating disorders. The meta-analysis of 28 studies conducted between 1983 and 1998 detected that a personality disorder accompanies an eating disorder in 58% of patients, and that B-cluster personality disorders (44%) and borderline personality disorder (31%) are seen more often in bulimia nervosa patients than in anorexia nervosa patients in this set of studies. In contrast, there is no difference between anorexia nervosa (45%) and bulimia nervosa (44%) with regard to C-cluster personality disorders (10). C-cluster personality traits and perfectionism were strong in the patient reported in this case.

We know that general and social factors (e.g., gender, culture), family factors (e.g., family obesity, parent psychopathology, family relationships, forms of communication); development factors (e.g., premorbid obesity, childhood period eating problems, pubescence and its problems, inappropriate comments about the body; childhood anxiety disorders); life incidents (e.g., physical and sexual abuse); psychological and behavioral factors (e.g., dieting, excessive preoccupation about the body, body dissatisfaction, low self-esteem, perfectionism, anxiety disorders, alcohol/substance abuse); and biological factors (such as genetic, neuroendocrine pathologies, EEG changes) are among the risk factors for eating disorders. But the exact factors at play and how the onset of psychopathology occurs are not clear (1). Many studies have shown that sexual abuse was related to binge-eating/purging behaviors in patients with eating disorders (4,11-13). In patients

with eating disorders who have a history of sexual abuse, there was a higher likelihood of development of symptoms of post-traumatic stress disorder (14). Although sexual abuse was not described in the reported case, emotional neglect was present during childhood. This situation was accepted by the mother, and the patient said, when she was asked about it, that she felt abandoned during that period.

Emotional abuse has begun to be considered as a factor in the psychopathology of eating disorders and it is now considered to be related to eating disorders, just like sexual and physical abuse (15,16). It is understood that emotional abuse negatively affects body satisfaction and lowers self-esteem in males and females (16,19). Furthermore, traumatic experiences and emotional abuse during childhood were reported to give rise to alexithymia, to affect emotional growth and cause body dissatisfaction and changes in eating behaviors (17).

In a study conducted with 62 female patients fulfilling the criteria for having an eating disorder, Ringer and Crittenden asserted that family relations and some unclear family problems play a role in the etiology of eating disorders and reported that in all patients, a family member had been exposed to a danger or had passed away, and that there were mother-father quarrels and a history of trauma in someone in the family in one third of the patients (7). There are also similar domestic occurrences in the patient in our case report. Domestic conflict, neglect, subsequent problems in relationships with the opposite sex, comparison of the body with that of others led to dissatisfaction with her own body, disruption of body perception, and a change in eating behavior.

CONCLUSION

Alongside many other factors, traumatic experiences during childhood and adolescence must not be ruled out in the development of eating disorders. In eating disorders, which are among the psychiatric disorders that are difficult to treat, detecting and processing traumatic experiences through interviews will improve the results of the treatment approach.

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