

Eating Disorders and Self-Induced Dissociation

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As counselors, we all know the symptoms of anorexia, bulimia, and binge eating disorder. We also know that many, if not most, individuals with disturbed eating patterns do not fall neatly into these diagnostic categories. We've worked with women who restrict severely, but still menstruate...men who binge and purge, but do not meet diagnostic quantity/frequency criteria for bulimia...women and men whose occasional binges disturb them, but generally have healthy patterns of food intake...and a host of other individuals whose eating and subsequent compensatory behaviors and/or thought patterns regarding food scatter amongst a variety of diagnostic categories.

I was reflecting on my work with students who struggle with eating disorders, and decided to write about what I believe to be a primary function of impaired eating patterns and the compensatory behaviors which often accompany them. This article is based on my clinical experience with eating disorders over the last ten years. It is not intended to be a research or literature based piece. I hope you will find it useful in your own work, perhaps as new ideas or validating your own clinical work.

There are so many hypotheses about what "causes" eating disorders. They all probably hold some truth, on some level, for some clients, at some point. There are the old ones such as enmeshment or emotional distance from parents, avoidance of sexual maturity or sexuality, chaotic or overly structured families, internalization of anger, a sense of emotional void within, and media influence. Some of the newer hypotheses have explored negative femininity (men or women who engage in negatively associated stereotypical feminine behaviors such as passivity, dependence, submission, and lower self-esteem), a culture of health and fitness, an explosion of diet and fitness "aids" (from water pills to steroids), and gender culture norms within heterosexual, gay, and lesbian communities.

Although I believe that understanding what caused an individual's eating disorder is important at some point, pinpointing those issues may be more interesting than necessarily useful in treatment. Events, issues, environments, and personality styles which cause and/or contribute to an eating disorder often seem more useful to understand when doing prevention than intervention work--whether that is initial prevention or relapse prevention. In my work, especially given the brief treatment time available to me in a college counseling center setting, I find that identifying the function of an individual's eating disorder is more useful to intervention.

Eating disordered behavior essentially is a coping mechanism, usually compensating for low self-esteem. And again, a whole host of events, issues, environments, and/or personality styles may have triggered that low self-esteem. The behaviors of an eating disorder--bingeing, vomiting, abuse of laxatives or diet pills, restricting, compulsive exercise--typically serve to distract, avoid, or alter an individual's experience of undesirable emotions. Typical avoided emotions are sadness, anger, and fear (which often shows up as anxiety and conflict avoidance). If one conceptualizes an eating disorder as a process of avoidance, it makes sense that the physical and emotional effect of the eating disorder behavior is dissociative in nature. In my experience, the most consistent experience of clients with eating disorders is that of emotional dissociation.

Clients who restrict their intake create a state of physical deprivation that dulls senses, slows cognitive processing, and impairs access to emotions. Clients who vomit create several different types of dissociation: sensory disconnection from the body in order to tolerate physical trauma to the GI system, cognitive disconnect from the responsibility of what they may have just eaten, and emotional disconnect from emotions felt prior to the purge. Vomiting over time also releases opiates and endorphins in the brain which, similar to substance abuse, can disconnect one from in-the-moment experience. Most of us feel a bit "spacey

after finding ourselves vomiting due to illness. Those who induce vomiting often create this sense of disconnection from self multiple times daily, creating somewhat of a chronic dissociation from their own feelings, senses, and

cognitive processes. Those who binge cause a slowing of cognitive processing as the circulatory system focuses on the stomach to help process food. Binges also cause abrupt changes in blood sugar which can create emotional highs and lows, further disconnecting the person from her/his body. Compulsive exercise, whether by intensity or frequency (or both), also can release endorphins which can have the same effect as mood-altering drugs, disconnecting one from in-moment experience. These are just some of the ways that some of the behavior of an eating disorder can create dissociation for clients.

An additional behavioral issue which often affects the disconnection between mind and body in those with eating disorders is sleep. Many clients with eating disorders experience sleep difficulty due to concurrent affective or anxiety disorders or the consequences of their eating disorder behavior on sleep, hormonal, and digestive cycles. Many college students suffer from sleep difficulties due to residence hall living, lack of self-care/discipline, and heavy study, class, and work schedules. Consequently, a college student with an eating disorder is particularly prone to sleep difficulties. Sleep deprivation can create a feeling of disconnection, often having the same effects that restriction of food can have. Long-term sleep deprivation can create a somewhat chronic dissociative state.

In my therapy work with clients, a primary part of my initial assessment is to explore with a client what effect their eating disorder behavior is having on their ability to stay present in their own bodies, tolerate difficult affect, and process cognitively (without distortion). Most are able to identify that their eating disorder is a powerful tool they use to disconnect from their bodies, feelings, and non-distorted thought processes. In other words, we focus on how the eating disorder is functional as a means of dissociation from self. More work follows, of course, figuring out what it is exactly that prompts each client to need to dissociate from self so dramatically. The longest term work with such clients is teaching them how to reconnect with themselves and making that process a safe one for them: building or strengthening their ability to remain present in themselves despite external concerns (people, places, events).

Relearning how to eat in appropriate portions, keeping one's food down, and not exercising to the point of exhaustion may all behavioral treatment goals for someone with an eating disorder. Essentially, they do not allow one to disconnect from body and mind. Instead, they create the experience of being in one's body and connected to one's emotions and thoughts. This is a goal we likely have for most of our clients, no matter the presenting concern. For individuals with eating disorders, creating this experience of connection with self is life-saving.

About the Author:

Dr. Laura Lyn is a graduate of the MA/PhD program in Counseling Psychology at Southern Illinois University at Carbondale. She is a licensed psychologist in Arizona, and is a Psychologist and the Training Coordinator at the Counseling & Testing Center of Northern Arizona University in Flagstaff, AZ. She has been a member of ACPA and CCAPS since 1992, and served on the Directorate from 1998-2001 on the Continuing Education committee. She was recently reelected to the Directorate for the term 2004-2007, and is serving on the Program and Elections Committees. Laura's professional interests include eating disorders, trauma, group therapy, diversity issues, and training/supervision.