

# THE BINGE-PURGE CYCLE AS A MEANS OF DISSOCIATION: SOMATIC TRAUMA AND SOMATIC DEFENSE IN SEXUAL ABUSE AND BULIMIA

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## ABSTRACT

*The relationship between childhood sexual abuse, dissociation, and bulimia in a sample of 65 bulimic women was investigated. It was hypothesized that the binge-purge cycle is used dissociatively in response to painful affects. The sample was divided into two groups, based on history of sexual abuse, and compared on demographics, and on level of dissociation as measured by the Dissociative Experiences Scale (DES). The phenomenological experience, purpose, and meaning of each phase of the binge-purge cycle was also explored. The entire sample was found to use the binge-purge cycle defensively, and marked alterations in affects characterize the phases of this cycle. Though DES scores between groups were not significantly different, phenomenological data revealed that the abused group was significantly more anxious and dissociative immediately after the binge. The binge-purge cycle appears to be a way that survivors of sexual abuse facilitate dissociation, numb feelings associated with the abuse, and keep dissociated memories and/or affects from consciousness.*

Case reports of clinicians have observed that the binge-purge cycle of some bulimic individuals either takes place during a dissociated state or actually serves to create a dissociated state (Chandarana & Malla, 1989; Demitrack, Putnam, Brewerton, Brandt, & Gold, 1990; Torem, 1986).

Despite differing theoretical understandings, several authors have reported the tension-reducing quality of bulimia, and have noted the bulimic's use of the binge-purge cycle to avoid fragmentation experiences (Brenner, 1983; Caspar, Offer & Ostrov, 1981; Goodsitt, 1983; Sands, 1991; Sours, 1980; Sugarman & Kurash, 1982; Swift & Letven, 1984).

The study reported here explores the role of dissociation in the binge-purge cycle of 65 bulimic women. The study tests the general hypothesis that dissociation is intrinsic to bulimic symptoms, and examines the potential defensive functions of bulimia as a dissociative process. In other words, this study contributes to an understanding of the binge-purge cycle by introducing the mediating variable of dissociation as the mechanism which allows for the management of untenable affects and disavowed affects related to past trauma that are triggered by events in the present.

## BULIMIA, DISSOCIATION AND HYPNOTIZABILITY

In order to develop an argument about the role of dissociation in bulimia, empirical research about the relationship between bulimia, dissociation, and hypnotizability will be noted. Beahrs (1982) and Watkins and Watkins (1981) have argued that hypnosis is merely a controlled state of dissociation. Bulimics are highly hypnotizable (Barabasz, 1991; Pettinati, Horne, & Staats, 1985; Vanderlinden & Vandereycken, 1990), and dissociative symptoms have been found among bulimics in empirical studies (Abraham & Beumont, 1982; Demitrack et al., 1990; Russell, 1979). Several clinicians (Chandarana & Malla, 1989; Sands, 1991; Torem, 1986) also suggest there is a connection between dissociation and bulimia. Hypnotizability declines with age, peaking in early adolescence (Ross, Ryan, Anderson, & Ross, 1989), so that during puberty, when self-hypnosis or dissociation becomes more accessible, bulimia may become a multidetermined, positively reinforcing, defensive "solution." Hypnosis has also been found to be useful in the treatment of bulimia (Barabasz, 1991, Torem, 1986, 1987; Vanderlinden & Vandereycken,

1990), further implicating the use of dissociation among bulimics.

### *The Adaptive Function of Dissociation*

While on one hand, dissociation is typically thought of as a symptom or a defensive process, there is also the adaptive aspect which should not be minimized. Dissociative defenses "allow individuals to compartmentalize and separate aspects of experience" (Spiegel & Cardena, 1990). This compartmentalization "helps individuals separate themselves from the full impact of physical and emotional trauma while it is occurring" (p. 4). Ludwig (1983) and others (Putnam, 1989; Spiegel, 1986) have found that dissociation plays an important adaptive role in dealing both with day-to-day stress and extreme trauma; it consistently occurs in response to severe psychic and/or physical trauma (Detrick, 1991; Herman, 1992; Putnam, Guroff, Silberman, Baran, & Post, 1986; Rost, Neuhaus & Florin, 1982). Further, some authors (Davies & Frawley, 1994; Liotti, 1992; Sands, 1995; Schwartz, 1995) have implied that dissociation is adaptive in that it allows severely traumatized individuals to develop and maintain attachments to traumatizing caretaker(s) as well as maintain relatedness to others.

Dissociation can be conceptualized on a continuum that ranges from "normal" dissociation such as daydreaming or "highway hypnosis" to the most extreme form of dissociation, Dissociative Identity Disorder (formerly Multiple Personality Disorder) (Ross, 1985; Watkins & Watkins, 1981). Dissociative Identity Disorder (DID) co-occurs with given histories of severe childhood trauma at least 90% of the time (Putnam et al., 1986). These trauma are primarily severe sexual and physical abuse.

In their research on multiple personality disorder, Ross, Norton, and Wozney (1989) found that 16.9% of 236 (MPD) subjects had been diagnosed with an eating disorder. Ross speculates that this is a "gross underestimate" of eating disorders in MPD – and finds eating disorders to be related to trauma disorders and sexual abuse in general, and to MPD in particular. He further speculates that this is so because eating disorders may provide specific dissociative mechanisms. Ross supports his contention with data from Goodwin and Attias (1988), who found that somatic memories and behavioral enactments of specific abuse incidents can underlie bingeing, vomiting, and purging. In other words, both incest survivors and bulimics are prone to dissociation (Courtois, 1988; Sands, 1991; Torem, 1986).

Just as some individuals cannot be hypnotized, some individuals are physiologically unable to dissociate (Van der Kolk, 1987) and must utilize other defenses to deal with trauma. There is speculation that those individuals who are unable to dissociate or "self-hypnotize" during trauma may become psychotic (S.Hanks, personal communication, December 8, 1989) or adopt alternative coping styles.

In the aggregate, these findings seem to suggest that, if

the binge-purge cycle can be shown to facilitate dissociation, then bulimia can be re-conceptualized as a "coping strategy." Though generally understood as dangerous and self-destructive to the physical body, eating disorders may thus also be creative and adaptive defenses psychologically when utilized in the face of overwhelming trauma. Therefore, in so far as the binge-purge cycle aids in dissociation, it can be understood as a general strategy for effectively, though temporarily, dealing with painful affects. Important to this point is the idea that dissociation can occur not only during traumatic events but also as an automatic response to the threatened re-emergence of residual trauma related affects, need-states, memories or conflicts.

### **SOMATIC BATTLEGROUND AND BOUNDARY ISSUES**

Since both incest and eating disorders are expressed behaviorally through the body and its physical boundaries, somatically expressed psychopathologies such as eating disorders may be employed to reflect early body trauma or regulate intolerable tension states experienced in the body. From this perspective, the acts of denying one's bodily needs, attempting to soothe the body, controlling what goes into and comes out of the body, or punishing the body, may represent ways that women with eating disorders symbolically address their life problems (Bruch, 1978; Root, Fallon, & Friedrich, 1986).

Some of these life problems have entered the psyche through the body. Using the language of Kohut's self-psychology, Sands (1989) understands eating disorders in part as a consequence of "distorted mirroring" (p. 101). Because sexual abuse is an extremely narcissistic use of the child's body, tremendous "distortions of mirroring" would also be experienced by a sexually abused child. Indeed, symptomatology resultant from trauma is increasingly being understood theoretically within the context of severe narcissistic or self-disorders (Schwartz, 1995; Smith, 1994).

Goldfarb (1987) speculates that the onset of puberty, with accompanying sexual feelings and the development of the female body, is a vivid reminder of the incest victim's original sexual trauma. Sexual development is also said to "trigger" the onset of an eating disorder (Bruch, 1973; Crisp, Kalucy, Lacey, & Harding, 1978; Crisp, 1980; Selvini-Palazzoli, 1974). Eating disordered patients' feelings about their bodies and sexuality seem to parallel much of what incest victims report. Both experience a variety of sexual difficulties, sex-role conflicts, distorted body image, and low self-esteem (Bruch, 1973; Boskind-Lodahl, 1976; Courtois, 1988).

### **SEXUAL ABUSE AND BULIMIA**

While a psychodynamic understanding of the relationship between a history of sexual abuse and the development

of bulimic symptomatology is proposed in the current study, no causal link between abuse and bulimia is suggested. Such a link has been a matter of controversy in the literature (Finn, Hartman, Leon, & Lawson, 1986; Pope & Hudson, 1992) and several authors (Folsom, Krahn, Nairn, Gold, Demitrack, & Silk, 1993; Kinzl, Traweger, Guenther, & Biebl, 1994; Rorty, Yager, & Rossotto, 1994; Welch & Fairburn, 1994) have now established that a history of sexual (as well as physical and emotional) abuse leads to a variety of psychiatric symptoms; bulimia is one, but bulimics are no more likely to have been sexually abused than are other psychiatric groups.

The study to be reported here provides a close analysis of the subjective experience of phases of the binge-purge cycle in 32 women with abuse histories and 33 non-abused bulimic women. The data implicate the powerful role of negative affect and dissociative processes for both groups, and suggest that bulimic behavior may be usefully understood as a complex sequence of defensive (coping) strategies with meaningful variation between abused and non-abused women.

## METHOD

### Subjects

A non-clinical sample of 65 women between the ages of 18 and 52 met the *DSM III-R* (1987) diagnosis for bulimia via telephone screening and a brief self-report measure. They were divided into two groups: thirty-two who self-identified as having been sexually abused as children, and thirty-three who reported no sexual abuse as children. Subjects were recruited through advertisements and flyers, and received and returned materials by mail.

Subjects in the sexually abused group were significantly older ( $M = 31.65$ ) than the subjects in the non-abused group ( $M = 26.78$ ;  $t = 2.21$ ,  $p = .03$ ). The two groups did not differ significantly on race, education, income, time in psychotherapy, sexual orientation, or parents' marital status. There were no significant differences between groups on the duration or frequency of bingeing, purging or bulimia. For the sample as a whole, the average duration of bulimic symptoms was ten years, while frequency of bingeing and purging ranged from two times per week to ten times per day.

There were no significant differences between groups on parental eating problems. The abused group reported significantly more maternal drug/alcohol abuse ( $X^2 = 9.20$ ,  $p = .002$ ), though paternal alcohol/drug abuse was not significantly different between the groups.

## MEASURES

### Demographic Questionnaire

Adapted from King (1985) and Esposito (1989), this form gathered information about demographics, duration, and severity of the eating disorder symptoms, and a brief sexual

abuse history. As this was a self-report measure, some subjects may not remember or wish to report sexual abuse; therefore, it is possible that some sexually abused subjects were grouped with the non-abused subjects. On the other hand, some subjects who suspected they had been sexually abused, but had not been, may have been grouped with abused subjects.

### Structured Questionnaire

A structured questionnaire asked about the subjective experience of disturbed eating behavior and the phenomenological meaning of the symptoms of disturbed eating. Participants were instructed to answer ten open-ended questions with an imagined narrative about *typical* thoughts, feelings, inner states, and body sensations at eight points during the binge-purge cycle.

*Rating of Subjective State.* Content analysis of these narratives made by independent raters yielded the following themes: 1) Anxiety; 2) Fragmentation; 3) Dissociation; 4) Negative Affect States; 5) Self-Hate; 6) Loss of Control; 7) Self-Soothing; 8) Gaining Control. The eight themes were collapsed into three broader thematic clusters for the purpose of quantitative comparison. The categories of self-soothing and gaining control were combined into one cluster, and negative affects, self-hate, and loss of control were combined into a second cluster. Because dissociation is thought to be related to extreme anxiety (van der Kolk, 1987), themes of anxiety and fragmentation were combined with dissociative responses to comprise the third cluster.

While the collapsing of the categories anxiety and dissociation may present some conceptual difficulty, the linking together of these states provides an important connection between Kohut's self-psychology and trauma theory. Fragmentation may be understood as anxiety in its most extreme form: somatically experienced and intolerable. Dissociation may be understood as a manifestation of fragmentation that "does away with" the unbearable affective or somatic experience (i.e., the anxiety state). As Herman (1992) notes, though a traumatically abused child may learn to banish knowledge of the abuse from her mind, bodily disruption continues on and bodily self-regulation can become severely impaired. It is well known that anxiety or fragmentation states can then be "managed" through tension-reducing somatically-oriented behavior like self-mutilation or binge-eating, which, it is proposed in this study, may then aid in the induction or maintenance of dissociation.

"Fragmentation" answers were those that conveyed intense or extreme anxiety or a sense of panic, as illustrated in the following examples: "I feel like I'm going to explode," or "I am usually very hyperactive and its very hard for me to settle down. I become overly nervous and find it difficult to concentrate. I find it difficult to control some of my body movements, such as stumbling when walking, drop-



ping things, banging into things."

Dissociative responses indicated depersonalization, numbing, or trance-like states. Examples are: "My mind begins to detach itself from my body," or "numb, I feel nothing," or "being completely tuned out to feelings or sensations other than the process of chewing food."

"Self-soothing" and "gaining control" answers indicated the person felt calmer, more relaxed or cohesive. Responses such as "I feel content" or "My body calms down and I feel relief" were scored as self-soothing.

"Negative-affect" answers were those that indicated dysphoria, self-hate, or loss of control. Responses such as "I feel like I'm bad, I'm depressed...feel shame," or "I feel totally disgusting, as if I deserve to die" or "lonely and trapped, no way out of this cycle" were scored as negative-affect responses.

Each subject's narrative was rated for presence/absence of the themes at specific points in the binge-purge cycle.

#### *The Dissociative Experience Scale*

The Dissociative Experience Scale (DES) (Bernstein & Putnam, 1986) was used to place each subject on a continuum of dissociative experiences and to compare group differences in severity of dissociation. The scale has been used to assess both normal and clinical populations and is designed as a trait measure of dissociation (Carlson & Putnam, 1993). It has good test-retest (.79-.96) and split-half reliability (.83-.93), and good internal consistency (.70) (Carlson & Putnam, 1993). This is the only measure of dissociation that has undergone replication studies (Ensink & van Otterloo, 1989; Ross, Norton, & Anderson, 1988; Strick & Wilcoxon, 1991) and has been found to discriminate people with MPD or Post-Traumatic Stress Disorder from other groups of clinical subjects (Bernstein & Putnam, 1986; Ensink & van Otterloo, 1989; Ross et al., 1988). Scores over 30 appear to reliably indicate dissociative pathology (Demitrack et al., 1990; Ross et al., 1988). Several studies using the DES among normal populations have been conducted (Ross, Ryan, Voigt, & Eide, 1991; Strick & Wilcoxon, 1991) and although a normative mean DES score for "non-dissociative" individuals has not been established, scores between 4.4 and 6.4 are reported in the general population. Studies with eating disordered individuals find average DES scores range between 12.7 and 17.8 (Carlson & Putnam, 1993).

#### *Data Analysis*

Descriptive statistics were calculated on all variables, in order to furnish a quantitative description of the sample and to establish a rich portrait of the binge-purge cycle.

In addition, a series of t-tests and X<sup>2</sup> tests evaluated the differences between women with a history of sexual abuse and those without such a history. The two groups were compared on themes of the binge-purge cycle, demographic

information, family history of drug/alcohol abuse, eating disorder symptoms, and level of dissociation.

## RESULTS

### *Dissociation, Negative Affect and Self Soothing in the Binge-Purge Cycle*

This section reports the frequency of anxiety and dissociation (Figure 1), negative affect (Figure 2), and self-soothing (Figure 3) at eight points during the binge-purge cycle. The figures allow the reader to follow those phenomenon stage by stage. Illustrative quotations from some subjects bring the subjective experience of the cycle to life.

#### *The Beginning of the Binge*

Seventy-seven percent of the sample report that in the moments before they begin to binge eat they feel some form of anxiety or negative affect. Typical responses were "Upset, angry, hurt, shame. A feeling of who cares anyway?" or "I'm usually depressed, scared or lonely before I binge."

When asked how they imagined they would feel if they were somehow prevented from the binge in those moments prior to the binge, 84.6% said they would feel some form of anxiety or negative feelings. Thirty-eight percent report that they would feel extreme anxiety such as "panic." One woman reported, "Too overwhelming, almost self-destructive state. No escape from feelings that would surface."

Once they begin to eat, the participants begin to feel much better. Only 3% report any symptoms of anxiety, while 46% report feeling soothed, relieved, or calmed although the soothing is transient and drops off at the end of the binge. Thirty-three percent report feelings of depersonalization, derealization, and/or numbing. Some typical responses are: "I really stop thinking about anything besides the food," or "Anxiety and tension goes away...it's a release," or "My body definitely goes on automatic pilot - no feelings, no cares, just eat."

#### *The Binge*

In the middle of the binge, about half (51.5%) the respondents feel both dissociated and soothed. At this stage the predominant feeling is still one of either numbness or relief. "I have no thoughts. I am totally unaware of anything but putting food in my mouth when I'm in the middle of a binge," reports one woman. Another says, "Nothing. Just peacefulness of the absence of feeling. Deep breaths."

When asked to imagine their thoughts and feelings if they were to stop eating in the middle of a binge, 67.6% reported they would feel anxiety or negative feelings. Some women (10%) would be pleased if they stopped themselves, and would feel an increase in self-control, while others mentioned the anger they would feel if they were stopped by another person. A typical response was, "Totally impossible to imagine...but, I imagine, panic - how am I going to get

FIGURE 1  
Prevalence of Anxiety and Dissociation During the Phases  
of the Binge-Purge Cycle

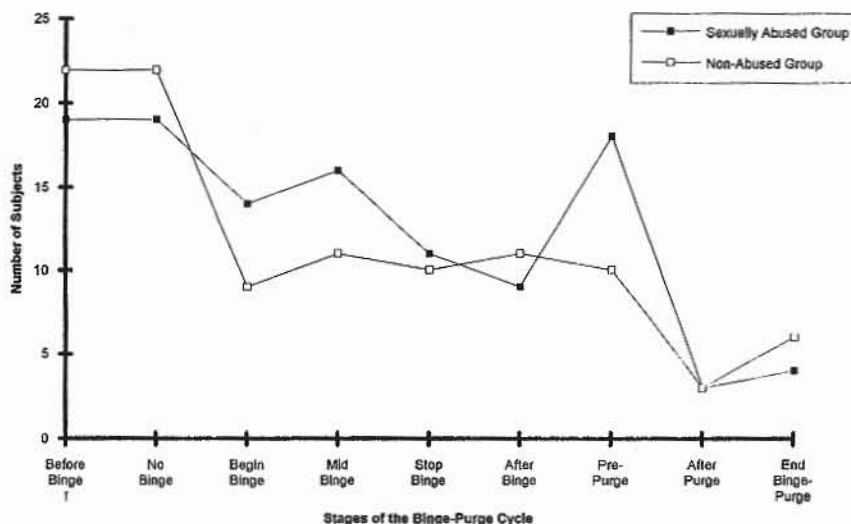
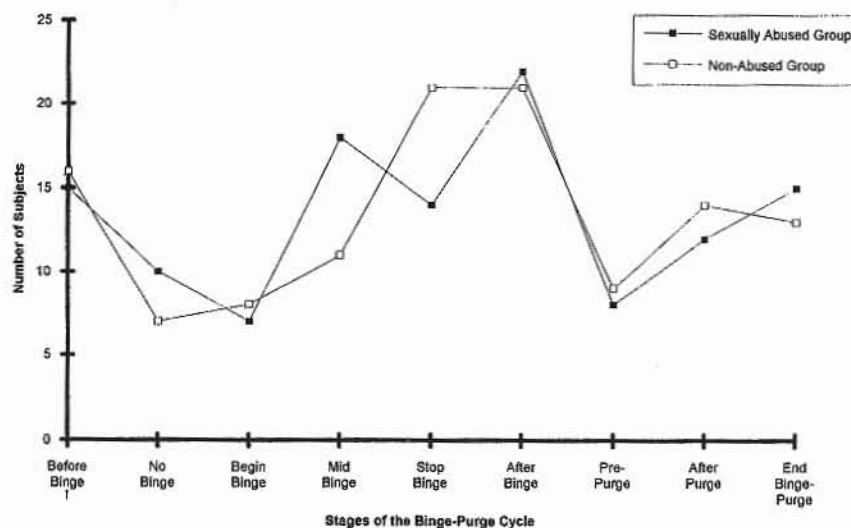


FIGURE 2  
Prevalence of Negative Affects During the Phases  
of the Binge-Purge Cycle



rid of these calories? *Fear* – shit, I shouldn't have started. Internal reprimand: This is weak. More than anything, *extreme* need and want and lust and craving for the rest of the food."

#### Between Binge and Purge

At the end of the binge, prior to the purge, 63% of the women felt an increase in negative feelings such as guilt, shame, disgust, fear, and/or intense self-hate. For some women these affects persisted throughout the binge, and increased sharply once they had finished eating. Only 7% felt better at this point of the cycle. One woman writes, "I get very angry like I don't have any control or any self-restraint. I feel fat and very ugly. I feel like an animal." Another says, "Scared of all the food in my body – I feel fat. Usually feel suicidal to some degree. Angry I've binged again!"

Subjects vary in their responses to how they feel in the moments before the purge, but 32% report feeling anxious to get the food out of their bodies, and anxious about the self-destructiveness of purging. Thirty percent feel soothed, largely because they feel in control and will not suffer weight gain as a result of the binge. It is notable that, at this stage, not one woman reported feeling out of control. Typical answers to this question are, "I feel relieved that there is a way out of the uncomfortable physical sensations. I feel relaxed and relieved the binge is over. I also feel shame that I am such a bad person to have devoured large quantities of junk food." or "I feel relieved, any guilt I have been feeling begins to pass but I become more anxious to get rid of the food."

#### After the Purge

After the purge, 65% report feeling relieved, soothed, and/or in control. Only one person reported feeling any signs of anxiety. The women expressed their feelings clearly, "I have energy though sometimes my body feels numb. Mentally I feel good and ready to face the day"; "Relief of built

up tension"; "I feel cleansed and pure and light. My mind forgets about any real ailments or pain in my life and I just want to sleep."

As time passes after the purge, the participants begin to experience conflicting feelings. Along with the relief they feel after a binge, they begin to be aware of remorse, self-hate, and dysphoria mostly related to the bulimia itself, much as they feel just prior to the purge. Forty-one percent report feeling soothed at this point in the cycle, while 33% feel negative feelings. One woman reports, "Can be very different reactions. Body usually feels relaxed, some lingering pleasure (like after an orgasm) - I'm usually pretty chipper, a little excited, at a distance from people, so free. I might be depressed or feel some shame in some cases, but not usually."

In some cases, the symbolic meaning of the purge is obvious. As one participant wrote:

It was a way to barf my brother's evil advances right up and out of my tortured mind and body. Of course, it didn't help to have parents who refused to believe me — but when the abuse stopped, the frequency of purging was greatly reduced.

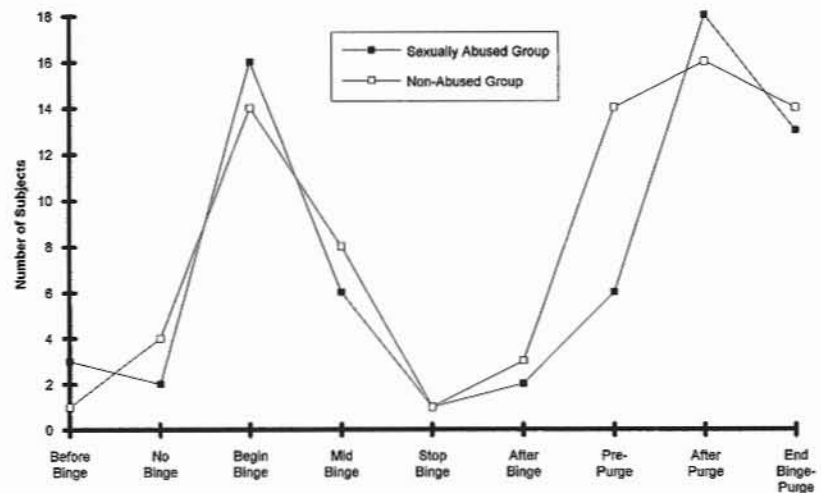
The secretiveness and shame which surrounds vomiting or laxative abuse seem to reinforce feelings of low-self esteem and worthlessness.

Finally, when asked if they feel any different at the end of the cycle than they did prior to binge eating, 95% reported they did, and 71% felt soothed, calmed and better than they did before they began, despite whatever feelings of guilt or shame or self-hate the bulimic episode precipitated. One participant understands the difference in the following way, "I forget whatever feelings were haunting me and I focus instead on the guilt of bingeing and purging." Others state the difference simply, "I feel anxious before and don't feel anxious afterward," or "Feelings of emptiness, depression, anger and frustration much diminished. A feeling of being renewed."

For many women, being in control and having "completed" the task seems to lead to feelings of calm. For others, the punishment and self-abuse they have inflicted during the purge seems to be satisfying:

I feel cleaned out, calm and renewed and strong enough to start life fresh. I feel satisfied with

FIGURE 3  
Prevalence of Self-Soothing During the Phases of the Binge-Purge Cycle



myself...

I feel tired but happy like I'm high. I look and feel like I'm sick, but I feel like I won...

Relief that its all over. A sense of accomplishment, completion. Shame...

During the purge I get a strong feeling of relief, it feels like punishment, or torture, it feels good to be punished because I feel like a bad person. I hate that I abuse myself this way, but I feel I deserve it. I also feel loveable because I know I'm not gaining weight. I feel a sick sense of satisfaction that I abused myself. I have a fantasy that someone will rescue me before I go too far, but feel I deserve the punishment...

At the end of the cycle, when the momentary feeling of wholeness, of calmness and externally induced soothing is fading, anxiety begins to mount and a need to repeat the process gets underway.

#### DIFFERENCES BETWEEN THE GROUPS

A significant association between anxiety/dissociation and sexual abuse history was found at the point of the cycle when the binge has ended and the purge has not yet begun. More of the women in the sexually abused group felt anxious and dissociative at this point in the cycle ( $X^2 = 4.46$ ,  $p$

= .04) than did the non-abused group. Not surprisingly, the sexually abused women also experienced self-soothing significantly less often ( $X^2 = 4.8$ ,  $p = .03$ ) than the non-abused bulimics at the pre-purge point of the binge-purge cycle.

There were self-soothing themes in only eight of the 32 abused group's responses, while 17 of 33 non-abused women's responses were self-soothing. In addition, the non-abused women found the binge to be helpful to them because it "fills them up" significantly more ( $M = 4.3$ ,  $t = 1.4$ ,  $p = .009$ ) than did the abused women ( $M = 3.9$ ).

These data suggest that, although the binge may provide an altered state, once it comes to an end the abused women have greater conflicts about having filled themselves, and perhaps greater urgency to get rid of the food. Examples of abused women's descriptions of this point in the cycle:

After a binge but before a purge I feel desperate and anxious. Hoping I can find a time I can purge without being caught. Waiting for my roommate to leave...

Thoughts: You are worthless! You have done it again! You are fat! You must get rid of this food! You can not get fat. Why did you do this again? Feel depression, panic, anxiety and guilt...

Examples of non-abused women's descriptions of this point in the cycle:

I begin to feel back in control. I feel fatter, but I feel as though I'm back on track. I feel more optimistic, that I can change my behavior...

I feel calmer, taken care of. I feel as if everything will be alright at some point. Uneasy, but focused on my mission to purge...

Several participants in each group felt purging was an expression of anger, but significantly more of the abused women saw it as "secret" ( $t = 2.2$ ,  $p = .03$ ) and "sick" ( $t = 1.6$ ,  $p = .04$ ). These brief responses exemplify how much more anxiety the sexually abused women feel about having "taken in" excess food.

## THE DISSOCIATIVE EXPERIENCES SCALE

For the 65 women in this study, the median score on the DES was 22.5; a median this high provides evidence of considerable dissociation among bulimic women. Previous studies have shown that DES scale scores of 30 or greater reflect "significant dissociative pathology" (Demitrack et al., 1990; Ross et al., 1988), and, as previously mentioned, scores of about 12-17 were reported among those with eating disorders

(Carlson & Putnam, 1993). Scores on the DES were not significantly different between abused and non-abused women in the present sample (abused group mean = 25.90, non-abused group mean = 20.32,  $t = 1.55$ ,  $p = .126$ ).

## DISCUSSION

Based on the data from this study, binge eating and purging can be conceptualized as a set of behaviors that facilitate or maintain a dissociative response to fragmenting affects, needs and memories, including those related to sexual abuse.

### *The Use of the Binge-Purge Cycle as a Dissociative Defense*

An essential component of hypnosis or other dissociative experience is the capacity to focus attention on the hypnotic stimulus. As the descriptive data show, in the binge-purge cycle, the individual narrows her attention and focuses only on the overeating, which she then "controls" by purging.

Participants repeatedly mention that during the binge, "nothing exists but the food." As in other reports (Sands, 1991; Torem, 1986), the women in this sample describe this narrowing of focus as a trance-like state, a form of auto-hypnosis in which eating food, with all its multidetermined symbolic meanings, transports the individual into an altered state. This state is described in the following way by two participants:

Once I begin to eat I feel very relieved. My body relaxes and I no longer have to deal with any outside problems. My focus is entirely on cramming as much food into my mouth as possible...

I tune out the feelings, I go into a numb state. Time passes very quickly. I can use up a day or an evening easily by just bingeing and purging...

However, the data suggest that abuse history (as measured in this study) does not necessarily lead to more severe bulimic symptomatology nor more use of bulimia for dissociative purposes.

### *Affect Regulation and Dissociation*

Fink (1988) finds that "mistrust of self-affectivity is a cornerstone of dissociative pathology" (pp. 45). Referring to survivors of trauma, Fink reports that, if the developing child is not allowed to learn to distinguish or trust her own emotional states, or to define them as part of herself, then she is left with difficulty in managing affect, and emotional arousal becomes a disintegrating experience. To avoid this disintegration, emotional arousal is met with dissociation. Krystal (1978) reports that when affects herald traumatic states, the individual must dissociate those affects or encapsulate them via behavioral enactments. This description is



also accurate for many bulimics; feelings are experienced as overwhelming and fragmenting (Sands, 1991). The bulimic, who is ill-prepared to deal with affective experiences, can turn to the binge-purge cycle in hopes of re-integration.

The dissociative aspect of the cycle – the numb, depersonalized state attained through the intense narrowing of focus and heightened concentration on the task of binge eating and purging – seems to be one way that affects can be regulated. Others have noted this function (Abraham & Beumont, 1982; Brenner, 1983; Goodsitt, 1983; Johnson & Larson, 1982; Steere, Butler, & Cooper, 1990), and the findings of the present study lend additional support.

### GROUP DIFFERENCES IN SUBJECTIVE EXPERIENCE

At the end of the binge and prior to the purge, the groups diverge. Significantly more of the sexually abused group feel anxiety and self-hate, while significantly more of the non-abused group feel soothed, in control and calmed. This difference may suggest that a concern with body boundaries (what goes into and comes out of the body) may be more salient to abuse survivors. If so, at this stage the experience of having been “filled” may not be as pleasurable to them.

The greater self-hate, anxiety, and distress that sexually abused women feel at the end of the binge may also be explained by disrupted object-relations. The act of having eaten, of having experienced symbolic ties to a care-giver, of having been nurtured, of having attempted to meet split-off needs, may be more fraught with anxiety for abused bulimics. Abuse-related enactments of forced feeding, body intrusion or pregnancy fears may trigger anxiety in this group. For these women, split-off needs for protection, soothing, affect-attunement or comfort may be activated and only met temporarily through the binge. Once the dissociation of the binge-eating is over, residual intense feelings of abandonment and disappointment may threaten.

### TOWARD A DEVELOPMENTAL CONCEPTUALIZATION

Now that the links between sexual abuse, dissociation and bulimia are clearer, it is possible to place this set of connections within a theoretical understanding. Fink (1988) finds that dissociative disorders can be explained as difficulties in early self development which later become “splits” in the individual’s psyche. Ego states – systems of thoughts, behaviors, and experiences organized around a common principle (Watkins & Watkins, 1981) – are normally separated from one another by permeable boundaries. In the bulimic, as in others with dissociative pathology, the boundaries between these states may have become more rigid and less permeable, and therefore more difficult to access. As Sands (1991) proposes, the achievement of an altered state may allow the bulimic access to another aspect of the self –

an aspect that is dissociated from the core self except during the bulimic cycle. This “bulimic self” is a more regressed, primitive aspect, but as Vanderlinden and Vandereycken (1990) put it, the part of the self that provides protection and support. Nurturance and self-soothing take over, so that, for a brief period, the bulimic woman allows herself a state of “oblivion” and fleeting or momentary experiences of integration which are highly pleasurable. The women in the present study describe an experience that seems much like what happens to a baby whose eyes become glazed and whose body relaxes while being fed.

Additionally, the women who report sexual abuse also report greater maternal substance abuse – another likely environmental deficit which may contribute to a disavowal of needs for caretaking, the development of omnipotent defenses and the conflictual response to binge-eating.

If the individual had ready access to the aspect of the self which could provide soothing or protection, as she would in normal development via internalization of the soothing function of the care-giver (Tolpin, 1972), then she would not so urgently need to binge eat in the face of strong feelings which trigger anxiety. The difficulty in dealing with stress, and the tendency to become fragmented is “solved” in several ways by bingeing and purging.

### LIMITATIONS

The differences found between sexually abused and non-sexually abused women cannot be fully explained by this data. As in all research on sexual abuse, the matter of memory and self-report makes it impossible to know if two distinct groups were used. The significant age-difference between the two groups may have contributed to the findings in unknown ways. The sexually abused group may suffer from a greater degree of self-destructive symptomatology and depression, contributing to the dysphoric and self-hating tone of their responses. Finally, it will be important in future research to understand the contribution of physical and emotional abuse to the tendency in bulimics to dissociate.

### CONCLUSION

The eating disorder literature has relied on drive-based and object-relations theories, while the sexual abuse literature has relied on the trauma response model for its understanding of psychopathology. The disparate approaches taken by eating disorder and sexual abuse investigators have impeded progress toward understanding eating disorders in the context of earlier traumatic events.

This study, and others on dissociation and bulimia (Chandarana & Malla, 1989; Demitrack et al., 1990; Pettinati et al., 1985; Sands, 1991; Torem, 1986; Vanderlinden & Vandereycken, 1990), point to the need for a re-conceptualization of the defenses that eating-disordered individuals



use, and to the need for a broader understanding of the relationship between trauma and psychopathology. The relationships among trauma, adaptation, and symptom formation are exemplified by the role bulimia plays in facilitating a dissociative defense against negative affects, including those related to sexual abuse. Treatment implications focus on the need to access split off ego-or self-states during therapy in order to halt the binge-purge cycle, and the need for great empathic understanding of the adaptive and protective function of the bulimic symptoms. ■

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