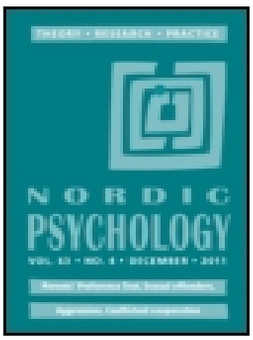

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ARTICLE

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«In solitude is safeness»: a patient perspective on eating disorders in the context of multiple childhood trauma

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Abstract

To capture the core pathology of eating disorders (EDs) in the context of multiple childhood trauma, the aim of this study was to describe variation and common features in the lived experiences of ED patients with childhood physical, emotional, and/or sexual abuse and neglect. Semi-structured interviews were conducted post-treatment with nine participants aged 25-59; data was analyzed with Interpretative Phenomenological Analysis. Four master themes emerged across EDs and trauma categories: 1) Shape and weight as regulators of closeness and distance, 2) ED as a sanctuary for counteracting feelings of helplessness and incompetence, 3) ED as a designated caregiver, and 4) ED filling an existential emptiness while emptying unwanted emotions. Informants emphasized interpersonal aspects through the overarching core theme of the ED as protective, self-preservative strategies in relationships with others. ED onset was described as related to the failure of parental figures and their functions, whereas ED maintenance related to the highly isolative and self-perpetuating nature of the disorder. The hypothesized model may have important clinical implications, especially in terms of the therapeutic working alliance, and we suggest that developmental issues are considered when developing future treatments for this ED subgroup.

Keywords: eating disorders, childhood abuse, childhood neglect, complex PTSD, interpretative phenomenological analysis

Eating disorders (EDs) impact many people. During a lifetime, 1-4% of European women are afflicted by anorexia nervosa (AN), 1-2% by bulimia nervosa (BN), 1-4% by binge eating disorder (BED), and 2-3% by Other Specified Feeding and Eating Disorders (OSFED). For males, the prevalence rates for any ED ranges from 0.3% to 0.7% (Keski-Rahkonen & Mustelin, 2016). Moreover, childhood trauma seems more common in ED patients (21-59%) than in other psychiatric populations (5-46%) and healthy controls (1-35%). In ED patients with childhood trauma, it is estimated that 45% have experienced emotional abuse, 31% sexual abuse, 26% physical abuse (Molendijk et al., 2017), 53% emotional neglect, and 45%

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physical neglect (Pignatelli et al., 2017). More specifically, sexual abuse and emotional abuse have been associated with EDs in females, and sexual abuse and physical neglect with EDs in males. Also, BED has shown a stronger association to family dysfunction and physical neglect than AN, whereas both BN and BED have shown a stronger relationship to emotional neglect than AN (Afifi et al., 2017). Similarly, a meta-review revealed an association between emotional abuse and emotional neglect in both BN and BED (Kimber et al., 2017). Also, in terms of chronicity, childhood sexual abuse combined with avoidant personality traits are predictors for longstanding EDs (Vrabel et al., 2010).

Moreover, childhood trauma has been related to earlier ED onset, higher ED severity, increased suicidality, more bingeing/purging behaviors, and greater psychiatric comorbidity compared to non-trauma EDs (Brewerton, 2007; Brewerton et al., 2019; Castellini et al., 2018; Molendijk et al., 2017). In spite of this, treatments are lacking: standard ED treatment outcomes are poor (Murphy et al., 2010; NICE, 2017) and dropout rates are high (Mahon et al., 2001). This actualizes the question of what treatment works for whom in what context (e.g. Holmes et al., 2018; Roth & Fonagy, 2004), and underscores the need for more knowledge about the functions of mental health sequelae of childhood trauma in the EDs (Brewerton et al., 2019).

To achieve this, we turn to a rarely used source of information: the patients themselves. Previous qualitative ED studies have most commonly been diagnosis-specific, failing to delineate histories of abuse and neglect. Although assessment of these patients is common in clinical practice, this scarce use of a patient-as-expert perspective in research is unfortunate since understanding a disorder beyond descriptive diagnoses requires acknowledgment of patients' subjective experiences (Lingiardi & McWilliams, 2017). However, 14 females' views on EDs in the context of physical abuse, sexual abuse and emotional abuse have been explored (Moulding, 2015). Overall, bingeing was used to relieve abuse-related feelings (shame, guilt, sadness, self-contempt), and purging to prevent weight gain. One participant described bingeing as self-punishment and protection from further sexual assault through weight gain in the absence of purging; self-punishment was otherwise mainly put forward by AN patients in relation to starvation. Moreover, informants emphasized a loss of interpersonal connections more so than the abuse itself: ED behaviors were hypothesized as attempts to overcome negative emotions associated with abandonment, and bingeing, purging, and starving were attempts to reestablish connection and gain acceptance. Another recent article described two female childhood trauma survivors' perspectives on the pathways to and recovery from an ED with concurrent PTSD, and discussed their lived experiences with reference to clinical practice and research (Brewerton et al., 2019). Apart from these studies, the «how» of these patients' perceptions of their illness is to the best of our knowledge nearly inexistent, and no qualitative study has thus far included emotional and physical neglect.

In summary, EDs in the context of multiple childhood trauma are understudied although suffering is substantial and treatment models are lacking. For the purpose of increasing knowledge about ED core aspects from a first-person perspective, the main aim of this study was to investigate variation and common features in how ED patients with histories of multiple childhood trauma conceptualize their disorder.

Method

Setting

The setting is a public psychiatric hospital in Norway, and the present study recruited patients from a randomized controlled trial (Clinical trials: NCT02649114RCT) comparing inpatient CBT for EDs (CBT-ED; Waller et al., 2007) with Compassion-Focused Therapy for eating disorders (CFT-E; Goss & Allan, 2010) for ED patients with or without childhood trauma. The trial took place between January 2015 and November 2017, and the current qualitative study recruited ED patients with childhood trauma only up until the point of data saturation, see below.

CBT-ED (Waller et al., 2007) is currently considered the leading evidence-based ED treatment, and includes CBT-techniques such as psychoeducation, cognitive restructuring, and dietary change. CFT-E (Goss & Allan, 2010), on the other hand, builds on evolutionary theory, neuropsychology, and attachment theory, and aims to balance patients' threat system, drive system, and soothing system. The specific target of CFT-E is patients' shame and self-criticism, and the ultimate goal is to promote compassion for self and others (see Goss & Allan, 2010). Some studies support the application of CFT for EDs. However, since the studies are either brief and/or with small samples, self-help in nature, or examine BED only, only tenuous conclusions can be drawn about its efficacy, hence, the need for a randomized controlled trial.

Procedure

A semi-structured interview guide was developed collaboratively with a reference group consisting of three patients who had previously been discharged from the eating disorder unit, and interview questions and techniques were revised according to feedback. Therapists considered potential participants according to exclusion/inclusion criteria as treatment proceeded, and offered written information about the study. Inclusion criteria were any ED diagnosis (DSM-IV) in combination with childhood histories of abuse and neglect according to CTQ, and exclusion criteria were: (a) acute suicidality, that is, requiring immediate attention, (b) current psychosis, or (c) ongoing trauma.

If interested, the researcher then met the participant for an informal introduction, and asked for informed written consent. Informants were then interviewed in their homes by the first author on average 30 days after discharge. Interviews lasted 20-45 minutes and were audiotaped and transcribed verbatim; transcripts were checked against audiotapes by a Norwegian psychologist who was not part of the research team. Finally, data saturation guided the final sample size: data collection ended when no essential information was added in three consecutive interviews (Strauss & Corbin, 2008).

Diagnostic assessment

The MINI International Neuropsychiatric Interview (Lecrubier et al., 2009) assessed DSM-5 axis I disorders, and the Structural Clinical Interview for DSM-5 axis II disorders (SCID-II; First et al., 1997) assessed personality traits. The MINI and SCID-II were administered by experienced clinicians pre-treatment. The Eating Disorder Examination Interview 16.0 (Cooper &

Fairburn, 1987) assessed eating pathology, and was conducted by two psychology students who were trained in diagnostic assessment.

Self-report measures

Self-report measures administered during the assessment phase were used to describe the sample. Time for assessment varied and took place on average 201 days prior to admission (range 92-250 days).

Eating disorder

Eating Disorder Examination Questionnaire 6.0 (EDE-Q; Cooper et al., 1989) is a 28-item questionnaire measuring ED frequency and intensity. Patients rate ED symptoms during the previous month on a 7-point Likert-scale for the subscales Restraint, Eating concern, Shape concern, and Weight concern. A global score indicates ED severity. The Norwegian EDE-Q has shown acceptable internal consistency, reliability, and validity, with a suggested cut-off of 2.5 to determine caseness (Rø et al., 2015).

Childhood trauma

A short form of Childhood Trauma Questionnaire (CTQ-SF; Bernstein et al., 2003) provided trauma definitions and guided informant inclusion. CTQ-SF is a 28-item questionnaire assessing presence and severity of different forms of abuse and neglect. Sexual abuse refers to sexual contact/conduct between a child and older person; Physical abuse refers to bodily assaults by an older person that pose a risk of, or result in, injury; Physical neglect refers to caregivers' failure to provide a child's basic physical needs; Emotional neglect refers to verbal assaults on a child's sense of worth or well-being, or any humiliating, demeaning or threatening behavior from an older person; Emotional neglect refers to the failure of caretakers to provide a child's basic psychological and emotional needs. Each subscale has five items graded on a 5-point Likert scale *(1= never true, 5= very often true)*. CTQ has shown satisfactory psychometric properties across Norwegian samples (Dovran et al., 2013).

Trauma-related symptoms

The PTSD Symptom Scale Self-report version (PSS-SR; Foa et al., 1993) is a 17-item questionnaire used to assess patients' degree of post-traumatic stress disorder (PTSD). Three subscales assess trauma-related avoidance, re-experiencing, and hyperarousal, and a total score assesses PTSD severity; a severity score above 14 indicate PTSD pathology. Patients rated PTSD-symptoms on a 4-point Likert scale *(0= not at all, 3= always, or five or more times per week)* during the previous week. The Norwegian version of the PSS-SR has shown good test-retest reliability and concurrent validity (Langkaas et al., 2017).

Participants

A total sample of nine patients (eight females, one male) aged 28-59 ($M = 38.4$, $SD = 11.6$) were interviewed out of 14 eligible, i.e. who consented to participate in the trial between

March and November 2016. Out of the fourteen, one declined participation, one was excluded due to loss of eligibility, and three were not introduced to the study for unknown reasons. Out of the nine remaining, three patients had received CBT and six CFT.

Mean age for ED onset was 13 years, and duration of psychiatric treatment prior to admission ranged from 1-26 years ($M = 10.5$, $SD = 8.4$). ED duration ranged from 9-53 years ($M = 25.4$, $SD = 13.5$), and EDE-Q global scores pre-treatment were within clinical range ($M = 4.41$, $SD = 1.1$, range = 1.7-5.1) with lower scores for the male participant. Average Body Mass Index (kg/m^2) was 24.9 ($SD = 9.5$, range 18.1-44.7).

PTSD severity scores on PSS-SR ($M = 25.3$, $SD = 8.0$, range = 13-41) were also within clinical range for all but one participant. The most common trauma was emotional abuse (100%), followed by emotional neglect (89%), sexual abuse (67%), physical neglect (70%), and physical abuse (56%). All had experienced a minimum of three forms of trauma, and four (45%) had experienced four categories or more. Comorbid psychiatric disorders were PTSD (n = 7), major depressive disorder n = 2), dissociative disorder not otherwise specified (n = 2), bipolar disorder (n = 1), dysthymia (n = 1), avoidant personality disorder (n = 1), borderline personality disorder (n = 1), and substance abuse disorder (n = 1) (DSM-IV).

Data analysis

Transcripts were analyzed in QSR-NVivo 11 (QSR International Pty Ltd, 2014). As the goal was to capture patients' unique experiences, we opted for Interpretative Phenomenological Analysis (IPA; Smith et al., 2009), which is aimed at accessing informants' life world through intersubjective meaning-making occurring in dialogue. As such, IPA builds on double hermeneutics: the interviewer tries to make sense of the informants trying to make sense of their life worlds. Consequently, to come close to the phenomenon under study, so-called bracketing is called for: the researcher attempts «to put to one side, the taken-for-granted world in order to concentrate on our perception of that world» (Smith et al., 2009, p.13), referring to the informant's life world. Also, as IPA tries to protect informants' idiography through in-depth case-to-case analyses, sample sizes are small. Still, the idiographic focus does not prevent exploration of patterns across cases, providing that individual experiences are not compromised. Accordingly, transcripts were first commented on one-by-one by members of the research team, whereby the first author noted initial themes. Second, higher-order themes and possible interrelations were analyzed jointly. The validity of the study wasaddressed through criteria proposed by Elliott et al. (1999). For instance, collaboration reduced the risk of idiosyncratic analyses and verified findings as grounded in data, and a reflexive process was continuous through a research journal and supervision.

Ethical considerations

All informants had therapists locally post-discharge. Procedures were conducted according to the Helsinki declaration and approved by the Norwegian Regional Committee for Medical Research Ethics (nr 2015/2160). It was made explicit that participation was voluntary, that participants were free to decline to participate at any time without providing a reason, and that their choice would not influence the possibility of future treatment at the treatment facility.

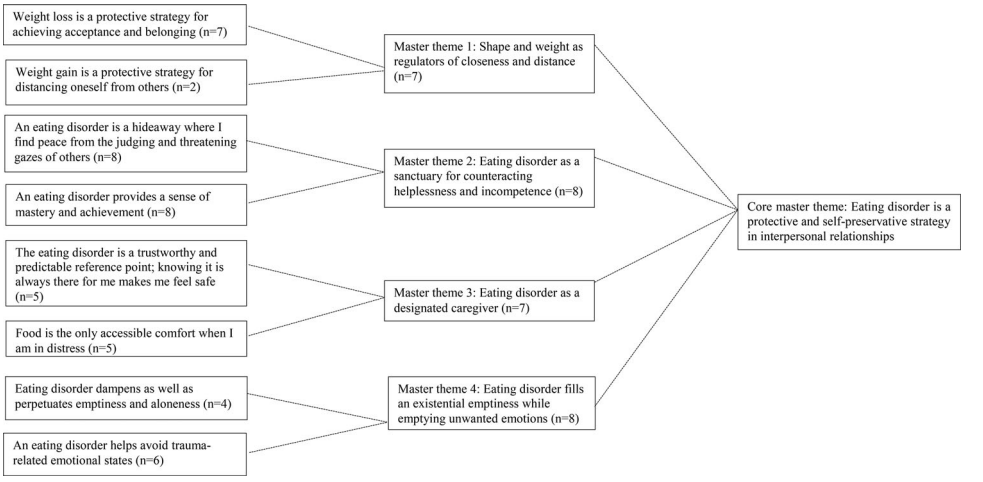

Figure 1. Subthemes, master themes, and core master theme.

Results

Four master themes and eight subthemes were developed (Figure 1, Table 1) and illustrated by informant quotes. Informants explicitly connected childhood trauma to ED onset and maintenance, and emphasized the ED as protection and self-preservation within relationships. Most subthemes were typical (over half of the cases) whereas some were variant (less than half of the cases), following Hill et al. (1997).

Master theme 1: shape and weight as regulators of closeness and distance

This master theme was represented by BN and OSFED, across trauma categories. Informants described the body as an instrument for regulating closeness and distance through weight loss/gain, emphasizing the protective aspects. First, informants were currently transforming or had previously transformed their bodies by purging, exercising, and/or restriction to lose weight. As an intended consequence, approval from others increased, leading to a sense of belonging. For instance:

> It's also very difficult, because, it's almost as if I sort of like walk around being scared to put on weight all the time/ … /in relation to whether I'm being liked or not, or what other people think about me, yeah, those kinds of things, where I often feel a bit, I don't know, lonely in a way. (Informant 3)

> And when I suddenly found out that I didn't want to be overweight anymore, and started exercising, and then after a while I became bulimic/ … /I got comments like «wow, you look great» and like, felt that people wanted to hang out with me a bit more, and that felt really good, while it at the same time was hurtful to think about the fact that they didn't want to be with me before, because I hadn't really changed my personality. (Informant 6)

The wish to belong relates to experiences of loneliness and alienation, and the belief that manipulating shape and weight is necessary to gain acceptance. Second, two informants (BN) represented a variant subtheme as they had abandoned previous weight loss attempts

Table 1. Overview of distribution of subthemes.

Alias (ED)	Subtheme 1a	Subtheme 1b	Subtheme 2a	Subtheme 2b	Subtheme 3a	Subtheme 3b	Subtheme 4a	Subtheme 4b
Informant 1 (BN)	X	X	X	X	X	X		
Informant 2 (BN)			X	X				X
Informant 3 (OSFED)	X		X	X	X		X	X
Informant 4 (BN)	X		X	X	X	X	X	X
Informant 5 (BN)	X		X	X			X	
Informant 6 (BN)	X	X	X	X		X	X	
Informant 7 (OSFED)	X		X	X	X			X
Informant 8 (BED)					X	X		X
Informant 9 (BN)	X		X	X		X		X
Total	7	2	8	8	5	5	4	6

and instead actively maintained obesity as protection from future sexual assault, for instance:

> You don't get the sexual attention in a way when you're very overweight, you just don't. Because being overweight is a bit like wearing a uniform/ … /In the way that if you look at people who are large and stuff, you see that we lose the shape of our faces, right, that we sort of float out, you know? In all sorts of ways. Well, and I find a sort of safety in that. (Informant 1).

Master theme 2: ED as a sanctuary for counteracting feelings of helplessness and incompetence

This master theme was typical for BN and OSFED, and all trauma categories. The ED was conceptualized as a room of one's own to retreat to regain a sense of control, and being able to co-exist with others perceived as powerful and threatening. First, informants described ED as a safe haven where they pause an underlying sense of inferiority and failure, exemplified below:

> I wished for— for my own room in a way, where I know I can relax, without any form for worry, or if I should call it anxiety, I don't know if it's the way to describe it, but I wish for a quiet room/ … /Yeah, a place where I'm able to relax, where I don't feel any pressure/ … /Uhm, and I do feel that during a tiny moment. (Informant 9)

Second, informants expressed that ED behaviors helped them obtain an otherwise impossible sense of mastery, for instance:

> It was more about control before, and in a way it's that kind of thing in life that you're the only one who can control yourself, regardless of how many who interfere with it, or have an opinion about it, it's you who controls the eating disorder/ … /No one can take it away from you, no one can stop you, no one can, right? It's one of those things in life that you feel only you control in a sense. (Informant 1)

> I have two parts. One of them is that I've been underweight for many years and had anorexia, but also bulimia with proper bingeing in the evenings, and the thing with feeling so strong by being able to not eat throughout the day. To have that control, and become and feel a little bit distant and almost like intoxicated makes everything easier to endure. (Informant 2)

Master theme 3: ED as a designated caregiver

This master theme summarizes the ED as a provider of stability, safety, and comfort, where parental figures have failed. The first subtheme was typical across EDs and describes the disorder as a continuous reference point. Informants especially emphasized the stabilizing function of the ED in relation to onset, underscoring that an ED can be returned to at any stage in life. For example:

> The eating disorder has been a kind of safety in the middle of all the insanity. Something that others couldn't control, they were very controlling. Yeah, in my house, they were very controlling or very boundless/ … /You never knew, for instance with boundaries, you never knew like where the limit was set today/ … /One day you were allowed to stay out until nine, another day you were beaten up for coming back at half past eight. You never knew, right? And there was a lot of alcohol. Lots of screaming. (Informant 1)

> Mm, yeah, it is safety, predictability, and the fact that I like haven't had any safety before. But it's like even if I'm safe now, I still have— I still use the eating disorder. But I'm always scared that unsafe things will happen, or I feel unsafe, now too, even if I know that I shouldn't. I know that, in my head, but still. (Informant 7)

The second subtheme was typical for BN and BED and related to bingeing as the only available source for comfort when distressed, for instance:

> I never knew when the abuse started or ended or— and then I compensated for it by eating and I remember that so very well./ … /. And there I see myself sitting in a corner, in a big chair, with a wool blanket around me, sitting there eating and crying./ … /It comforted me, because at least then I had something that felt good. (Informant 8)

Master theme 4: ED filling existential emptiness while emptying unwanted emotions

This master theme was typical across EDs and trauma. Informants stressed the anxiety-provoking experience of existential emptiness (deficiency), and the just as anxiety-provoking trauma-related states (excess). The first subtheme depicts the ED as a remedy for an underlying feeling of emptiness and alienation, for instance:

> The first thing that comes to mind without thinking too much is relief/ … /Yeah, that it fills a void in a sense./ … /It's— it's that feeling of loneliness anyway that has become a very big, or a very big heading/ … /everyone has in a way had their own stuff to deal with so we haven't had any stable reference point, everything has been floating around and I didn't think that the loneliness, feeling abandoned was so strong as it turned out when it came up during therapy, where I in a way got hold of it. (Informant 3)

Simultaneously, ED behaviors recreate feelings of emptiness through its isolative essence, as ED activities are occurring in solitude. This paradox is exemplified below.

> I'm pretty sure that it's emptiness, that I want to dampen something/ … /that the dampening has sort of been the reason for it, but because I'd been dampening for so long I felt that I had to start starving myself to make it okay again, and then I sort of got a kick out of it, but then I'm sure I became empty again, and then I started to like feel like a failure or needed someone, and then I started to dampen again. (Informant 4)

> But it's obvious that in loneliness there's also safeness, right? And food is lonely, safe, and mine. But that also means excluding everything, in relation to love, safety, which are things that I feel that I'm really made to wish for. (Informant 5).

The second subtheme summarizes ED as a strategy to dampen or avoid trauma-related states, as described below:

> I've at least traced it back to the age of six, that's how far back I can remember. Yeah. I've used food to compensate, yeah, and now that my brain is used to using it as a compensation— every time things get difficult, or I call it «disarranged rows», the eating disorder takes over, because then I don't have to get into all the painful stuff. (Informant 8)

> It's in relation to trauma and those kind of things, or trauma memories, that it has— when I'm experiencing painful things, or like difficult emotions/ … /I guess it's a lot of images and stuff that comes up from previously, and, a lot of worry and anxiety and stuff like that. (Informant 7)

Altogether, these subthemes reflect experiencing difficult emotions, and regulating these through ED behaviors rather than together with others.

Discussion

The main aim of this study was to investigate variation and common features in how ED patients with histories of childhood trauma conceptualize their disorder. The overarching core theme was the illness as protection and self-preservation in interpersonal relationships (Figure 1). Patients themselves perceived childhood trauma as directly related to ED onset and maintenance, and relational issues permeated their conceptualizations. All master themes occurred across childhood trauma and ED diagnoses (Table 1).

The master themes and their interaction add new information that may nuance our understanding of EDs in the context of childhood trauma in several ways. First, the disorder may serve as regulator of closeness and distance through weight control: the overweight body as boundary setter relates specifically to sexual abuse, whereas weight loss as a prerequisite for approaching others relates to early experiences of rejection by parents or peers (Master theme 1). Second, as others are mainly perceived as unpredictable and threatening, the ED may function as an internalized sense of stability and a safe place when a need to dampen trauma-related emotions emerges; emotional co-regulation is not a viable option (Master theme 3). Third, the ED also represents a stable place to return to in order to remediate a relationally triggered feeling of failure and helplessness, and build a sense of mastery (Master theme 2). Finally, these isolative emotion-regulation behaviors may perpetuate longstanding experiences of existential aloneness and emptiness (Master theme 4). Altogether, findings indicate that the lived experiences of the disorder are highly interpersonal, hypothetically preventing informants from fully connecting to others.

Our findings are concordant with the only existing qualitative study on this topic by Moulding (2015): bingeing was conceptualized as comfort, and obesity as protection from future sexual abuse. Also, the ED as a means to fulfill a need to belong rooted in experiences of rejection emerged in our study. Self-punitive or self-harming aspects of the disorder were not, however, central in our material. Previous findings relate these aspects specifically to patients with AN, and such patients were not part of our sample.

Since informants emphasize relational issues as their core ED pathology, we apply an attachment framework to findings (e.g., Bowlby, 1997). Interestingly, ED onset coincides with a time in patients' lives when attachment figures have failed. As such, they describe a transfer of important parental functions (e.g., stability, comfort, building self-confidence), moving from the primary attachment figures to the disorder. Hypothetically, the ED becomes the consistent, secure base for exploring and retreating, and consequently the main emotion regulation strategy. These self-perpetuating functions remain stable over time, maintaining the disorder. Through these avoidant behaviors, we hypothesize that these patients end up in recurrent negative feedback loops, missing out on corrective information about the world and others. This is in line with avoidant personality traits predicting longstanding EDs when co-occurring with childhood sexual abuse (Vrabel et al., 2010), and that attachment processes seem to be at work in the ED-patient relationship for some, but not all (Forsén Mantilla et al., 2018).

These findings may have potential clinical implications. We hypothesize that our informants' interpersonal distress and difficulties in forming productive working alliances are central in aggravating therapeutic progress and promoting treatment drop-out, since the therapeutic working alliance is a strong outcome predictor (Bordin, 1979; Horvath & Symonds, 1991), with insecurely attached patients forming weaker alliances (Diener & Monroe, 2011). Moreover, we speculate that patients' mistrust may hinder successful outcomes in current ED treatments, failing to properly address the pervasive relational aspects that reach beyond overevaluation of shape and weight and the behaviors associated with these appraisals when childhood trauma plays a prominent role. In fact, the subjective descriptions of trauma-related symptoms in our sample stretch further beyond PTSD in terms of interpersonal, emotional and self-image regulation difficulties, implying complex PTSD (ICD-11). Accordingly, and in line with a trauma-informed approach to ED treatment (Brewerton et al., 2019), we hypothesize that the pervasive patterns that are manifested through ED behaviors in our sample may need priority in treatments for this patient group in line with treatment for complex PTSD (e.g., Cloitre et al., 2011).

This study has some limitations. First, the sample size may restrict generalizability; the richness of data does, however, provide in-depth knowledge that helps develop understanding of these phenomena, and may as such facilitate generalizability at a meaning level (e.g., Maxwell & Chmiel, 2013). Second, this study did not include a comparison group consisting of patients without post-traumatic sequelae of childhood trauma, which outrules comparative analyses. Finally, as most informants had long psychiatric histories and were interviewed post-treatment there was a risk of psychiatric terminology contamination. Interview techniques were, however, carefully revised prior to data collection to avoid institutionalized and cliché language. Nevertheless, this study is the first to also investigate the intertwined relation between eating pathology and childhood neglect from a patient perspective; our data closely reflect clinical reality as it is not decontextualized.

Altogether, this study touches upon a possible heterogeneity in the group «ED patients», and raises new hypotheses about the clinical illustrations of EDs when co-occurring with childhood trauma. Further in-depth investigations of patient characteristics and EDs' functions beyond diagnoses are therefore necessary as it may entangle differences and similarities between ED subgroups. Specifically, we advocate for comparisons between trauma patients and non-trauma patients to test our hypotheses further, preferably using larger samples, as well as studies targeting the intersection of relational functioning and psychotherapeutic change or lack thereof in these patients. Such knowledge may fruitfully contribute in the development of evidence-based treatments for this specific ED subgroup.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Appendix. Semi-structured interview guide for eating disorder patients with childhood trauma on the phenomenology of their eating disorder (translated from Norwegian)

Introduction

«This interview aims to capture your personal experience of your own mental health issues. Your experiences are very valuable information that may help us understand eating disorders for those who have also experienced difficult relationships and episodes during their childhood, which in turn may help us to improve eating disorder treatment for this particular patient group. I will ask you a number of questions about your thoughts and feelings about your mental health. If you are in need of a break during the interview, just let me know».

1. If you were to describe what an eating disorder is to you in your own personal experience, what would you say?
2. If anything, what would you say has led to that you developed issues around food, your body, and your weight?
3. When you think about how the eating disorder is affecting you in your everyday life, what kind of function would you say that it has for you?
4. Has the eating disorder changed during the time that you've had it?
5. Would you lose anything by giving up the eating disorder? If so, what?
6. Is there anything that you haven't had the chance to say so far, that you would like to add?

The interviewer expresses gratitude to the informant for participating and closes the interview.