Food and Alcohol: Preferred Substances of Abuse among Individuals Struggling with PTSD

Pamela Phillips, PhD, RN
University of South Carolina-Beaufort
(For more information, contact: pphillip@uscb.edu)

Introduction

Exposure to physical and psychological trauma has produced a post-millennial epoch of posttraumatic stress disorder (PTSD), a debilitating mental health disorder that occurs after exposure to an extreme stressor or prolonged victimization.

After an extensive review of treatment protocols in 2008, the Institute of Medicine (IOM) exhorted clinicians to focus on defining the concept of recovery, concentrating on symptom reduction, removal of the PTSD diagnosis, and end-state function. Although the IOM report mobilized large-scale efforts to quantify treatments and standardize delivery of treatment protocols, PTSD recovery remains a concept that has been largely unexplored. The goal of this study was to analyze narratives of participants who regarded themselves as recovered from PTSD and to produce a model of the recovery process. *The findings regarding substance abuse and risky behaviors on this poster were produced during this discovery process.*

Participants in this study provided demographic information and narratives regarding their PTSD symptoms, the effects of PTSD on daily life, treatments, and the trajectory and process of recovering from PTSD. The resulting PTSD Recovery Model was nonlinear and included six universal stages that occurred during PTSD recovery: Experiencing Trauma, Dominating Diagnosis, Seeking Solace, Surviving Symptoms, Marking Time, and Navigating Recovery. Support for the model's correctness came from research participants and experts.

Objectives

The primary aim of this study was to answer the following question: *What is the basic psychosocial process that men and women undergo in recovering from PTSD?*

Methods

- This was a qualitative research study.
- Forty-one participants submitted written recovery narratives and demographic data, which were collected within a closed, password-protected website.
- The narratives were analyzed using grounded theory methodology[1, 2, 3, 4] to generate a theory on PTSD recovery.
- Data analysis also identified factors associated with PTSD and recovery, such type of traumatic exposure, length of/duration of trauma exposure, length of time symptoms occurred, consequences of symptoms, and non-helpful/useful therapies.

Sample:

- Research participants had to consider themselves to be currently functional in life roles.
- Data was gathered from trauma survivors who had been given a psychiatric diagnosis of PTSD and who reported at least partial recovery. They may or may not have had formal treatment for PTSD.
- Social media, PTSD websites, victims' advocacy groups, and veterans' groups were used for recruitment.
- Respondents were primarily from the United States (n=37), White (n=38), and female (n=31) with a mean age of 44.2 years. The largest grouping (n=17) were married and living with a spouse, and many (n=21) had children.
- More than 80% (n=33) had graduated from college and many (n=23) had attended/completed graduate school.

Results

Table 1. Frequency Distributions of Demographic Attributes (N=41)

Characteristic	**n**	**n**	**n**	**n**
National Origin	US = 37	Australia = 3	Wales=1	
Gender[a]	Male=9	Female=31		
Which of the following ethnic groups do you consider yourself belonging to?	White=38	Hispanic=1	Black=2	
Age (in years)	N=41	Mean=44.2	SD=12.38	Range 27-70

Table 2. Substance Abuse and Risky Behaviors Related to PTSD Symptoms

Symptom[b]	**n**	**100%**
Food, including excess eating, deprivation, and binging/purging	20	50.0
Alcohol	20	50.0
Risk-taking behaviors such as driving your car or motorcycle at excessive speed, going into dangerous sections of town alone, etc.	14	35.0
Working excessively long hours by choice	13	32.5
Did not abuse alcohol or drugs or exhibit risky behaviors	10	25.0
Out-of-control sexual behavior, including risky behaviors and multiple affairs	10	25.0
Nicotine, including cigarettes and smokeless tobacco	9	22.5

Symptom[b]	n	100%
Marijuana	6	15.0
Prescription drugs, including pain pills and antianxiety drugs (please specify)[c]	5	12.5
Cocaine	2	5.0
Methamphetamine	2	5.0

[a] One participant declined to specify gender.
[b] Some respondents did not answer these questions.
[c] Drugs specifically mentioned included Soma, trazodone, Ambien, Lorcet, Xanax, and Lunesta; herbs misused included ephedrine; and one respondent reported huffing compressed air.

Findings

When participants were queried regarding abuse or use to excess of alcohol, drugs, or exhibition of risky behaviors while experiencing PTSD symptoms, the two highest categories each contained 20 individuals (50%).

- The first category was using food, including excess eating, deprivation, and binging/purging.
- The second category was using alcohol.

Participants reported their two most used coping mechanisms were food, including excess eating, deprivation, and bingeing and purging, and overuse of alcohol.

- Emotional eating suppresses/soothes negative emotions, such as stress, anger, fear, boredom, sadness and loneliness.
- Major life events and the hassles of daily life trigger negative emotions that lead to emotional eating.
- While some people actually eat less in the face of strong feelings or emotions, many eat impulsively or binge.
- Anorexia nervosa and bulimia do co-occur with PTSD, and traumatic events tend to occur before onset of these disorders[5].

Clinical Application

The findings for these participants strongly suggest that eating disorders are linked with the trauma associated with the development of PTSD, especially in females with histories of victimization. Clinicians dealing with PTSD should screen for the occurrence of eating disorders; conversely, clinicians dealing with extreme obesity and eating disorders should screen clients for trauma history and associated PTSD.

References

[1]Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage.

[2]Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Piscataway, NJ: AldineTransaction.

[3]Strauss, A. L. (1987). *Qualitative analysis for social scientists.* Cambridge, United Kingdom: Cambridge University Press.

[4]Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.).* Newbury Park, CA: Sage.

[5]Reyes-Rodriguez, M. L., Von Holle, A., Ulman, T. F., Thornton, L. M., Klump, K. L., Brandt, H., . . . Bulik, C. M. (2011). Posttraumatic stress disorder in anorexia nervosa. *Psychosomatic Medicine, 73*(6), 491-497. doi: 10.1097/PSY.0b013e31822232bb

Poster photos by the author.