

The Relationship Between Sexual Abuse/Trauma and Eating Disorders

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Deborah was fourteen years old when she entered a residential treatment facility for bulimia with anorexic symptoms, along with drug dependency. During her initial phase of treatment, she remembered a traumatic memory that had been repressed for years. When Deborah was on a family vacation with her family at age 11 years, she was sexually assaulted by a group of unknown predators. As she had repressed this memory, she had told no one about the event, and had received no social support or an outlet to express and heal her pain resulting from the trauma.

After four years in the residential facility, Deborah came to us for treatment still plagued with body shame, self-blame and bulimic symptoms. She blamed herself for the sexual trauma, feeling she was responsible as she was without adult supervision at the time, and perceiving she had led the abusers on by being too nice. The self blame was not surprising considering her early mistaken decisions or interpretations about herself. From an early age Deborah believed that everything was always “her fault.” By the age of eighteen she had completely dissociated from her body, denying her femininity and unwilling to embrace her womanly sexuality. She had severe issues in her interpersonal relationships and achieving intimacy, particularly in romantic relationships, and was unable to feel deserving or derive pleasure from these interactions. In treatment, we first helped Deborah to reframe her negative self image and alter distorted perceptions surrounding the traumatic event, helping her to counteract shameful thoughts about her body and to cease self-blame. Her bingeing behaviour was a way to metaphorically ‘fill herself up’ emotionally and subsequently push out and occlude some of her feelings of disgust and self-loathing. To counteract this behaviour, therapy included generating positive self affirmations to combat her negative feelings towards herself and her body. To deal with the emotional aspects of the trauma and eating disorder, we also engaged in a variety of experiential and body-oriented techniques with Deborah. The therapeutic technique of psychodrama was utilized to give her a sense of power over her abuser and the abusive scenario. Through yoga and movement exercises, she learned to better connect with her body and learn that it was okay to move and “feel” her body. Finally, after a few years, therapeutic touch was used to show Deborah that she could accept and be touched lovingly in a non-abusive way, and that being touched was not something to be feared.

At the end of our work together, Deborah was able to be rid of her bulimic symptoms and reported feeling a greater sense of love and acceptance towards her body. By working through issues surrounding her traumatic sexual experience, Deborah was able to better understand and ameliorate much of her eating disordered behaviour and to learn how to deal with her emotions in a healthier way. This case study is only one example of the impact of sexual assault or trauma that resulted in an eating disorder.

The presence of sexual abuse among women is of an epidemic proportion, with prevalence estimates of lifetime sexual abuse varying between 15 and 25% among the general female population (Lesserman, 2005). Sexual abuse and trauma can occur across the lifespan, and despite variable definitions, is typically defined as unwanted sexual contact, ranging from exposure and fondling to rape (Bagley, 1990). Certain circumstances relating to sexual trauma have been associated with heightened eating disorder symptoms in particular, including if the sexual trauma involved parents or if it occurred more than once, (Murray and Waller, 2002). The consequences of sexual abuse may not be immediate, for when the abuse ends, the emotional trauma may remain. The effects of such abuse can be seen rather overtly in one's social relationships, as abused individuals are likely to express discomfort and fears relating to love and sexual intimacy with others. Other consequences of abuse or trauma may remain more covert and hidden, but be equally unhealthy and destructive. This includes the development of an ingrained disgust and hate for the body, as well as an overwhelming sense that events in one's life are uncontrollable. Essentially, past occurrences of sexual abuse or trauma may affect how one experiences living in their body, and ultimately existing and interacting in the world. It appears that a previous history of sexual abuse or trauma is a risk factor for a wide range of physical illnesses and psychopathology, including depression and obsessive-compulsive symptoms, as well as low self-esteem (Carter, Bewell, Blackmore, & Woodside, 2006). Importantly, both researchers and clinicians on the whole agree that trauma resulting from a history of sexual abuse can play a role in body image disturbance and eating disordered symptoms

Sexual trauma in relation to eating disorders

Prevalence estimates of sexual abuse among individuals experiencing eating disorders is variable, and reported more in females, seeming to fall around approximately 30% (Connors and Morse, 1993; Woodside, Garfinkel et al., 2001). This estimate is likely disturbingly underestimated due to the personal nature of sexual trauma and the associated secrecy, guilt, and embarrassment that often accompanies such. Research has found that patients presenting with an eating disorder and a past history of sexual abuse and trauma are more likely to report engaging in self-destructive behaviour and impulsivity (Wonderlich, et al., 2001). However, for some individuals, the experience of sexual abuse may be consciously inaccessible, that is, it may not be expressible or available to one's memory, highlighting the importance of a therapeutic relationship that can bring forth and address these memories in a safe environment.

Another contributing factor that could account for the abuse-eating disorder link is the perception that one lacks control. According to Peterson and Seligman (1983), humans have a need to perceive control over their lives, specifically in relation to aversive events, and feel distressed otherwise. Due to the coercive nature in most cases of sexual abuse, survivors of sexual trauma may experience feelings of powerlessness and feel little control over their own bodies. As the desire for self-control is evident in many individuals with eating disorders, when coupled with a history of sexual trauma, an increased need to gain control over the body can result. By restricting one's food intake, the abused individual may feel that their body is, at least for a limited time, under their own control.

Body dissatisfaction and lack of acceptance of one's own sexuality and femininity is prevalent in women with eating disorders and a history of sexual trauma or abuse. Some may believe that their bodies were too attractive and seductive/provocative to their abuser and thus blame their bodies for bringing on the traumatic experience, associating feminine sexuality with negative consequences. Starving the body may become a way to express one's anger towards the experience itself, and or punish the body. The low levels of sexual desire and lack of menses that are symptoms of anorexia may appear to the client as a way to regress to a child-like state in which they don't have to deal with issues of sexuality and femininity that cause them emotional and psychological distress. Essentially, eating disorders and the destruction of the body may be a way to deny sexuality and avoid the painful feelings and memories connecting to abusive and traumatic violation.

The strongest association between sexual abuse and eating disorders has been found amongst individuals with bulimia. When combined with other psychiatric comorbidity, particularly substance abuse, bulimia has been linked with higher frequency and more severe history of sexual abuse (Deep, Lilenfeld, Plotnicov, Pollice, & Kaye, 1999). Why bulimia? Purging behaviours may serve as a way to 'purify' or cleanse the self, and serve as a metaphor for expelling uncomfortable or "dirty" feelings and experiences from the body. For example, an individual may feel that vomiting is the only way to rid herself of the feelings and memories of the unwanted sexual encounter she experienced and to feel relief.

Healing Sexual Abuse and Eating Disorders in Therapy

What are some key elements that should be involved in therapy to treat this specific population? Like any therapeutic relationship, supportive empathy, and the development of a trusting, safe and nurturing therapist-client dyad is of the utmost importance. Previous traumatic experience may have left the client with a lack of trust in others and the perception of the world as a threatening place. For survivors of sexual abuse who have issues surrounding intimacy, boundaries within the therapeutic relationship must be clearly set in order to ensure that the client is not intimidated or confused and feels they are in a safe place to explore and heal their emotions and suffering.

In therapy, it is important to acknowledge the purpose or goals behind eating disordered behaviours and to eventually help the client to understand that that those behaviours were a necessary survival mechanism until they were able to live in a more positive and emotionally healthy way. Eventually it is helpful for the client to recognize that their eating disorder was an actual gift for growth and learning in all aspects of life. The therapist should supportively explore the reason for a client's bingeing behaviours that likely emanate from an attempt to cope with one's feelings relating to abuse or to cleanse the body of feelings of disgust. Also, since issues of control are a central theme in this population, a focus on perceived control should be explored in therapy, for example, by letting clients actively make choices about their therapy and giving them the opportunity to choose to stop if the discussion becomes too uncomfortable. Finally, as encouragement is the antithesis of discouragement, the therapist can help the client accept that they are

not to blame and can not change the past, and instead can actively choose to move forward and work to recover from their trauma, regaining a sense of personal power, femininity, and learning to nurture and love their body again.

Other specific techniques to explore with abused-eating disordered clients including body-oriented exercises that enhance awareness, control, and ownership of one's own body are suggested. Verbal therapies may be less effective for some survivors of sexual abuse or trauma, particularly if the trauma occurred early in development, as it likely that the memories were encoded non-verbally. For these clients, Psychodrama, Art, Movement, Yoga and other body oriented therapies may be more effective, as they can help the individual to learn to connect and love their body again, and to re-awaken their sexuality. Relaxation training may also be used to develop awareness of the many interconnected, lovable and worthy aspects of one's own body and to help attain feelings of inner peace. Similarly, guided imagery can be used during therapy to help clients reacquaint themselves with a safe place that provides them feelings of safety and comfort. Anger and fear release techniques in particular, such as using a tackle dummy in a safe place of healing, can also augment a sense of empowerment, instead of the feeling that one is a victim. Which strategy to use in conjunction with the above mentioned therapeutic goals will depend on the specific experiences of the individual, the stage of their recovery process, and their openness to change and their current perception of safety.

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