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Treatment of Childhood Sexual Abuse in Anorexia Nervosa and Bulimia Nervosa: A Feminist Psychodynamic Approach

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In this article a parallel is drawn between the psychological problems experienced by victims of childhood sexual abuse and by clients with eating disorders. In particular, we describe how sexual abuse has a significant and lasting effect on body image, identity, self-regulation, and interpersonal functioning. Treatment issues are outlined including the nature of the healing relationship, assessment of abuse, development of capacity for self-soothing, techniques for assisting in memory recall, sculpting of images, description and reenactment of abuse, dealing with shame, and ending the cycle of repeated victimization. © 1994 by John Wiley & Sons, Inc.

"An unacknowledged trauma is like a wound that never heals over and may start to bleed again at any time" (Miller, 1984, p. 47).

Eating disorder experts are currently engaged in a heated debate concerning the role of childhood sexual trauma in the etiology of anorexia nervosa and bulimia nervosa. Although few would argue that sexual abuse is unrelated to the development of eating disorders, the disagreement centers around specificity of risk: Does sexual abuse constitute a specific risk factor for an eating disorder or is it merely a general risk factor for development of any psychiatric disorder? The former position is exemplified by Root (1991), who describes eating disorders as a form of gender-specific posttraumatic stress disorder (PTSD). In contrast, Pope and Hudson (1992) have concluded that eating disorders are not caused specifically by childhood sexual trauma. Although this debate is useful in stimulating research of the role of sexual abuse in the development of eating disorders, in our opinion the equally important question of how to treat victims of sexual abuse who have an eating disorder is not addressed adequately in the eating disorder literature. In this paper, we will briefly summarize the arguments for and against the

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role of sexual abuse as a specific risk factor for eating disorders. Against this back-
ground, we will then introduce a set of therapeutic techniques that we have found
helpful in treating women with an eating disorder who were sexually abused before the
onset of the disorder.

IS SEXUAL ABUSE A SPECIFIC RISK FACTOR FOR EATING DISORDERS?

Proponents of the “specific link” hypothesis describe complex, multiple mediating
mechanisms between sexual abuse and disordered eating. They emphasize the adverse
effects of sexual abuse on body esteem, self-regulation, identity, and on interpersonal
functioning (Kearney-Cooke, 1988; Pribor & Dinwiddie, 1992; Root & Fallon, 1988).
Sexual victimization, these proponents argue, has a direct effect on body image: The
victim comes to see her body as a source of vulnerability, shame, and betrayal. In their
efforts to understand and cope with the abuse many victims attribute the cause of the
abuse to aspects of their physical appearance and feel ashamed and guilty for the role
they believe it played in the abuse. The connection between having been abused and
experiencing one’s body as deficient may not always be available to conscious aware-
ness. In a culture that is saturated with messages that women’s bodies must be changed
to conform to a narrowly defined beauty ideal of thinness, striving to be thin may bring
focus to the diffuse, yet pervasive, body loathing experienced by the victim of sexual
abuse. On the other hand, for women who attribute sexual abuse to being too attractive,
overeating may be a strategy in defense against further victimization.

The equation of eating disorders with arrested psychosexual maturity has long been
a tenet of theory. In his widely accepted formulation Crisp (1980) regarded the central
psychopathology underlying the weight phobia as related to avoidance of psychological
maturity and to its concomitant problems. For the survivor of abuse, the phobic avoid-
ance of normal weight, secondary sexual characteristics, and menstruation may be used
in the service of denial, by producing a shutdown of sexual impulses and other physi-
ological reminders of a painful and shame-bound sexual past. Also, feelings of pleasure
experienced during the abuse may have heightened the child’s sense of shame and guilt,
thus increasing vulnerability to the development of an eating disorder. The intense need
to lose weight and “get rid of the body” may be a defensive way of handling the
shameful feelings. Bulimia can become a ritual of self-purification that provides the
victim with hope that if she is “perfect,” she will be cared for and no longer will feel
ashamed. The failure of the weight loss to rid her of shame sets the foundation for
further hopefulness and self-destructive behaviors.

According to Cole (1985) the violation of the victim’s bodily integrity and safety
teaches her that she has no control over her own physical space. The breaks in the
continuity of the self, the discontinuity of memory resulting from dissociative states, the
loss of self-control accompanying environmentally triggered states of consciousness
such as flashbacks, panic attacks, and regressive states, all contribute to feeling out of
control. It is widely accepted that issues of control are central in the etiology of an eating
disorder. Bruch (1978) states that clients with anorexia nervosa seem to believe “that
neither their bodies, nor their actions are self directed, or not even their own” (p. 38).
Abuse victims may believe that if they control their appetite for food, sex, and human
contact they will feel in control and competent. It has been proposed (Johnson & Con-
nors, 1987) that from birth, children develop feelings of personal mastery by gaining
control of their bodies. From the time they are able to reach out, grab things, crawl,
walk, ride a bicycle and so on, an important feedback loop exists between control of
body and self-esteem. Given that our culture promotes the view that one can achieve
control over one’s life through thinness, it is not surprising that victims of abuse may
attempt to regain control by changing the size and shape of their body through dieting,
which in turn puts them at risk for the development of an eating disorder (Polivy,
Herman, Jazwinski, & Olmsted, 1984).

Developing a secure, cohesive sense of self is central to psychological adjustment. As
described by Cole and Putnam (1992), the pervasive, sustained stress of incest specifi-
cally affects self-development, particularly the development of self-regulatory processes,
such as modulation of affect and impulse control. An eating disorder may become an
adaptive effort to defend against self-regulatory deficits resulting from abuse. For the
eating disordered client, regaining the safety that was lost during the abuse becomes
associated with being able to restrict “bad” foods and only take in “good foods.” Moreover,
reestablishing control is associated with needing no one, with isolating oneself on
an “anorexic island,” with becoming a self-contained system in which one will never feel
vulnerable to the betrayal of others. The need to be “perfect” to cover up the “badness,”
“dirtiness,” “ugliness,” of abuse becomes associated with being in complete control
over one’s appearance (e.g., not a hair is out of place), over one’s needs and feelings
(e.g., never feeling the pangs of hunger for food, human contact, or sexuality), and over
one’s relationships with others (e.g., never being disappointed again). Thus the eating
disorder represents an effort to develop a positive sense of self.

In our view, a basic goal of development is to establish and maintain meaningful
relationships. The “self in relation” model (Surrey, 1985) of identity development as-
sumes that other aspects of self (creativity, autonomy, assertion) develop within the
context of meaningful relationships. Sexual abuse by a trusted adult violates the child’s
basic beliefs about safety and trust in relationships. It shatters her hopes for satisfying
relationships in which she can feel loved and protected, and in which she can negotiate
the fulfillment of her needs. The resultant hopelessness about human relationships then
may be displaced into concerns about food, body shape, and appetite. For example, the
anorexic’s denial of the need to eat may be a metaphor for her denial of the need for any
other person because she learned through the abuse that others can be psychologically
dangerous. Relying on food, a substance on which the bulimic can call 24 hours a day
to soothe herself and make herself feel full, may become a survival tool that replaces the
need for any other person.

In summary, sexual abuse has been described to have a significant and lasting effect
on body image, identity, self-regulation, interpersonal functioning, and feelings of ef-
fectiveness in ways that echo the clinical issues encountered in clients presenting with
an eating disorder, whether or not they have experienced abuse. As we will describe
next, despite the compelling arguments that have been made in support of the specific
link hypothesis, empirical evidence seriously challenges the notion that sexual abuse is
a causal variable in the development of an eating disorder.

Opponents of the specific link hypothesis typically challenge explanations of eating
disorders as caused by sexual abuse based on epidemiological studies that have failed to
show that women with an eating disorder have suffered disproportionately higher rates
of sexual abuse than women with other types of mental disorders (e.g., Fairburn, 1993;
Pope & Hudson, 1992). As Pope and Hudson (1992) point out, studies that offer support
for sexual abuse as a specific risk factor are characterized by methodological problems
including failure to ascertain that abuse occurred prior to the onset of the eating disorder
or absence of an appropriate control group. We would argue that existing studies of the
association between sexual abuse and eating disorders do not do justice to the complexity of the issue at hand. Several researchers have described in detail the methodological issues involved in studying the impact of sexual abuse (e.g., Herzog, Staley, Carmody, Robbins, & Van der Kolk, in press; Pope & Hudson, 1992; Wonderlich, 1993). Currently, there is no uniformly accepted definition of what constitutes sexual abuse, nor have researchers agreed upon a particular methodological approach to solicit information about sexual abuse. For instance, Herzog et al. (in press) argues that the nature of interview used to determine abuse may influence significantly rates of reported sexual abuse. Beyond these unresolved questions of definition and measurement of sexual abuse, to date, insufficient attention has been paid in the eating disorder literature to the fact that the specific impact of sexual abuse on mental health is determined by a wide array of factors including the age at which the abuse occurred, the severity of the abuse, the response of significant others to the abuse, and revictimization to name only a few (Burnam et al., 1988; Cole & Putnam, 1992; Herman, 1992; Waller, 1992). Lastly, we agree with Connors and Morse (1993), who argued that the role of sexual abuse in the etiology of eating disorders needs to be studied together with other variables thought to cause these disorders (e.g., Striegel-Moore, Silberstein, & Rodin, 1986). We believe that a simple determination of presence or absence of abuse is as inadequate toward furthering an understanding of etiology as is the simple determination of whether or not someone has been dieting (not all dieters become eating disordered). As Garber and Hollon (1991) argued in their recent paper on specificity designs, when examining a single variable in a specificity design, one can only rule out a single variable causal model. One cannot, however, extrapolate from results of a single variable model to a complex etiological model. Given these complex unresolved issues, it appears premature to offer a conclusion about the role of sexual abuse in the etiology of eating disorders.

To therapists working with eating disordered clients who have a history of sexual abuse, the challenge to answer the question of specificity of risk may pale in comparison to the clinical challenges posed by these clients. Although clearly important, attention to the question of the etiological significance of sexual abuse in eating disorders seems to have eclipsed attention to another pressing question confronted daily by therapists working with victims of sexual abuse: How can the therapist facilitate recovery from sexual trauma? We will now turn to a description of steps and strategies aimed at facilitating recovery from sexual trauma in clients with an eating disorder.

COMPONENTS IN THE TREATMENT OF SEXUAL ABUSE

Our approach to the treatment of sexually abused clients with eating disorders has been influenced by the path breaking work of Herman (1981, 1992) and of Courtois (1988). As Judith Herman (1992) described, recovery from trauma involves three stages: establishing safety, remembrance and mourning, and reconnection with real life. Moreover because traumatic experiences fundamentally involve disempowerment and disconnection from others, recovery is based on the empowerment of the survivor and the creation of new connections. To enable a client to move through the stages of recovery, we believe that treatment needs to encompass the following components: comprehensive assessment of the abuse, developing clients' capacity for self-soothing, enabling clients to recall and work through the abusive event, dealing with shame, and ending the cycle of victimization. Before describing each of these components, we will briefly
comment on type of therapeutic relationship most suited to the techniques we will suggest.

**Nature of the Therapeutic Relationship**

The therapeutic relationship is crucial to the success of therapy. It serves as a blueprint for the client’s future relationships and as a vehicle through which to achieve change. We encourage therapists to approach the survivor as a partner on a journey of recovery and to refrain from entering the relationship as a silent expert or observer. For therapists, taking an active role in the relationship includes making an empathic connection with the survivor as well as allowing for disagreement and conflict. The therapist must be deliberate about his or her role of “bearing witness” (Herman, 1992) as well as about awakening the heroic potential of these often isolated clients who have been preoccupied with the pursuit of thinness and perfection. Conflicts between the therapist and the client must be out in the open; and the victim must learn that she can be separate, and that she can have a voice while keeping the connection with the therapist. She needs to learn that although the perpetrator did not take her needs seriously, the therapist does and that it is time for her to pay attention to her reactions, label them, and speak the truth. It is important to process breaks in empathy, incorrect interpretations, and other mistakes on the part of the therapist. Eating disordered clients must learn that people, like bodies, are not perfect; they make mistakes and have flaws, but still are acceptable and worthy of care. Clients must learn that intimacy can be achieved without acting out physically or emotionally. The therapist must encourage the client to reclaim her power and competence, and must not collude with the client’s sense that she lacks control of her symptoms. It is important to help the client make the connection between her eating disordered symptoms and the feelings, thoughts, and memories related to her victimization experiences. This connection decreases the client’s sense of powerlessness she had experienced without such an understanding (Root & Fallon, 1989).

As therapy progresses, the therapist must send a clear, unambiguous signal that he or she is able to handle the client’s growing sense of personal authority. The therapist can remind the client that she was not permitted to have a voice in the abusive relationship, but that she has a voice now and can practice using it within the therapeutic relationship. For example, a therapist suggested to a client in recovery from abuse who wanted to work on her sexuality that she read two books to begin this process. At the next session, the client said she was uncomfortable with the exercises in the books and preferred to view movies that introduced safe, healthy sexuality. The therapist commented on her courageousness in her ability to reclaim her sexuality at a pace and with the methods that felt right to her.

This type of relationships helps clients to develop a renewed sense of trust in others and leads to a hunger for relationships, food, and other forms of nourishment. With renewed hope in their ability to be their own person with their own set of needs, which can be expressed and negotiated in relationships, victims can let in food as well as other people. They can “climb out of the anorexic box,” where power equals a perfect body and no needs, to a world of complex relationships. It is essential that the therapist develop a strong therapeutic alliance with the client before using the following techniques to treat abuse.

**Initial Assessment**

Research suggests that many victims of sexual abuse do not tell their therapists about their history of victimization (Pribor & Dinwiddie, 1992). As therapists we must ask
ourselves these questions: Will we, like other significant people in the client’s life, ignore the abuse? Or will we ask about it, believe it, and treat it? Bearing witness (Herman, 1992) is a central therapeutic task; and therapists must make it clear that they will be able to tolerate hearing about atrocities without becoming overwhelmed by the client’s accounts. In our work with eating disorder clients, we routinely ask about sexual abuse as part of the initial assessment. We preface this inquiry with a reassuring statement that many clients with eating disorders had unpleasant or distressing childhood sexual experiences, and then ask whether anything of this nature happened to them. The fact that the therapists raises the matter during the initial assessment signals specifically that she/he is comfortable in dealing with sexual abuse, is knowledgeable about it, and regards it as an important issue to address in therapy.

The specific details of the abuse need to be explored, including the type of contact (e.g., exposure, touching, oral sex, intercourse), the degree of threat or violence involved, the victim’s relationship to the offender(s), the duration of the abuse, the developmental stage at which the abuse occurred, whether the victim received any support from others in ending the abusive situation and/or dealing with its effects, and the meaning the victim attached to the event, to herself, and to others. Moreover, the therapist must “debrief” the client upon disclosure of this painful material. This includes exploring the client’s reactions to having told about the abuse, making clear that the therapist will offer continued support, and beginning to examine what the client has done to cope with the trauma.

Many clients will be unable or unwilling to report sexual trauma early in treatment. Weisberg (1991) listed several indices of sexual abuse history that should alert therapists to the possibility that their client has been sexually victimized in the past. Examples include self-mutilating behavior, presence of dissociative symptoms (see also Vanderlinden, Vandereycken, vanDyck, & Vertommen, 1993), alcohol and drug use at an early age, history of suicide attempts at an early age, sexual acting out, placing self in dangerous situations, history of estrangement from mother, and having an intrusive possessive father.

**Developing the Client’s Capacity for Self-Soothing**

Before introducing techniques to help the client remember and work through abusive memories, it is important that the therapist assist her in developing the capacity for self-soothing. The use of transitional objects, and of behavioral and cognitive techniques, helps the survivor to tolerate the affect and to relieve the tension during the phase of working through the abuse.

**Internalization of Therapist as Soothing Object**

Van der Kolk and Kadish (1987) refer to the “therapist as a soothing object.” The therapist’s empathetic responses to the client’s victimization experiences permit the internalization of soothing and tension-reducing mechanisms. Helping clients to feel a sense of calm and control, both within themselves and in the therapeutic process, is critical if healing is to occur. The first step in this regard is to educate the client about the physical and psychological after-effects of trauma and to help her identify these as they occur in the client’s own situation. Often the symptoms of PTSD increase temporarily during the working-through process of therapy. The client needs to know that difficulties in falling asleep, hypervigilance, distressing dreams about the event, and psychological distress at exposure to events that symbolize or resemble an aspect of the event,
are all symptoms of PTSD. The client must be reassured that experiencing these phenomena does not mean she is “going crazy.”

Therapists must also introduce, develop, and strengthen inner soothing techniques of survivors. They must model the soothing, for example, by pacing the work. For clients in the numbed, dissociated phase of PTSD, techniques that encourage expression (journal writing, guided imagery, psychodrama) should be used. If memory has returned in flooding flashbacks, techniques that offer support and slow down the process enable the therapist to work carefully and slowly with memory segments (Courtois, 1988). For many trauma victims, initially the methods of soothing may have to be quite concrete. The therapist should ensure that the office is physically comfortable and that the session is calm and free from distraction. It is important that the therapist displays a sense of control (e.g., maintaining time limits on the session) and exhibits the ability to remain emotionally in touch with the client even in the face of intense affect or resistance.

Development of Affect Tolerance

It is important to encourage clients to develop strategies to deal with uncomfortable feeling states resulting from the working through of sexual abuse. Our clients have discovered certain soothing techniques for themselves; these include rereading favorite children’s books, meditation, relaxation tapes, or gardening. Exercise seems to be helpful in dealing with constriction and with high levels of anxiety and tension. It is also useful to encourage clients to keep a special box for storing memories that they bring to sessions. They can open the box in the safety of the psychotherapy session, and can work through the memories with the therapist. When they close the box, they will be closing off the memories until the next session. This technique becomes a way of placing a boundary on memories outside the session.

Evenings and nighttime hours can be particularly difficult for many clients. During these times, the client may find assurance in form of a transitional object such as a letter or a relaxation tape from the therapist, a card with affirming messages from therapy group members or significant others, or a list of people the victim can call to feel less alone. The goal is to interrupt the client’s sense of being alone with her terror and to replace it with healing connections with others.

It is also useful to encourage clients to distract themselves in a positive way from the work on sexual abuse. Clients must learn that they are permitted at times to not work on abuse and to distract themselves, as by viewing comedy tapes, completing crossword puzzles, or playing tennis. In the course of therapy, so much feeling is stirred up in the internal world that external diversions are a healthy break. The overriding concern is to help the client develop wholesome ways to tolerate feelings rather than turn to inanimate objects such as food and alcohol in order to handle difficult flashbacks and memories.

Techniques for Assisting in Memory Recall

In a safe therapeutic relationship, repression often lifts during the course of therapy; memories return and must be worked through. At times, however, techniques are needed to facilitate the retrieval of memories. Recovery from sexual abuse is aided by rendering memories available for recall, by making these memories “concrete,” by developing an object that symbolizes the abuse, and by reenacting the abusive event. Each of the techniques described below serve to empower the client by allowing her to gain control over what once was an uncontrollable event.
Evoking Abusive Memories

Guided imagery, a fantasy-inducing process that combines deep muscle relaxation with suggestions of images, is especially useful in recovering repressed memories and reconstructing disconnected memory traces. A theme-centered guided imagery has been developed (Kearney-Cooke, 1988) to assist clients in understanding the role of past sexual experiences in their current feelings about body and eating. After a short relaxation exercise, clients are encouraged to remember the following scenes: early sex play with peers, early sexual experiences with adults (including incest and pedophilia), masturbation experiences during adolescence, and recent sexual experiences. Clients visualize the actual settings where sexual experiences occurred and recall their feelings about their body and their eating habits at that time. When the imagery is concluded, clients use clay to sculpt the most salient images from the sequence.

Guided imagery can also be used to help a client complete a memory fragment. This memory is demonstrated in the following example.

A 26-year-old woman suffering from anorexia nervosa (we will call her Kirstin) described waking up at 2:30 a.m. and being unable to fall asleep again. She had experienced a disturbing dream; she did not recall the entire dream, but remembered only that her mother and father were fighting and that she felt responsible for their fight. She blushed as she described the dream fragment. The therapist commented on the blushing; Kirstin reported feeling embarrassed but did not know why.

We worked with the dream in the following way. The therapist asked Kirstin to close her eyes, to go back to the dream, and to use her five senses to describe the room she was in.

Kirstin: I am in my bedroom. It is about 6:30 p.m. I can smell dinner cooking—it’s hot in the room. It’s summertime, and there is no air conditioning. I hear Dad, who is drunk, arguing with Mother who has just returned from work.

Therapist: What are they arguing about?

Kirstin: Can’t hear them.

Therapist: What do you imagine they are arguing about?

Kirstin: Don’t know. Money maybe . . . can’t hear.

Therapist: How are you feeling as you hear them fighting?

Kirstin: Bad, embarrassed, guilty. Like I’ve done something wrong.

Therapist: Hold onto that feeling. Imagine we have a magic rope in here that can safely take you back into time. Imagine putting your right hand on a rope, then left hand behind right, right behind left as you move back through time. You are getting younger, beginning to see people from your childhood, your school, house, etc. You are moving back through time until you end up in a scene where you have a feeling similar to the one you had in the dream. Don’t censor. Trust whatever scene comes. Describe it as if it is happening in the here and now.

Kirstin: I am in a bar. I am seven years old. My dad takes me to this bar sometimes and always buys me beer nuts and Coke. Because I am the only kid in the bar, a lot of men are nice to me and give me a lot of attention. (Silence)

Therapist: What happens next?

Kirstin: My father is getting drunk. The bartender asks my dad who he is going out with now, how he’s dating. My father looks at me and says “My little lady.” The bartender says “You don’t mean Kirstin.” Fa-
The therapist says “I do.” The bartender says “That’s sick,” and walks away from us and goes to the other end of the bar.

Kirstin begins to cry in session and says “I’m shattered. What did he mean, it was sick? My daddy meets me at the corner after school because my mommy works, and he does special things to me. He told me he was teaching me special things and they were our secrets. That bartender said it’s sick.”

Therapist: You feel betrayed, sad, dirty?

Kirstin: Yes. My dad leaves the bar, takes me to another bar. I want to go home—maybe Mom is home now. He gets more drunk. When we get home I sit down and open the window and look out. Mom comes home and Dad immediately starts criticizing her. They are fighting. They are fighting about me. I know it’s my fault. Does she know, or does she think I am sick too? He told me I was special, his little lady. He lied to me.

Therapist: You were betrayed and wounded by your father. This is a disturbing memory and we will spend time working with this. Experiences like this often teach us something about ourselves or myths about what life will be like. What did you learn about yourself or life?

Kirstin: That I am bad, dirty. I would have to hide this from others forever. That I could never let anyone get too close or they will see how sick I am.

When the traumatic state is reactivated in the present, it is characterized by a subjective sense of loss of control similar to what occurred in the original traumatization. Emotions connected to the trauma state are primitive, intense, and overpowering, leading to a sense of helplessness and a feeling of inability to function (Krystal, 1978). When the client relives a traumatic event, the strong affect activated by the therapeutic intervention may lead to fragmentation. Therefore, to help the client return to the real world, therapists need to allow 10 to 15 minutes at the end of the session to assist the client in making the shift back into day to day life. To aid this shift, several interventions are useful. The therapist should make an empathetic connection, for example by saying “You’ve shared a lot today. We will spend time in the next few sessions working with this memory.” The therapist may explicitly refer to the present situation: “There are five minutes left in the session, and you will be returning to work soon.” Moreover, the therapist may offer a chance for cognitive mastery: “Let’s stop and see if we can understand what it means.” These interventions communicate that the client has control, that she can move from an affective state to a cognitive understanding of the event.

Childhood abuse often occurs in the context of extreme familial disruption and chaos (Chu, 1991). In the absence of adequate interpersonal support, the trauma results in overwhelming dysphoric affects, which are repressed and dissociated. When the trauma is reexperienced in the session, it is overwhelming again—but the sharing of the experience with a safe person makes it bearable. A new anchor is provided for the victim: An empathetic therapist or group members listen, acknowledge the reality of the abuse, and are there for the client. The intense aloneness of being abused without help from another person is alleviated. One of the results, according to Chu, is that the trauma is retained and integrated into memory as past experience rather than remaining a dissociated time bomb that is waiting to explode into consciousness.

Creating Concrete Representations of the Abuse

After a client has retrieved memories of abuse, it is useful to ask her to sculpt these memories in clay or to draw them. These methods are effective for helping victims to
organize chaotic feelings and memories in the external environment, where they can be examined. This process helps to structure and integrate the memories and feelings by providing a concrete representation of the affective experience. For example, an incest victim sculpted a female body with a major piece missing in the genital region. She wrote “My father took a part of me that I can never get back.” Another client, a bulimic woman, sculpted a torso and head with no arms or legs, and poked holes in it with pencil. She said “My body must be punished and mutilated.” She had been raped repeatedly by her older next-door neighbor when she was 8 years old.

Reenactment of the Abusive Experience

After retrieving the memory through guided imagery and making a concrete representation through sculpting, the client must describe the trauma to the therapist. The therapist should reassure the client and help clarify the details of the abusive experience. The therapist should encourage the client to be specific and not to speak in generalities. The client should be encouraged to talk about the age at which the abuse occurred, the frequency, the duration, the relationship to the molester, exactly what was done, why the molester did it, and why it ended. The therapist must believe the client’s story and must appreciate the complexity of the victim’s feelings towards the perpetrator. The client may feel confused, concerned, affectionate, angry, or betrayed.

The therapist must be willing to listen to the client’s positive feelings toward the perpetrator or toward aspects of the abuse. For example, the client may have felt sexually aroused and, as a result, may assume responsibility for the abuse. Clients often feel reassured when being told that it is not unusual to experience sexual pleasure or excitement during abuse because the perpetrator often touches parts of the body that are easily excitable. The victim may view the perpetrator as the only source of affection and caring in her life. Therapists who do not accept these positive feelings will be reinforcing the client’s belief that her feelings are shameful or bad.

Reenactment of the abusive experience is the next step in the treatment process. This is best accomplished in group therapy. The therapist helps the client to explore the meaning of her images by proposing structured activities to assist her in reexperiencing the abuse. This experience is organized to facilitate catharsis, insight, and eventual mastery of the original trauma. Psychodrama, role playing, and gestalt therapy techniques seem most effective in reaching these goals and are best implemented in group psychotherapy. These methods seem to break through the intellectualizing and denial that many eating disordered clients use as a defense against their feelings.

Susan, a 23-year-old bulimic woman who had been sexually abused by her father, described how he had taken her body and her power. The therapist suggested that a black cloth represent the power he took and proposed that Susan attempt to grab this power (the cloth) from her father (played by one of the therapists). On a movement level, this act gave her an opportunity to be creatively aggressive and to take back what belonged to her. Susan started out weak, but eventually grounded her body and used her body and words to take back the power. She said “Give it back, it belongs to me. You shouldn’t have taken it in the first place. You can’t come in me like that anymore. It’s mine. I’m taking it back.”

Both the client and the therapist gain much during a reenactment. The therapist and the group members experience the event as if it is occurring in the present, and feel it in intense detail. The feelings of the victim, as well as of other members of the group, then become available for joint exploration and support. This process often dramatizes the victim’s fears and intense anger toward the perpetrator. In playing roles and ob-
serving, members of the group learn about themselves and make connections to their own lives. As other members of the group remember their own sexually intrusive experiences, these become available for immediate feedback and therapeutic intervention. Sharing her experience with the group in such an intense way offers the victim the chance to feel that she belongs and breaks down her feeling of isolation.

Often the client is terrified by her own anger. The therapist must help her to see that the group can tolerate the rage and will provide a context in which to develop healthy ways of expressing it. The victim needs to see that she will not lose or destroy this group when she expresses her rage.

This form of treatment encourages victims to reexperience very intense feeling states. Therefore it is important to make the reenactment a structured experience in which the therapist provides rules and safeguards that protect the victim at a time when she may feel out of control and when her defenses are weakened. The victim is offered time after the session, if needed. During the actual reenactment, other members support her physically and emotionally by playing roles and protecting her from physical injury.

**Dealing with Shame**

Feelings of shame and guilt do not dissolve after the sexually abusive relationship ends, but persist into adult life. Shame is a powerful emotion involved in the development of psychiatric symptoms in general (Lewis, 1987) and eating disorders in particular (Rodin, 1992; Silberstein, Striegel-Moore, & Rodin, 1987). A primitive, imaginative emotion, shame presents itself in various, often very subtle ways. Seldom do clients speak explicitly of shame; instead they may speak of feeling foolish, ridiculous, pathetic, damaged, insignificant, invisible, or worthless. This is exemplified by a quote from a sexually abused woman: “I couldn’t figure out why that person had done this to me. Did he think I was pretty enough to desire in an unhealthy way? (After all, everyone else was saying how homely I was at that time.) Or did he abuse me only to make fun of my physical plainness and humiliate me? . . . I think of my body as a toy for someone to play with. I feel humiliated and dirty most of the time.”

The therapist must become familiar with the language of shame in order to recognize and probe for underlying shame feelings and experiences. It is important to label shame and to point out areas in which the client seems most shame bound. Clients need to be encouraged to examine self-talk about shame and to replace it with positive affirmations. It may be helpful to compare the brain to a computer: Our brain will believe what we tell it, that is, how we program it. For example, “I am bad” can be replaced with “Something bad happened to me.” The adult self is strengthened by confronting irrational beliefs about the self and linking them to their sources in traumatization. Gestalt exercises such as the “empty chair” in which the client talks to the shamed child, also can be helpful.

A shame ritual to help resolve the feelings of shame and guilt resulting from sexual abuse has been developed. This shame ritual is most effectively performed in group psychotherapy. Our work with shame rituals draws upon the extensive history of acknowledging ritual as an important aspect of healing. Rituals speak on multiple levels, metaphorically and directly, physiologically and cognitively, consciously and unconsciously (Van der Hart, 1983). The shame ritual is a ritual of transition, which facilitates the passage from a state of shame to one of shamelessness. The following account describes the sequence of steps in our ritual.

Participants are asked to cover themselves with black cloths and to remember the times when they have felt ashamed of their bodies. Then each client is instructed to find
a partner who will be her listener for the first half of the ritual and for whom she will serve as listener during the second half. The client in the listening role covers her partner with the cloth, places her hands on her partner's shoulders, and leads her backwards, as a symbol of receding into the past. Slowly she repeats the statement, "Tell me about the times you felt ashamed of your body." She listens and accepts the other woman's response by not asking questions or making comments. She simply repeats "Tell me about the times you have felt ashamed of your body." Next, still leading her partner backwards, the listener slowly repeats the statement, "Tell them about the masks you wore to hide the shame." Examples of responses include the following: "I lost weight and tried to make myself less noticeable." "I acted like I was hard. No one could ever effect me or get to me." Then, continuing to lead her partner backwards, the listener slowly repeats the statement, "Tell me about the ways you punished your body because of the shame." "I tried to make myself disappear by starving myself." "I pinched the flabby/fat parts of my arms and thighs to try to make the fat disappear." The listener then repeats the question, "Which names would you be called if you no longer felt ashamed of your body?" Repeating the names spoken by her partner, she now moves her partner forward and slowly removes the cloth. Clients have spoken these names, among others: "shameless," "honest," "feminine," "Joan of Arc," "Margaret Mead," "white dove." The participants thank each other and exchange roles. The dyads then return and form a circle to process the ritual as a group. The following responses are among others that have been given during the processing phase of the ritual. "I feel like I've been carrying around this load—feel like it's been unloaded and I have been accepted for who I really am." "Shame let me sink into my dark lonely world of depression, void of caring, love, trust, pleasure, and enjoyment. The shame restricted me from telling anyone what happened, but I see today that by keeping it to myself I felt worse. By talking about it I feel relieved and at peace with myself. Shame will no longer pollute my body, soul, or emotions. It's time to let go of the shame. Most of it belongs to someone else. I no longer need to use my body as a battleground where I hide, but want to take care of it."

We have found that through this ritual, group members can grant each other absolution as nobody else can. The ritual diminishes the humiliation of the client's role because in each dyad, each group member gives to the other and in turn becomes the other's source of acceptance and support. Taking the helping role enables all of the participants—but especially those who have been sexually abused and who feel undeserving—to accept attention and care from others.

### Ending the Cycle of Repeated Victimization

Research suggests that victims of child sexual abuse are at high risk for revictimization in form of physical or sexual abuse (Briere & Runtz, 1988; Jackson, Calhoun, Amick, Maddever, & Hasif, 1990; Wyatt & Newcomb, 1990). This indicates that treatment needs to incorporate a component dealing specifically with the pattern of revictimization.

In a recent group session, Mary, a 29-year-old bulimic woman, related the following experience: Her best friend asked her to come to the bar where the friend's boyfriend
was playing in the band. Mary was tired, so she told her friend that she would come but would stay only for an hour. When Mary arrived at the bar, her friend's boyfriend was drunk and began to harass her. Between sets of playing music, he called her names and told her how selfish she was. Mary stayed at the bar until 2:00 a.m., and binged and purged as long as she stayed. After listening to her story, a group member asked Mary why she stayed at the bar so long. Why didn't she leave as soon as the boyfriend began to harass her? Mary said she never considered leaving. Once he began to abuse her, her energy went into survival—how could she get through the night?—and she called on "her old friend bulimia" to help her. She could take his abuse as long as she was binging and purging.

Mary had never learned the skills required to protect herself and assert her rights in a relationship. She had acquired only a very limited or inaccurate sense of what she might reasonably expect from others. Freud's concept of the repetition compulsion is helpful in understanding the role of trauma in continued victimization and ultimately in psychological problems. In his 1920 paper, "Beyond the Pleasure Principle," Freud described the role of repression in the development of the repetition compulsion, which he saw as the emergence of repressed instinctual conflicts that became superimposed on current reality. He described how the client can remember little or none of what is repressed, and stated that he or she tends to repeat the repressed material in present life rather than remembering it as something in the past. Chu (1991) points out that actual trauma that has been repressed is often repeated. Persons who experienced trauma in the past find these experiences intrude into their current reality and they often feel a true compulsion to repeat repressed experiences. Repressed and dissociated events can emerge through dreams and nightmares, or as flashbacks. In addition, the victim unconsciously may find others with whom to act out traumatized relational patterns.

Thus it is crucial to the treatment to explain the concept of repetition compulsion. Clients must be encouraged to examine their present lives by identifying self-destructive patterns and relationships that they wish to change. The effects of repeated victimization must be discussed—how each experience deepens the individual's distrust of other people and increases feelings of aloneness. This pattern can lead to dependence on inanimate objects such as food or drugs to fill the self because the client has no hope that her needs can be met in a relationship.

Survivors' ability to assume control over sexual experiences is central to their healing and sense of control over their lives. Treatment should include strategies aimed at decreasing the likelihood of subsequent sexual abuse. Helpful interventions include teaching clients to identify the early signs of an abusive relationship (e.g., threats by the lover if she does not comply with his demands), examining clients' feelings and attitudes about abuse (e.g., clients may think that sexual abuse by a partner is due to men's inability to control intense sexual feelings and is a necessary aspect of sexual relationships), and facilitating responsible decision making about the potential consequences of sexual relationships such as pregnancy and sexually transmitted diseases (Wyatt, Guthrie, & Notgrass, 1992). As Wyatt et al. (1992) describe, sexually abused women need to learn to perceive themselves as sexual beings and not as sexual objects, to communicate their sexual needs, to anticipate when contraceptive use is needed, and to negotiate with partners about the type and frequency of behaviors in which to engage. This may be crucial to efforts to prevent revictimization. It is important not to limit questions on the client's ability to identify and communicate her own needs and her skills regarding sexual relationships. Rather, therapists should be careful to include an exploration of the client's partner's ability or willingness to relate to the client in a nonabusive way.
CONCLUSIONS

We possess a rich literature on behavioral and cognitive approaches to important issues in the treatment of eating disorders such as dietary restraint and cognitive distortions. Little has been written, however, on the treatment of sexual abuse. In this paper we discussed how sexual abuse can become the pathway for the development of an eating disorder and we described an approach to the treatment of abuse from a feminist psychodynamic perspective.

We have learned that through the development of self-soothing techniques, the client can tolerate the affect that is generated by working through the abuse and can achieve a sense of calm and control both in and outside of therapy. Through the appropriate pacing of memory retrieval techniques, the client can reconstruct the traumatized memory traces and can regain a sense of continuity and safety in her life. By experiencing and describing the effects of abuse in words, visual arts, and movement, she receives an opportunity to give a voice to the frightened, abused child and to say what could not be said in the original abusive scene. Through acceptance and care by the therapist, and at times by other group members, the survivor can let go of the shame, which in fact belongs to the perpetrator.

Recovery from abuse involves learning the details of the abuse and discovering how it has affected the victim’s life. Understanding the past enables the client to move to the next step, that of writing a new story for her life and body. This is no longer a tale of repeated victimization, but instead is an account of listening carefully to internal feelings and reactions, taking them seriously, and insisting that others take them seriously as well. It involves claiming the whole self in the world, reintegrating all parts of the self—past and present, anger and joy, sensuality and sexuality—a process that leads to more vitality and energy with which to meet the demands of adult life. Through a safe therapeutic connection, in which victims can be close to the therapist without risking betrayal or loss of self, survivors develop a renewed hope that their needs will be met with people rather than with food or other inanimate objects. Their focus switches from the arena of food, appetite, and weight to the world of relationships.

REFERENCES


