

## RESPONSE TO TRAUMA CAN TAKE MANY FORMS – PHYSICAL, MENTAL, EMOTIONAL – AND UNDERSTANDING THESE SIGNS CAN HELP PROFESSIONALS ENGAGED IN TRAUMA INTERVENTION AND PREVENTION.

Both established and emerging research has discussed the potential connections or relationship between sexual violence, more specifically child sexual abuse and disordered eating behavior (Neumark-Sztainer, Story, Hannan, Beuhring, & Resnick, 1999; Smolak & Levine, 2007). This Technical Assistance Bulletin outlines some of the available research with the hopes of helping practitioners in the anti-sexual violence movement begin building new partnerships and inform direct service practice.

## EMERGING LINKS WITH SEX ABUSE AND EATING DISORDERS

An eating disorder, understood as a broad concept, is when an individual's diet, exercise regimen, relationship to food, body image (or any combination of these factors) takes an enormous amount of time and energy in their everyday life (U.S. Department of Health and Human Services, National Institute of Mental Health [NIMH], 2011). Eating disorders can have life-threatening consequences and recovery can be a lifelong process. Rituals concerning weight control and eating, restrictive eating behaviors, and purging have been suggested not as results of child sexual abuse, but as strategies for managing trauma and stress related to victimization (Hudson, Hiripi, Pope, & Kessler, 2007; van Gerko, Hughes, Hamill, & Waller, 2005; Wonderlich, Wilsnack, Wilsnack, & Harris, 1996). Larger-scale studies can help with determining prevalence of behaviors and victimization – there are few studies that look at these relationships, but some have begun to draw concrete connections.

In the mid-to-late 1990s, Kaiser Permanente and the Centers for Disease Control and Prevention (CDC) surveyed 17,000 individuals within a health care management network regarding what they termed Adverse Childhood Experiences (ACE) (For more information on the ACE Study, head to the CDC's ACE Study resources). The findings revealed a number of realities that many working in trauma and intervention have known anecdotally for decades: early abuse and traumatic experiences impact physical and mental health throughout life. Attitudes toward eating and weight could be argued as coping strategies for individuals who have experienced trauma. The most often



**PENNSYLVANIA COALITION AGAINST RAPE**

125 North Enola Drive • Enola, PA 17025

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investigated health outcomes have been obesity<sup>1</sup>, binge eating, and bulimia and bulimia-related behaviors.

A person diagnosed with or exhibiting behaviors of **bulimia nervosa** will consume large amounts of food, while feeling out of control, and then force themselves to vomit, use laxatives excessively, restrict caloric intake, exercise excessively, or some combination of these behaviors (Hudson et al., 2007). The binging (consuming a lot of food) is a source of stress and anxiety, and the purging (vomiting, excessive exercise, etc.) is a way to relieve that anxiety.

Some distinctions between bulimia and anorexia are that individuals with bulimia are typically an average weight, but are preoccupied with losing weight or getting to an ideal weight. Approximately 1-2% of young women and adult women meet criteria for the diagnosis of bulimia nervosa with symptoms started around 20 years of age on average (AED, n.d.; Hudson et al., 2007).

Studies have looked at the potential links between childhood sexual abuse and bulimia or bulimic behaviors in young and adult women (Miller, McCluskey-Fawcett, & Irving, 1993; Pope & Hudson, 1992; van Gerko et al., 2005; Wonderlich et al., 1996), as well as male and female adolescents (Neumark-Sztainer, 1999). Further research needs to explore these potential linkages, but bulimic behaviors in adolescence and adulthood could be one way an individual may manifest trauma from the abuse or cope with body image and interpersonal relationships.

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<sup>1</sup> It should be noted that obesity is not an eating disorder or the outcome of an eating disorder. Research examining obesity and child sexual abuse has been focused on health outcomes in general, not on eating disorders specifically. Obesity is mentioned in this resource because of the connections between controlling eating or physical appearance as a coping mechanism or response to trauma.

Individuals who experience **binge or compulsive eating disorder** share the emotional components of other eating disorders, particularly bulimia, but do not purge after consuming large amounts of food. Individuals with compulsive eating disorder are typically normal or slightly above average weights (National Eating Disorders Association [NEDA], 2005). Although obesity is most often not caused by an eating disorder such as compulsive eating, there can be feelings of negative self-worth and body image due to social norms and pressures to achieve thinness. One investigation using data from the ACE Study found that abuse of any kind was a significant risk factor for obesity in adulthood, with the frequency and severity of abuse being a considerable contributor (Williamson, Thompson, Anda, Dietz, & Felitti, 2002). Other studies looking at obesity and child sexual abuse have found similar connections, suggesting weight gain to be a protective mechanism to prevent sexual interest or further abuse (Felitti, 1993).

**Anorexia nervosa** and restrictive eating and weight management behaviors are characterized by extreme weight loss and food restriction or dieting (NIMH, 2011; NEDA, 2005). It is estimated that up to 1% of young women and adult women meet criteria for the diagnosis of anorexia nervosa; behaviors begin at age 19 on average (AED, n.d.; Hudson et al., 2007). Research connecting eating disorders and sexual violence is still emerging and investigations of other eating disorders, such as anorexia, are slowly entering the dialogue. Although studies have found low self-esteem and body image disturbances to be related to sexual abuse, restrictive eating behaviors such as anorexia have not been clearly or concretely connected (van Gerko et al., 2005).

## RECOMMENDATIONS FOR ADVOCATES

The eating disorders discussed above and eating disorders not otherwise specified (EDNOS), as well as concerns about body-image, can reflect unresolved trauma or lingering effects of sexual abuse on the body. These behaviors and attitudes can be understood as coping or survival strategies for victims of sexual violence. There are a number of strategies sexual assault practitioners can take when trying to better understand eating disorders and disordered eating behavior, as well as strengthen their skills to serve survivors of sexual violence who may be experiencing anxiety regarding weight control or body image. Below are just a few resources – for more, see the NSVRC’s online collection exploring the links: *Eating disorders & sexual violence*.

- Use some of the research presented to support or advocate for sexual violence prevention efforts that include conversations of body image and critical media literacy skills. This research can also give support to groups focused on child sexual abuse prevention as childhood trauma is connected to negative physical and mental health outcomes.
- Share the connections between eating disorders and sexual violence with clients. This can be done through activities that help survivors identify areas where they may have a difficult relationship with their body, create opportunities to concentrate on and celebrate strengths and abilities, and encourage times where that celebration can be incorporated into daily life.
- Get familiar and comfortable with discussing concepts around healthy sexuality and connecting mindfully to the body. These connections can help counteract a



negative self-talk or media messages about weight, appearance, and control.

- Outreach to professionals that focus on eating disorder treatment and discuss potential collaborations or cross-trainings. To find a professional in your area, head to the National Eating Disorder Association’s website.

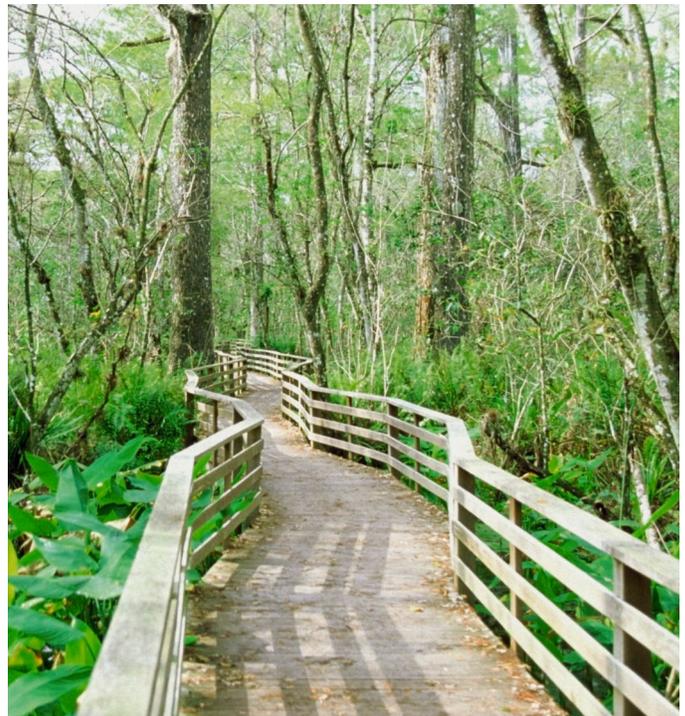
## ABOUT THE AUTHOR

*Liz Zadnik is Education & Resource Coordinator at the Pennsylvania Coalition Against Rape (PCAR), and has worked in the violence prevention and reproductive justice movements as a community educator and organizer.*

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