AN EXPLORATIVE STUDY ON THE EXPERIENCES OF BULIMIC WOMEN WHO HAVE BEEN SEXUALLY ABUSED.

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DECLARATION

The author hereby declares that this entire thesis, unless specifically indicated to the contrary in the text, is her own work.

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ABSTRACT

Eating disorders, may be conceived of as a psychological and physiological disorder, which has received a large amount of attention from academics from various disciplines. The incidence rates and aetiological factors involved in the development of eating disorders, specifically anorexia nervosa and bulimia nervosa. have recently been highlighted. A number of researchers have suggested that sexual abuse is a predominant factor in the development of bulimia while other researchers argue that the relationship between sexual abuse and bulimia remains unclear. This study is a qualitative exploration of bulimic women's experiences of sexual abuse and is intended to highlight the 'lived experiences' of these women. Thematic content analysis was used to investigate the experiences of the women by using verbatim quotes from the semi-structured interviews that were conducted with the women. The women were four participants who were admitted as inpatients into Kenilworth Clinic's Eating Disorders Unit. All four women were diagnosed with Bulimia Nervosa according to the American Psychiatric Association (APA, 1994) criteria and had disclosed to a staff member that they had been sexually abused by either a known or unknown perpetrator. Findings revealed that the participants had experienced four salient issues that were discussed as themes. These themes were anger, issues regarding control, the participants' experiences of abusive relationships and feelings of detachment. Based upon the findings of the interviews conducted, recommendations towards enhancing the psychological well being of women who have been sexually abused and diagnosed with bulimia were generated.

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I would like to thank everyone who supported me while completing this thesis.

GLOSSARY

P1	:	Participant one
P2	:	Participant two
P3	:	Participant three
P4	:	Participant four
Tanya Burger	:	dietitian of the participants at Kenilworth Clinic
Graham Alexander	:	Individual therapist of participant four
An Fiske	:	Individual therapist of participant three
dunno	:	don't know
ja	:	yes
wanna	:	want to
cause	:	because

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CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION TO THIS STUDY

The focus of this study is to qualitatively explore the experiences of bulimic women who have been sexually abused. The women who volunteered to be interviewed in this study were four women who were patients in the Eating Disorders Unit at Kenilworth Clinic. They were diagnosed with bulimia nervosa according to the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders- Revised (APA, 1994) and had disclosed to staff members that they had been sexually abused in the past.

The research method used in this study was a qualitative one. Thematic content analysis was used to explore the experiences of the four women interviewed. A psychoanalytic theoretical framework was used to locate the experiences of the women.

Eating Disorders have gained attention from the media, mental health professionals, and associated allied professionals, such as dietitians, over the past four decades. According to Gordon (1990) the media portrays the image that thinness amplifies emotions and values that were already latent within the populace. Malson (1998) suggests thinness is synonymous with delicate, meek and childlike femininity and the very thin body can be seen as a particularly efficient signifier of traditional romantic femininity.

Feminists challenge the necessity for women to be thin. They question the communications inherent in disordered eating. A conclusion mentioned by Brown (cited in Brown & Jasper, 1993) is that women's ability to control their bodies becomes an accessible and viable way in which they could have some measure of control in their lives.

Studies indicate that traumatic events in early childhood are often common amongst women who have developed anorexia nervosa or bulimia nervosa (Andrews, 1997; Harned, 2000). Sexual abuse is one specific type of trauma that women have been subjected to and a predisposing aetiological factor in the development of bulimia nervosa. However the debate regarding the correlation between sexual abuse and eating disorders, including bulimia, remains unclear (Mahon, Winston, Palmer, & Harvey, 2000), although there is continuing research in the area (Myers, 2001).

The motivation for this study arose from my personal experiences at the Eating Disorders Unit at Kenilworth Clinic prior to my training as a psychologist. Whilst working at the unit, many anorexic and bulimic patients were admitted into the unit for therapeutic intervention. As part of their therapeutic intervention patients who were sexually abused were often referred to me for sexual abuse counselling as I was a trained Rape Crisis counsellor. This counselling was separate from their psychotherapy and would only occur if they expressed discomfort about speaking to their individual therapist who was often a male therapist. During my interaction with the patients I considered the idea that patients would benefit more from a psychotherapeutic intervention if their sexual abuse counselling could be combined with their

psychotherapy sessions and to be addressed by only one therapist. This would be discussed in more detail as a recommendation in the final chapter.

1.2 RATIONALE FOR THE STUDY

Research conducted by Matsunga, Kaye, McConaha, Plotnivoc, Pollice, Rao and Stein (1999), and Waller (1996) over the past decade has been directed towards finding the relationship between sexual abuse and bulimia nervosa. The outcome of their study was that women who were diagnosed with bulimia nervosa and who were sexually abused tended to have difficulties trusting people in their immediate environments. Waller (1996) found that sexually abused bulimic women had more external locus of control than bulimic women who had not been abused. Although this study reviewed literature, which concentrated on the notion that sexual abuse may be an aetiological factor in the development of bulimia nervosa, it is not the intent of this study to prove that. The rationale of this study is to consider the experiences of four bulimic women who have been sexually abused, in order to have an integrated understanding of their intrapsychic psychodynamics. An understanding of this nature could be used to inform psychotherapeutic interventions with patients with similar backgrounds in the future.

1.3 BULIMIA NERVOSA

1.3.1 History and definition of bulimia nervosa

The origin of bulimia nervosa dates back to the tenth century and was a common practice after elaborate banquets in Rome. In 1380 the purging or vomiting of food was

used as a method of punishment and penance by the nuns during the time of feud. It is reported that a nun by the name of Caterina de Siena would vomit out her food and would consume large amounts of grass which served as a diuretic for her (Matzkin, 2002).

At the beginning of the 20th century bulimia was regarded as a somatic disorder, cerebral injury and congenital abnormality. It was further described as the presence of 'own vomit followed by voracious appetite' (Matzkin, 2002). As time progressed it was described as a neurotic disorder. Kinoy, Holman, D.S.W and Lemberg (1999) stated that a French psychiatrist, Pierre Janet was amongst the first who documented a profile of a woman who binged and purged compulsively, but whom never appeared to have lost her appetite. In 1979 an American authority, Dr. Russell, defined bulimia nervosa. The definition used in the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994) is based on the definition of Dr. Russell, which is the excessive ingestion of food in a short period of time, accompanied by a loss of control of the ingestion (Matzkin, 2002). The DSMIV-R diagnostic criteria of bulimia nervosa are summarised below as:

- recurrent episodes of binge eating,
- recurrent inappropriate compensatory behaviour in order to prevent weight gain,
- the binge eating and inappropriate compensatory behaviours both occur on average, at least twice a week for three months,
- self-evaluation is unduly influenced by body shape and size,
- the disturbance does not occur exclusively during episodes of Anorexia Nervosa. (APA, 1994, p. 549-550).

According to Kaplan and Saddock (1998) bulimia nervosa is defined as 'binge eating combined with inappropriate ways of stopping weight gain' (p. 727). The avoidance of

weight gain is achieved through self-induced vomiting, the use of laxatives, abstaining from food and excessive exercising. However a bulimic woman's weight is often in her expected goal weight range. The withdrawal of food and the engaging in obsessive exercising is known as compensatory behaviours. According to the DSM IV–R's criteria binging and compensatory behaviour must both occur minimally twice a week for a period of three months before a diagnosis of bulimia nervosa can be made (APA, 1994; Kaplan & Saddock, 1998).

Bulimic women are often referred to by themselves or others as "failed anorexics" as they do not display the same resistance to food as women who are diagnosed with anorexia nervosa (Lawrence, 2001). Bulimia nervosa is considered to be a secret disorder as women's bingeing and purging behaviours often transpire without anyone being aware of their disorder.

Matzkin (2002) states that concerns around weight have always being unconsciously associated with sociocultural values, with bulimia becoming a social epidemic in the 1970s. However, she argues that the disorder was probably much more common than reported, but could have been diagnosed under other psychiatric disorders or medical conditions.

1.3.2 Incidence

Rand and Kuldau (cited in Brown & Jasper, 1993) stated that it was originally thought that eating disorders affected primarily young women who were from advantaged financial backgrounds. However it now appears that women of the lower socio-economic classes and older women also have difficulties related to food, weight and shape. Dolan (cited in Brown & Jasper, 1993) argues that women from western socialisation and cultural influences appear to be at a greater risk in developing eating disorders than African American, Asian or Greek women. Conversely Brown and Jasper (1993) state that researchers and clinicians may not be aware of the extent of eating disorders among black populations because they do not ask the right questions or recognise the symptoms of those who are outside of their framework.

The clinical presentation of eating disorders may vary across cultural groups, contributing to the number of underreported cases (Cavanaugh & Lemberg, 1999). It is noted that an increase in the prevalence of eating disorders among African American women is due, in part, to increased affluence amongst the population. Furthermore it is stated that African American women probably have access to upper and middle class white values that may be related to thinness (Cavanaugh & Lemberg, 1999).

The onset of bulimia is often in adolescence or early adulthood (Kaplan & Saddock, 1998). Women are diagnosed more frequently than men, with studies indicating that males make up five percent of the eating disorder population (Burstow, 1992). Bulimia nervosa is known to occur in families where there has been familial depression and

and dysfunction (Kaplan & Saddock, 1998). Research studies are further aimed at examining the impact of childhood trauma and societal pressure on the development of bulimia nervosa. Women diagnosed with bulimia tend to describe their families as neglectful and rejecting in their childhood (Kaplan & Saddock, 1998).

1.4 SEXUAL ABUSE

1.4.1 History and definition of sexual abuse

Female activists in the 1870s were amongst the pioneers who petitioned in the British Parliament against the sexual abuse of girls. At approximately the same time psychoanalyst Sigmund Freud was developing his own theory around sexual abuse as he recognized the significance of childhood experiences and the direct relationship the abuse had in the later life of the young girls.

Freud's theories had to be retracted as his audience did not find them acceptable (Deblinger, 1992). However he addressed the sexuality of young children by developing his theory around the Oedipal Complex which was more acceptable to his colleagues. When Freud had to withdraw his theory regarding sexual abuse, people in the broader society continued to deny that sexual abuse was occurring frequently (Deblinger, 1992). However for the past two to three decades there have been a concern about whether sexual abuse was being over diagnosed in children (Good, 1994). Prior to this, the focus was directed towards addressing the role of the family when viewing the traumatic experience. It has been argued that it was never the intention to discount the children's sexual accusations against adults (Good, 1994).

Child abuse is the physical abuse, sexual abuse and child neglect that is experienced by male and female children across ethnic groups and socio-economic levels and is associated with a wide range of emotional problems. According to Kaplan and Saddock (1998, p. 847) 'children who are physically or sexually abused exhibit psychiatric disturbances such as anxiety, posttraumatic stress disorder and depressive disorder and may have increased suicidal ideation.'

Researchers such as Kendler, Bulik, Silberg, Hettema, Myers and Prescott (2000) define sexual abuse as any sexual act before the age of 16 years and for the perpetrator to have been an adult. The sexual acts include unwanted incidents such as being invited or requested by the perpetrator to behave sexually by kissing, hugging, touching, fondling of genital areas of perpetrator as well as exposing sex organs to the perpetrator against the survivor's will. Sexual abuse also includes forced or attempted sexual intercourse with a survivor (Kendler *et al.*, 2000).

Researchers such as Dickinson, deGruy, Dickinson and Candib (1999) consider moderate sexual abuse to include intentional sexual kissing, genital or breast contact, or simulated intercourse before the age of 14 years by a person at least two years older than the survivor. Severe sexual abuse is defined as attempted or completed sexual intercourse against the wishes of the survivor (Dickinson *et al.*, 1999).

1.4.3 Incidence

In the United States 150 000 to 200 000 new cases are reported every year (Kaplan & Saddock, 1998). In South Africa, 9399 new cases of sexual abuse were reported for the period between January and June 1999 (South African Police Services, 1999). These cases only present the number of cases that are reported to the Child Protection Unit. The numbers are therefore under-reported cases of sexual abuse crimes committed against children. Statistics indicate that sexual abuse occurs between 3% to 31% in males and 6% to 62% in females. The perpetrators who are often identified in the reported cases are fathers, stepfathers, uncles or older siblings, friends and strangers (South African Police Services, 1999). In international studies 21.4% of the perpetrators were relatives living in the home of the survivor, 2.4% were relatives who were not living in the home of the survivor. Perpetrators such as family friends and other important adults made up 13.5% of perpetrators, with 11.3% of perpetrators who were identified as strangers (Kendler *et al.*, 2000).

1.5 SUMMARY

The earliest documentation on bulimia nervosa dates back to the late 13th century. At the beginning of the 20th century bulimia was considered as a somatic disorder and by 1979 appeared as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (Matzkin, 2002; Kinoy *et al.*, 1999). Current feminist literature focuses on the incidence of the disorder, stating that bulimia nervosa is more common amongst certain cultural groupings than was previously thought (Brown & Casper, 1993).

Female activists in the 1870s at approximately the same time that Freud had developed his theory on the Oedipal complex petitioned the British Parliament against the sexual abuse of girls (Deblinger, 1992). Since the early 1970s and 1980s much more research has been conducted in the area of sexual abuse, with researchers such as Good (1994) being concerned about the over diagnosis of sexual abuse in children.

Research in the development of bulimia nervosa has directed studies by researchers such as Matsunga *et al.*, (1999) and Waller (1996) to look at the influences that sexual abuse experiences may have on women who are bulimic. The rationale of this study is to qualitatively report the experiences of bulimic women who have been sexually abused. An analysis of their disclosures will be used to inform recommendations for future therapeutic interventions for women who have similar experiences.

1.6 CHAPTER ARRANGEMENT

Chapter Two provides theoretical overviews of bulimia and sexual abuse that are relevant to this study. These theoretical perspectives are the Psychoanalytic, Feminist, Systems and Cognitive-Behavioural perspectives. The chapter will integrate the literature reviewed regarding the theories of bulimia and sexual abuse and will conclude with an overview of studies conducted by international and national researchers regarding bulimia and sexual abuse.

Chapter Three examines the use of qualitative research methods as adopted in this study. This includes the aim of the study and the rational for employing this method. The chapter will focus on demographic details about the participants, the interview procedure, along with ethical considerations, aspects of reflexivity and reliability and validity regarding this study.

Chapter Four explores the findings of the interviews, highlighting the salient themes that emerged during the interviews. These themes will identify the participants' physical and emotional experiences of the sexual abuse and their bulimia. The themes will be discussed in relation to the literature that was provided in chapter two.

Chapter five will summarise the findings of the study. The study will be evaluated by discussing the limitations of the study and by providing recommendations for future research in this area.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

Richard Morton, a physician in 1689 was the first mental health professional to document the medical condition of a patient that he described as 'nervous trophy', which was a loss of appetite, accompanied by digestive difficulties. Morton could not locate any pathological signs for the patient's condition and considered it to relate to a 'singular manner' of depression (Palazzoli, 1963). From this time forth, more and more researchers have become interested in eating disorders, and are able to explain both anorexia nervosa and bulimia nervosa from different theoretical frameworks. While the research on eating disorders increased in the early parts of the century, Sigmund Freud is noted to be amongst the first writers to document writings on sexual abuse (Deblinger, 1992).

The aim of this study is an exploration of the experiences of four women who were diagnosed with bulimia nervosa. These women were also sexually abused. In order to contextualise the experiences of the women, literature from different theoretical frameworks will be reviewed. Four different theoretical orientations including the psychoanalytic, feminist, systems and cognitive-behavioural will be discussed to create an understanding of bulimia nervosa and sexual abuse. There will, however, be an emphasis on psychoanalytic theories.

2.2 THEORETICAL PERSPECTIVES ON BULIMIA AND SEXUAL ABUSE

2.2.1 Psychoanalysis and bulimia

Psychoanalysts such as Guntrip (cited in Dana & Lawrence, 1988) believe that bulimia nervosa starts as early as infancy in women. Women who have been diagnosed display tendencies in which bulimia manifests itself during infancy. According to Dana and Lawrence (1988) an infant's ability to survive depends on the relationships they have with their mothers or the relationships that the mothers are able to form with the infant. Guntrip (in Dana & Lawrence 1988) suggests that bulimia may result from a relationship in which an infant's needs were not met. A primary need of an infant is that of being fed, with the infant depending on the mother to fulfil these needs. When the need is met the infant feels nurtured. The infant is aware that needs such as being fed will be met again. However if the infant's needs are not met it may result in the infant feeling desperately hungry (Dana & Lawrence, 1988).

When needs are not met spontaneously the infant will attempt to swallow the breast/ bottle to internalise the object (mother) to ensure that it can not be taken away from her again. However by swallowing the breast/bottle, high levels of anxiety are incorporated into the psyche of the infant as it now fears for the safety of her mother (Dana & Lawrence, 1988).

If an infant's needs are not resolved in infancy food will be used as a defense mechanism against problems that arise in adulthood. According to Kader (1999) the bulimic woman is hungry for food and the nourishment it provides. Furthermore she is seeking attention and nurturance from people but her needs are not being met

emotionally. The bulimic woman creates relationships for herself where she believes that her love is destructive. This leaves her feeling either withdrawn or fearful that she will be 'swallowed' in the relationship (Guntrip, in Dana & Lawrence, 1988). Thus she rejects both food and people as she is afraid of rejection as well as her own neediness (Kader 1999).

Guntrip (in Dana & Lawrence 1988) suggests that a large amount of food is consumed to substitute for the neediness that is being experienced by the bulimic woman. However she vomits out what she has consumed to separate herself from the people she cannot possess. Symbolically it is as though the bulimic woman wants to possess, consume and control the person that she desires, namely her mother. Not being able to do so, the bulimic consumes food, which is representative of the mother. She becomes terrified of succumbing to her needs, so much so that she immediately vomits out what she has consumed (Guntrip, in Dana & Lawrence 1988). Lastly Guntrip argues the bulimic woman's continual bingeing and purging is an attempt to satisfy as many of her needs as possible so that she will never be deprived again.

Dana and Lawrence (1988) consider a Klienian approach in understanding bulimic women. They state that a woman who develops bulimia may feel insecure to integrate the good and the bad parts of herself. Sometimes the bulimic woman can have a sense of herself and other people as a complex mixture of love and hate. At other moments she feels quite overwhelmed by their badness. According to Dana and Lawrence (1988) the bulimic woman will consider that her badness and imperfections have a tendency to threaten and attack anything good within her. According to Kader:

> Bulimia functions both as a means of stifling these bad and disturbing emotions as well as a way of giving them some expression. It is also a way of attempting to feel the intense feelings which bulimics split off and repress (1999, p.22).

Lawrence (2001) argues that the bulimic behaviour of a woman represents an attempt to control the internal world and that eating disorders should be considered as mechanisms that women use as manic defenses against depressive pain. Episodes of vomiting represent a phantasy of killing internal objects (i.e. mother/parents) but the objects will not die or stay dead hence the need for serial killing or repeated vomiting. For the bulimic her objects appear more resilient than she had anticipated, but at the same time she is aware of her intense need for them as demonstrated by her binges (Lawrence, 2001). However the bulimic realises her dependent personality on her objects and vomits again to display her hatred and repudiation of her objects. Although Lawrence (2001) speaks about the bulimic murdering her internal object she suggests the ultimate aim is control over internal worlds. However this control is kept a secret. The bulimic destructiveness is hidden and denied and is often the behavioural aspect of her personality that she dislikes (Lawrence, 2001).

Psychoanalytic writers Sugarman and Kurash's theory on bulimia nervosa extends from as early as infancy (cited in Josephson, 1985). According to their theory the infant's separation from the mother is slow, suggesting that women with bulimia were not able to proceed beyond the initial phase of separation. Sugarman and Kurash (cited in Josephson, 1985) believe that infants use their own bodies as the first transitional object. The body represents a combined sense of tactile and sensory features of an object. After this, infants find transitional objects that are separate from themselves,

making them more autonomous in the process. Sugarman and Kurash draw on object relation theorist Winnicott's concept of transitional objects and which explains that the infant uses a blanket or some other object to represent the mother. Sugarman and Kurash (cited in Josephson, 1985) argue that the infants who have failed at separating from their parents become bulimics later in life. This is due either to over involvement or under involvement, making it difficult for the infant to progress through the first stage of transitional objects, therefore making it difficult for the infant to separate from her mother and achieve independence.

According to Josephson (1985) the problems of identity and autonomy re-emerge under the pressures of biological change. Since the young adolescent with bulimia has not adequately separated from her mother she reverts to early synthesis of her mother with her own body. The bingeing and purging behaviour of the bulimic adolescent allows her to develop a sensorimotor representation of the mother. It is argued by Sugarman and Kurash (cited in Josephson, 1985 p. 93) that 'food is not the issue, rather it is the bodily action of eating which is essential in regaining a fleeting experience of mother'

Psychoanalyst Bruch's theory on bulimia nervosa is described as cumulative difficulties in the infant's interactions with her parents (Josephson, 1985). Infants learn to distinguish emotions from each other in the manner in which their parents interact with them and how the parents respond to their needs. According to Bruch's theory, if the infant's parents consistently misinterpret the infant's needs, she herself will not be able to judge her needs accurately (Josephson, 1985). It is believed that parents who constantly offer their infants food as a consolation for emotional injury may convince

the infant that feelings of hunger concur with emotions of pain. Drawing on the idea of Bruch's theory, Josephson (1985) states that if a mother's reaction is continuously inappropriate the infant will experience confusion and when the infant is older she will not be able to distinguish between nutritional needs and any discomfort or tension that she is experiencing. Without being able to assess her own needs, the infant who has now matured is not able to understand her own needs and might feel helpless to control herself (Josephson, 1985).

According to self-psychologist Bachar (1997) bulimic women cannot depend on human beings to fulfil their self-objects and resort to food to assist them in fulfilling these needs. Self-object is described to be when one person relies and expects another person to fulfil their internal needs for them. The person fulfilling the needs becomes the self-object, normally the mother (Bachar, 1997).

Food is considered to be an extension of the mother's interactions with the child, often seen as a soothing substance. If the mother is unavailable or fails to satisfy the child as a self-object then food becomes a substitute selfobject experience for eating disorder patients (Bachar, 1997 & Krueger, 1998).

Bachar (1997) considers bulimic women to receive satisfaction of their self-objects through food and experience this as omnipotent power. Food provides the nurturant qualities such as calmness and comfort that are required by bulimic women for their emotional survival. Food can also be used as an expression of painful and difficult emotions such as anger, depression, shame and guilt. The bulimic women depend on

food as their selfobject to defend and protect them against their emotional distress in much the same manner that others will defend against human self-objects (Bachar, 1997).

Krueger (1998) considers an aspect of control to be present in eating disorders patients; namely the bulimic who is knowledgeable about food such as its calorie and fat content. A binge can provide the illusion that the bulimic can attain anything, and everything she wants is within her limits. There is no separateness of herself from the food or its unavailability because the selfobject is ingested and becomes one with her body and psychological self. The bulimic can vomit the food out and divest herself from any of her "bad objects" (Krueger, 1998).

2.2.2 Psychoanalysis and sexual abuse

According to Miller (1986) the consequences of sexual abuse not only lead to problems in one's sexual life, but further impair the development of the self and of an autonomous personality. Miller (1986) explains that there are several reasons for this, for example having one's helplessness and total dependency taken advantage of at an early age, which produces an interlinking of love and hatred. If the perpetrator was previously known and if there was a relationship of love, anger towards the perpetrator cannot be expressed. There is a fear of losing the love and therefore the interlinking of love and hatred remains. These impact on characteristics of later relationships, for example 'many people cannot imagine that love is possible without suffering and sacrificing without fear of being abused, without being hurt and humiliated' (Miller 1986, p. 162).

The sexual abuse must be repressed to enable the survivor to survive and any attempt to undo this repression must be warded off immediately. If not, this might result in the disintegration of the personality and manifest itself in for example, depression. Miller (1986) argues that if a survivor has no emotional support structure her emotional well-being will deteriorate and leave her with feelings of fear and powerlessness. She further argues that the consequence of the trauma is not eliminated by the repression, rather that it is reinforced. The inability to recall the sexual abuse, or to articulate it to someone who the survivor feels emotionally supported by, creates the need to articulate it in the *repetition compulsion.* The form in which the repetition often occurs is when the survivor is in a situation where she can be abused again by another loved object, and where the abuse is perpetuated in a passive or active role, or simultaneously (Miller, 1986).

Weissberg (in Du Zulueta, 1996) considers incest, a form of sexual abuse, to be a symptom as well as a cause of individual and family dysfunction. Incest may result from parents who are unable to be empathic and will use their own child to satisfy a self-centred need. The parents further need the family to stay together, with the mother passing on her central role in the family to her daughter. The father turns to his daughter in an attempt to seek love which he may not have received from his own parents or his wife. According to Du Zulueta (1996) the daughter is coerced into keeping the secret and later on develops an understanding that something bad is occurring to her. Friedrich (1990) describes these mothers as passive-aggressive or dependent personalities on their husbands or as both. This would occur especially if the

herself has unresolved abusive experiences. Often her experiences may create a conscious or unconscious motivation for her daughter to be abused (Friedrich, 1990).

Theoretical considerations by theorists such as Sullivan and Winnicott (cited in Freidrich, 1990) suggest that young children do not have the emotional or cognitive repertoire to adequately process threatening events such as sexual abuse (Friedrich 1990). According to Sullivan (in Friedrich, 1990) the child has not developed a 'not me' persona to exclude threatening memories. He goes on to explain that personalities are reflected in our interactions with other people. Positive interactions contribute to the development of a "good me" while negative interactions contribute to the development of a "bad me" and overwhelming experiences to a "not me" persona. Since the experiences such as sexual abuse are overwhelming to the survivor they are not psychologically processed and are perceived to be held in the survivor's unconscious unless triggered by a precipitant event (Sullivan, in Freidrich, 1990).

Winnicott (in Freidrich, 1990) argues that children divide their experiences into good and bad. With the proper nurturing children grow and become differentiated and are able to distinguish right from wrong and realise that they cannot rely on the two polarised ends to function adequately in their daily lives. For this reason they need to find a place in between which becomes their frame of reference. Incidents such as sexual abuse are overwhelming for the child and out of the survivor's frame of reference, creating extraordinary anxiety. Winnicott, like Sullivan (in Friedrich, 1990) states that since the abuse is out of the survivor's frame of reference the event remains in the unconscious and becomes "split off" from her differentiated self.

Sandberg, Lynn and Green (1994) refer to the concept of "spilt off" as a defense mechanism that may also be referred to as dissociation. Dissociation is a defense that serves to protect or block out any threatening material to the conscious awareness. By being able to use this defense mechanism people such as survivors of sexual abuse are able to protect themselves from traumatic memories and to mobilise against the pain and helplessness that were engendered. However Sandberg *et al.* (1994) state that the continued reliance on dissociation as a protective measure may become maladaptive and the survivors of sexual abuse may lack the anticipatory anxiety that would normally signal the presence of danger. This would increase the survivor's vulnerability, increasing her opportunities to be revictimised. Furthermore survivors who dissociate lack the nuances required for interpersonal relationships since they have not been educated to protect themselves from any potentially painful experiences in the environment.

Object relations theories by psychoanalysts such as Fairburn and Cashdan (cited in Sandberg *et al.*, 1994) argue that their theories may be used to further understand the psychodynamics of sexual abuse as it is a fundamentally interpersonal experience for survivors. Object relations theory focuses on the way in which the young child creates mental representations of herself and others. Through the process of introjection, the child views herself in the same manner she is treated by significant care-givers (Sandberg *et al.*, 1994). Thus if the child is subjected to severe abuse, she will form a negative view of herself. The child might also experience it to be too threatening to experience the parent as bad or evil, since the child must depend on the parent to

survive. thus the child is likely to blame herself. This enables her to preserve the parent as a good object. (Sandberg, *et .al.*, 1994).

Wakefield and Underwager (2002) asserts that the memory of sexual abuse is often buried with the happy memories of the survivor's childhood. The part of the abuse that is remembered is vague recollections or awareness that the abuse occurred. Blume (1990) argues that while the survivor may not remember all the abuse that has occurred, the survivor might still display symptoms which are suggestive of sexual abuse. Dolan (cited in Wakefield & Underwager, 2002) describes the symptoms which form a wide range of psychological disorders such as eating disorders, substance abuse, depression, anxiety disorders and personality disorders. Other symptoms include dreams of being pursued, distrust of others, self-destructive behaviours, guilt and difficulties with interpersonal relationships (Wakefield & Underwager, 2002).

2.3.1 Feminism and bulimia

Feminist theorists consider eating disorders to be laden with gender identification that is prescribed to women in a male dominated society (Burstow, 1992; Kuba & Hanchey, 1991; Sesan & Katzman, 1998). There is further a sociocultural belief and expectation that thin is synomous with being attractive. Women therefore believe the ability to be thin and attractive is what is expected of them and may become prone to an eating disorder to achieve this status (Kuba & Hanchey, 1991; Sesan & Katzman, 1998).

Kuba and Hanchey (1991) argue that women are considered to be weak and dependent while men are viewed as strong and dominant. The men are also often the individuals

who possess power given to them in their public portfolios such as leaders of nations and corporations. Oppressed women do not necessarily have the opportunity to exert their power in society like the men are able to, and are forced to exert it in the domestic sphere such as the kitchen, which includes control over weight and eating patterns (Kuba & Hanchey, 1991).

Burstow (1992) and Katzman (1998) argue that one aspect of eating disorders is that they are saturated with racial discrimination and prejudices. Burstow (1992) argues that women are expected to violate themselves and conform to the social and moral values of the men who are descendents from dominant white societies. This often involves having to alter their bodies to fit the desired description, which may result in the development of an eating disorder.

Burstow (1992) and Kuba and Hanchey (1991) mention that women not only violate their bodies to satisfy the needs of others, but they often have to physically and psychologically cater for the needs of those around them. Food is considered to be a source of nurturance and much of the women's attention is given to choosing and preparing meals. This is deemed as acceptable, as it is an expectation that is being fulfilled by the women to provide others with love and attention while the women themselves remain unnurtured (Burstow, 1992; Kuba & Hanchey, 1991). These behaviours often occur because women again have less power to access their control and have a strong need to conform to social norms resulting in behaving in traditional feminine ways (Sesan & Katzman, 1998).

of the family would be a consequence of the survivor's behaviour and not that of her father (Burstow, 1992). Furthermore it is not easy for the survivor to separate psychologically from her father while he remains in the house, as they still interact with each other (Walker, 1998). It is suggested that this occurs because she cannot accept the reality of his abusive behaviour towards her. It is too complicated and painful for her to understand, thus the perception of the idealised father remains. Lastly Burstow (1992) suggests that when the father abuses his daughter, a trusted adult violates her basic beliefs about safety and trust in relationships. Her abusive experiences shatter her hopes for satisfying relationships in which she can feel loved and protected (Kearney-Cooke & Striegel-Moore, 1994).

2.4.1 Systems theory and bulimia

According to Yager and Strober (1985) the family is viewed as a self-regulating and constantly evolving system. Features of the system are its characteristic structures, transactions and subsystems. The subsystems are composed when members of the family align with each other by age, gender and the roles in the family. Family systems can be described as the communication styles of the family's ability to express emotions, the power of the family members, and boundaries in the family and how each member of the family relates to each other. The family further functions to provide the members with a sense of belonging as it presents as a unit in which members of the family can rely on each other (Yager & Strober, 1985).

Strober and Humphrey (1987) consider bulimia to be strongly associated with a lack of parental affection, overly negative and hostile attitudes of family members with each other, and disengaged patterns of parental affection. The parents are also described as people who lack warmth, affection, empathy and at times display high levels of protection (Murray, Waller & Legg, 1999). The parents of bulimic women are further described as people who engage in impulsive behaviours such as alcoholism and binge eating which results in obesity (Strober & Humphrey 1987). The children can therefore learn addictive behaviours from their parents and incorporate this into their adult life.

Yager and Strober (1987) consider families of bulimic women to resemble patterns of enmeshment, parental discord and triangulation. Munuchin (cited in Yager & Strober, 1987) first described these patterns in his work with eating disorders patients. He suggests that enmeshment is when family members are over-involved with one another, often intruding on each other's thoughts and feelings. This results in family members developing poorly differentiated perceptions of one another and themselves. Over-protectiveness may also occur whereby the parents and children become extremely protective of one another (Yager & Strober, 1985).

Parental discord often exists within marriages. However, it has been hypothesised that the distraction of a sick child e.g. a bulimic child in the family helps to diffuse the conflict in the family. The parents focus their attention on the child and the bulimic symptoms get rewarded and sustained, as they allow the parents to remain united for the sake of the child. Parents become depressed and anxious with the bulimic child

when her emotional and physical well-being improves as it returns them to their own problems (Yager & Strober, 1985).

Triangulation occurs when either one or both parents reject messages from each other, leading to negative communication between them. The parents become reluctant to engage with each other or taking responsibility for one another. Decisions in the family are rendered as "for someone else's good" and blame is shifted to the entire family as oppose to blaming the parents for their shortcomings. The mothers tend to blame themselves and attribute their behaviour to the devotion that they need to give to the children. Each parent portrays him or herself as the victim who is making sacrifices for the family (Yager & Strober, 1985).

2.4.2 Systems theory and sexual abuse

Gelles (1993) considers sexual abuse to form a part of violence that is occurring in families. He suggests that violence should be viewed as a system problem rather than the result of individual pathology. Fossum and Mason (1986) attribute the occurrence of sexual abuse to inappropriate fondling of young boys. Often a female member of the family or a friend would have perpetrated the abuse. For the young boy his physical and psychical boundaries have been violated and he learns to repeat the abuse in the next generation often in his own nuclear family after leaving his family of origin (Fossum & Mason, 1986).

Sholevar (1977) considers sexual abuse to occur in families if there is evidence of a longstanding unsatisfactory marital relationship between the parents. Often the fathers are portrayed as the disturbed members of the family as it helps other members of the family to deny their own contributions to the problem. It is suggested by Sholevar (1977) that husbands become overwhelmed when their wives behaviour in sexually restrictive manners, leaving the husbands with strong sexual urges that are not being met within the marriage. Faller (1988) suggests that this occurs when there is infrequent sexual intercourse between the mother and the father and the relationship is not emotionally gratifying to the father. Situations may then be created by the mother in which she withdraws from the household to make herself unavailable. The mother's reasons for withdrawing herself may be that she does not enjoy sex, she is overwhelmed by the amount of responsibility that her children require from her, she does not have the energy for sex, and at times may not be sexually attracted to her husband (Faller, 1988). These situations created by the mother are opportune moments for fathers to take advantage of their daughters as they are left alone in the home. The daughters do not report the sexual abuse, as they believe that their mothers won't listen to them. Furthermore the daughters display empathy towards their fathers and Sholevar (1977) argues that the daughters have felt that their mothers were depriving the fathers. Sholevar states that daughters felt the need to compensate for what the fathers were not receiving i.e. the sexual compensation that they had to endure so that their father's social functioning would be restored (1977).

Finkelhor (1984) argues that sexual abuse against children is not motivated by sexual desires; rather it is motivated by the need for power and nonsexual needs such as

affection and need for confirmation of masculinity. This type of attention is not always obtained from a partner i.e. mother and fathers turn to their daughters for this attention which may include sexual undertones from the father (Finkelhor, 1984). The father's need for power may be imposed on the family given that he is inadequate, weak, insecure, vulnerable and dependent outside the confines of his family. Power would be illustrated by acting violently towards members of the family, restricting the movement of family members or selecting one child of the family to be scapegoated. This child would often be a female and would be sexually abused by the father in his attempts to regain power in his domain (Herman & Hirschman, 1981).

2.5.1 Cognitive-behavioural theory and bulimia

Cognitive-behavioural theorists believe that the "core psychopathology" of bulimia is based on irrational beliefs that women have about themselves. These irrational beliefs are used to determine their self worth or value. These perceptions of themselves are based on their body, weight and shape (Bonifazi, Crowther & Mizes, 1998). There is a need to be thin and to avoid "fatness," as fatness is associated with being lazy. The notion of thinness is encouraged by socio-environmental variables such as cultural values, the influence of the media, family members and peers (Spangler, 2002). Women avoid gaining weight by excessive exercise, dieting, self-induced vomiting and the use of diuretics (Garner, 1992). It is argued that restrictive diets lead to physical and psychological deprivation which produces hunger cues and elicits loss of control during eating e.g. binge eating (Spangler, 2002).

Cognitive theorists believe that over-concern with shape and weight is often associated with long standing feelings of ineffectiveness and worthlessness, which contribute to low self-esteem. Alternatively Garner (1992) and Spangler (2002) believe that low self-esteem suggests body dissatisfaction such as shape and weight concerns. It is further considered that feelings of boredom, anxiety, and unexpressed anger and stress may trigger binge and purge episodes. The binging is often an excuse not to deal with the issues in a more appropriate fashion (Garner, 1992).

2.5.2 Cognitive-behavioural theory and sexual abuse

Authors find it difficult to separate the child from their family of origin and perpetrator when discussing sexual abuse. Becker and Abel (1981) argue that often parents feel guilty as they believe that they did not adequately protect their child. When parents react in this manner they tend to adopt irrational thinking and may become overzealous in their attempts to regain retribution (Deblinger, 1992). The behaviour of parents in this regard may traumatise the child and prolong the healing process that needs to transpire (Becker & Abel 1981).

Briere (1992) views the perceptions of helplessness to be a result of the abuse that occurred when the survivor was young and physically and psychologically unable to defend against the perpetrator. If the abuse was ongoing, the experiences were often chronic feelings of hopelessness regarding the future. Furthermore if the abuse was ongoing the survivor may come to accept that they cannot avoid the abuse as it is beyond their control (Follette, Hall & Palm, 2002).

in domestic situations where they will not be criticised because what is expected from them is to fulfil a traditional role in their society. They further believe that the more controlling behaviour that is experienced by bulimic women such as restraints on food consumption and body images is suggestive of their struggles with emotional issues that are too painful for them to process and their bingeing and purging are attempts to contain themselves. The bingeing and purging behaviour might further be considered as an opportunity for corrective experience for the bulimics as they are seeking reparation from their mothers, but their mothers are not able to provide them with this which leaves them feeling angry and wanting to separate themselves from their mothers.

According to the systems theorists such as Yager and Strober (1985) control is a function that is required by the rest of the family. It is manifested in the manner in which the family relates to each other, with the family being over involved with one another and not allowing individualisation in the family to occur. Cognitive behavioural theorists, Bonifazi *et al.* (1998) and Spangler (2002) believe control is related to how a bulimic views herself physically and her ability to alter her bodily weight and shape to increase her perceived self-esteem.

The experience of sexual abuse is considered to be a result of dysfunction of the family where the survivor's experiences of the abuse is overwhelming for her and makes her vulnerable to future traumatisations. According to psychoanalysts Sullivan and Winnicott (in Freidrich, 1990) abuse is not acceptable to the internal world of the child as she depends on her external objects to create her personality. Her objects are people

whom she trusts but when the perpetrator is known to her she does not know how to respond and attempts to repress the abuse until it is provoked by an event again later in life. The feminist writers Burstow (1992) and Walker (1998) and systems writer, Sholevar, (1975) consider sexual abuse to be a dysfunction of the family, where the daughter is given the role of a mature and sexualised woman in the home. The abuse enacted by the father is also considered as a power struggle that the father is experiencing and often his daughter becomes a means of asserting his power within settings where he is considered to be the dominant member of the family. The abuse is often not disclosed because the father is idealised, in the family as well as because the rest of the family including the survivor depend on him to create homeostasis in the home. The cognitive-behavioural theorists believe that the parents adopt feelings of guilt and helplessness as they concluded that as the caregivers they were not able to protect the survivor from such pain (Becker & Abel, 1981).

The cognitive-behavioural and psychoanalytic researchers such as Briere (1992) and Blume (1990) agree that survivors of sexual abuse will enter into relationships which are threatening to them or engage in self-destructive behaviours such as self-mutilation and eating disorders. Cognitive theorists such as Waller, Meyer, Ohanian, Elliot, Dickson and Sellings (2001) believe the origins of bulimic symptoms are rooted in traumatic experiences such as sexual abuse. The abuse would result in the survivor adopting beliefs about herself being weak, undesirable and incompetent. Survivors often feel guilty about not stopping the abuse or believing they had consented to it and report thoughts such as "I did not physically resist therefore I must have wanted to have sex." The survivors who internalise these thoughts about themselves adopt negative

thoughts such as being disgusted with their bodies and seek to punish themselves by inflicting self-injury. The survivor will engage in bingeing and purging behaviour to release her emotions, but only feels calm for a brief moment after purging (Chand, 1999). According to Bass and Davis (1999) binge eating behaviour or compulsive eating in sexually abused survivors is an attempt to repress and escape from feelings. It is a means of protecting the survivor and they suggest that compulsive eating leads to weight gain and serve to increase the physical size of the survivor to compensate for her smallness or littleness when she was abused as a child or the littleness and humiliation she felt when sexually abused (Bass & Davis, 1999).

Anna Freud (in Du Zulueta, 1996) understood this behaviour to be the result of an unconscious 'identification with the aggressor.' Identifying with the aggressor gives the survivor a sense of control and power that she is trying to acquire. Du Zulueta (1996) argues that identification with the abusing parent further implies that the survivor is wicked and deserves to be punished. Psychoanalyst Rose's (1986) concept of 'identification with the aggressor' is considered to be seen in the survivor's expressions of feeling physically dirty, damaged and that her femininity has been spoilt. Identification with the aggressor is thought to be having "compassion" for the perpetrator because he is 'sick and troubled" and like the survivor herself, needs help and caring.

2.7 REVIEW OF THE LITERATURE

2.7.1 International research on bulimia and sexual abuse

The debate with regard to whether sexual abuse is a contributing factor to the development of bulimia nervosa is extensive. This area has been researched over years (Myers, 2001). Various researchers have come to different conclusions with some arguing that sexual abuse is a predominant risk factor in the development of bulimia nervosa. While others conclude differently stating that sexual abuse as a cause of eating disorders remains unclear (Matsunga, Walter, McConaha, Plotnicov, Pollice, Rao and Stein, 1999; Myers, 2001).

Deep, Lilenfeld, Plotnivoc, Pollice and Kaye (1997) looked at previous studies, which indicated that 12% to 75% of bulimic women reported sexual abuse, when anorexic, and bulimic subtypes were placed together in the study. The figures for the anorexic subtypes were between 4% to 53%. In their own study Deep *et al.* (1997) found that approximately 49% of women with bulimia were sexually abused. The researchers however point out that these numbers are not necessarily accurate, since there is no universal definition of sexual abuse. They go on to state that sexual abuse can therefore take on a different definition depending whether it was childhood sexual abuse or adulthood sexual abuse. Therefore the figures obtained might not be a true reflection amongst the women who participated in the study. Myers (2001) reports that although many bulimic women have been abused, sexual abuse was as common amongst groups

with other psychiatric disorders as it is in bulimic women. Nash (1999) stated that sexual abuse is higher in bulimic women who are substance abusers as well.

Waller (1996) in her study suggests that reported sexual abuse has been shown to be associated with eating psychopathology, particularly when the eating problems involve a bulimic component. Her argument can be understood within a psychoanalytic framework stating that sexual abuse has also been linked with poor perceived personal control, especially if it involves childhood incest. Her aim was to examine the role sexual abuse plays in eating disordered women and their perceptions of control. In her study using 55 eating disordered women (40 were bulimics) 27 reported sexual abuse perpetrated mostly by a family member and almost all the women were abused before the age of 14. She concluded that women who were abused had more external locus of control (lower perceived control over their own lives) than those who were not sexually abused.

Matsunga *et al.* (1999) conducted a study of psychopathological characteristics of recovered bulimics who have a history of sexual abuse. The authors wanted to determine whether sexual abuse was one of the risk factors contributing to the development of bulimia nervosa. In their study they used 2 groups namely, bulimics with sexual abuse experiences and bulimics without sexual abuse experiences. During their research the following results were obtained: bulimic patients with sexual abuse scored similarly to those without sexual abuse when measuring for the influences that abuse has on subjects. However the patients with sexual abuse scored higher on the subscales for the interpersonal distrust as opposed to their counterparts. One might

gather from this that they were not able to trust themselves as well as others in their immediate environment. Although the research concentrates on the relevance of sexual abuse in the development of psychopathological disorders, the researchers overlooked the duration of the abuse, who the perpetrators were and if this influences pathology amongst sexual abuse survivors.

Blume (1990) in her book *Secret Survivors* addresses the issue of sexually abused females who have to sacrifice trust or have limited ability to trust both themselves and those around them. These women learn to deny their own awareness and know that they are expected to meet the ends of others (often perpetrators) and expect to be hurt. They do not allow themselves to be vulnerable because this might result in their being taken advantage of and learn skills that are necessary for their survival. Blume (1990) elaborates and mentions that a sexually abused female learns behaviours to mask her true feelings and to compensate for her poor self-esteem. A sexually abused survivor has to teach herself a range of skills in order to avoid intimacy. The sexually abused female also has poor social effectiveness because she is always addressing the needs of those around her and does not have enough trust or confidence within herself to be in a position that requires her to be close to someone (Blume 1990). She further argues that sexually abused women repress their feelings of being abused until they can identify the "core" of their problem and often will bounce from addiction to addiction, including bulimia nervosa to avoid experiencing the psychological pain of being sexually abused. The bulimia helps to distract them from dealing with the sexual abuse (Blume 1990).

Research conducted by psychoanalysts Grisset and Norvell (1992) considered the perceived role of social support and the quality of relationships that bulimic women form in the latter parts of their lives. Their research proposed that bulimic women do not have emotionally stable environments and are often dissatisfied with their social supports and relationships. It is argued by the researchers that the women react in this manner because they are fearful of negative evaluation from their peers and often have low self–esteem. This makes it difficult for the bulimic women to be honest or "real" in their communication with others for fear of been rejected. Grisset and Norvell (1992) suggest that the bulimic women therefore learn to mistrust themselves and those around them. This contributes to the poor and disturbed interpersonal relationships as well as increased conflict with others.

Dana and Lawrence (1988) in their book *Women's Secret Disorder* speak about the patterns of the bulimic women's lives in relationships. They argue that unconsciously we choose people and patterns of relationships with whom and in which we can repeat our childhood experiences. According to Dana and Lawrence (1988) a female who is a survivor of violence (sexual and physical) will often "find" or "choose" a man who is violent towards her in her adult life. Similarly a female who was sexually abused may often find herself in circumstances later in life, which are a repetition of the traumatic event. The feelings and memories may have been repressed and forgotten but the survivor is compelled to create a situation in which these feelings are aroused again. In their book Dana and Lawrence (1988) present a case study of a female bulimic patient who after bingeing and purging felt extremely dirty, disgusting and unacceptable and further felt completely hidden and withdrawn. This aftermath description sounds

similar to feelings that would resonate after a survivor has been sexually abused, hence a repetition of a traumatic event/s in her life (Blume 1990).

Sandberg, Lynn and Green (1994) argue that a sexual abuse survivor re-enters into abusive relationships in order to master and understand her previous trauma or overwhelming experiences. The way in which she may achieve this is to engage in situations which resemble the initial trauma, wherein she can master and control her actions. However by repeatedly entering into situations where the survivor's vulnerability may be increased, she places herself at a higher risk to be abused again. Sandberg *et al.* (1994) strongly emphasis that survivors do not want to be revictimised, however are motivated to establish caring and nurturing interpersonal relationships. Unfortunately because of their dysfunctional pasts survivors have difficulty in establishing and maintaining nonabusive relationships. Herman (1997) suggests that sexual abuse survivors not only maintain their abusive patterns by entering into relationships with perpetrators after the initial abuse, but they enter into alternative abusive activities which prove to be traumatizing for them. Abusive activities include chronic suicidality, self-mutilation, eating disorders and substance abuse. According to Herman (1997) these self-destructive behaviours can be understood as symbolic or literal re-enactments of the initial abuse. They serve the function of regulating intolerable emotions in the absence of more adaptive self- soothing strategies.

Blume (1990) argues that a sexually abused female is not able to follow the natural evolution of friendships to romantic relationships. For Blume (1990) the survivor sees all relationships as sexually orientated and it does not feel authentic if sex is lacking in

a romantic relationship. Since sex is an important factor for the sexually abused woman, her emotional needs are often not met and she wanders from relationship to relationship not wanting attachments from anyone. Dana and Lawrence (1988) talk about similar experiences in bulimic women. They state that often a bulimic woman may have many relationships but may long for a close relationship with one particular partner. However when an opportune moment presents itself the bulimic woman will immediately dismiss the notion. Her anxiety around intimacy and of being attached to another person brings about ambivalent feelings within herself. At this stage she will convert all positive attributes of herself into negative ones. Mahon, Winston, Palmer and Harvey (2000) argue that the inability of bulimic women to form secure attachments in adulthood is a reflection of the trauma they experienced in their childhood. Tiller, Sloane, Schmidt, Troop, Power and Treasure (1995) concluded similarly that bulimic women tend to lower their expectations from relationships stemming from their possible negative childhood experiences, namely sexual abuse. Unfortunately the article by Mahon *et al.* (2000) does not provide adequate evidence of the aetiological factors contributing to bulimia.

2.7.2 Research in South Africa on bulimia and sexual abuse

Research into eating disorders in South Africa is limited, with most of the research focussed on specific groups, for example university female students and ballerinas or other performers such as dancers and gymnasts (Le Grange & Gelman, 1998). One such study was by conducted by Montanari and Zietkiewicz (2000) on young South African ballerinas between the ages of 14 to 17 years. These adolescents were all from

the same ballet school and full-time students of the school. The group represented a heterogeneous sample consisting of twenty-five white, one indian, seven black and three coloured females. The information gathered from this sample was compared to adolescents of the same age group but who were not eating disordered. The aim of the study was to examine the drive or need for thinness in ballet dancers (Montanari & Zietkiewicz, 2000). According to previous studies, ballet dancers are socialised to believe that the only way to succeed in the profession is to develop a thin and emaciated body which represents beauty, grace, fragility and strength; alluding to the notion of an ideal femininity. The results of this study indicated that the ballet dancers as well as the adolescents from the control group expressed desires to be thinner than they are. However the need to be thin was greater amongst the ballet dancers. Results of the study further suggest that the bulimic dancers displayed more tendencies towards uncontrollable episodes of eating and other punitive eating patterns such as restrictive eating and binge-purge behaviours. The anorexics alluded more to dissatisfied body shape and size. The researchers concluded that the ballet dancers displayed internalised irrational thinking patterns about themselves and their profession. Montanari and Zietkiewicz (2000) report the information gathered by the dancers may not necessarily have been a true reflection of the extent of eating disorders amongst the ballerinas, as they might have been concerned with the reaction of their teachers. However the bulimic participants of the sample tended to be more open about their disorder than the anorexics participants and more open to the suggestion of treatment (Montanari & Ziekiewicz, 2000).

A study was conducted by Le Grange & Gelman (1998) to assess the perceptions of female university students who were eating disordered about treatment for their disorder. The central theme that emerged from the study was the students' irrational beliefs about themselves. The students believed thoughts such as eating food immediately transforms into a person gaining excessive weight. Irrational thinking patterns were also evident in the students' dysfunctional values and attitudes about themselves as well as other people with whom they had regular contact (Le Grange & Gelman, 1998). Struggles for power and control were two of the issues around which the participants had developed irrational thinking patterns. The participants believed that power and control could be measured in the way their binge and purge behaviours were acted out. If the participants were not able to delay a binge and purge episode it meant that uncomfortable emotions were coming up for the student and attempting to intervene in the episode was often not successful. This implied that the students were not in control of what was happening to them (Le Grange & Gelman, 1998).

During the in-depth interviews that were conducted to assess their emotional progress, the students suggested that while their irrational beliefs had been addressed in their therapeutic interventions they were not aware of why they had developed eating disorders. The use of cognitive therapy helped them to address their symptoms but did not help as much as they would have liked in addressing their emotional issues. The cognitive behavioural techniques further seem to be more suitable for the students who were 'less' severely eating disordered. However the more severe eating disordered students considered their symptoms to be too overwhelming for them to be able to intervene during a binge and purge episode (Le Grange & Gelman, 1998).

In an article by Wilbraham (1995) no clear indication could be given about possible diagnostic categories for the participants in the study because the data used were collected from letters written to advice columns. However the participants' letters suggested that they had issues around distorted body perceptions, and emotional indictors suggested they were struggling with interpersonal distress. The author suggested that the participants felt uncontained for various reasons and would resort to bulimic behaviours such as bingeing and purging to satisfy internal distress. Their distress would often be related to feelings of powerlessness and lack of control that they experienced. An example of this is described when a participant disclosed her sexual abuse at a young age. She, like some of the other participants of this study, did not value herself. She sees her bulimic behaviour as an attempt to gain weight so that she becomes fat and ugly and hopes this will guard her against any attention she would receive from males (Wilbraham, 1995).

From the above-mentioned example Wilbraham (1995) suggests women have adopted irrational patterns of thinking. One of the salient irrational thinking patterns is in the causal equation of Holloway (cited in Wilbraham, 1995) who believes that 'BEAUTY=MAN=HAPPINESS.' This statement assumes men are in powerful positions over women and therefore women are positioned to be 'objects' of a male sex drive. This assumes that men are biologically driven and opportunistic and seek sexual variety and women are compelled to follow the enforced conventional beliefs and values (Wilbraham, 1995).

Women are further oppressed in South Africa by more direct means such as being sexually violated. This form of oppression appears to be extensive and often accompanied with sexual coercion (Shefer, Strebel & Foster, 2000). A specified type of coercion would be sexual harassment. A study was conducted by Mayekiso and Bhana (1997) to determine students' perceptions and experiences of sexual harassment at the University of Transkei. The researchers concluded that students at this university tended to report more cases of harassment than specified forms of sexual abuse such as rape. The survivors of sexual harassment reported incidents of unwelcome touching, fondling, pressure to perform sexual favours and date rape. The women of this study further reported that they had experienced similar emotional feelings to women who had been raped. Such feelings included anger, fear, anxiety, low self-esteem and depression. The students stated that they did not report incidents such as rape more frequently because very little would transpire legally i.e. the perpetrators would not be punished appropriately and would be free from any serious charge. Furthermore the perpetrators would often be men who were in positions of power such as lecturers at the university and who could academically exploit the students (Mayekiso & Bhana, 1997). This supports the argument of Herbert (in Mayekiso & Bhana, 1997) that abuse of power is often committed by an individual of strength against an individual of weakness. Sexuality is also considered to be an aspect of the construction of gender that places men in positions of power over women. The article argues that feelings of powerlessness are often intensely experienced by students who assume responsibility for the harassment and believe it was their fault (Mayekiso & Bhana, 1997). A limitation of this study was that the definition of sexual harassment was too broad as it incorporated all acts of sexual violence against women.

It is proposed by researchers such as Harned (2000) that sexual harassment places adolescent girls at considerable risk for the development of body image and eating disturbances. Studies that assessed the impact of sexual harassment on eating disturbances found that the two phenomena correlated. An explanation offered by Larkin, Rice & Russell (cited in Harned, 2000) of the relationship between the two phenomena is that sexual harassment tended to include offensive comments about body image, sexist comments and exposure to pornographic material.

The following two studies reflect specific forms of sexual abuse namely child sexual abuse and rape. Collings (1995) considered previous studies which concluded that child sexual abuse occurs four times more in South African women when being compared to studies in North America. In her study, Levett (cited in Collings, 1995) incorporated all acts of sexual abuse which was used more broadly than the definition used by the American researchers. In Collings' (1995) study the definition of child sexual abuse indicated all unwanted sexual experiences involving physical contact experienced by a child before 17 years of age. From the definition Collings (1995) was able to gather a sample of 734 university students whose ages ranged from 17 years to 50 years old. They were undergraduate students who represented a racially mixed group. The research further suggested that young girls were at risk of experiencing intrafamilial forms of child sexual abuse. Young girls presented as vulnerable to family members who were perpetrators. Collings argues that previous prevention programs had been formulated around the concept of 'stranger danger,' which is not beneficial in teaching young girls to protect themselves within the family.

2.8 SUMMARY

The literature presented leans towards evidence that bulimic women who have been sexually abused often struggle in interpersonal relationships with others, namely their families. One such struggles for bulimics is that of trust, especially if trust was violated by a family member such as their fathers, and when the status of the rest of the family needs to be considered before they can disclose details of the abuse. Since they are not able to trust themselves or people from their immediate environments, bulimic women will enter into relationships where they will be victimised by their partners (Dana & Lawrence, 1988).

South African studies on eating disorders indicate that women often have irrational thinking patterns about their bodies and how they should be perceived. This was most evident in a research study conducted with young ballet students who believed that they must appear as feminine and as graceful as possible as this is what the profession required from them.

Bulimic women have further internalised that they are dirty, disgusting and unacceptable. This will be reinforced for them by their violent and abusive partners (Blume 1990). Their bulimic behaviour also helps them to avoid dealing with issues regarding the sexual abuse. Researchers such as Mahon *et al.* (2000) and Tiller *et al.* (1995) conclude that traumatic childhood experiences such as sexual abuse have negative implications for future relationships that the women might enter. These women are not able to form secure attachments (Mahon *et al.*, 2000) because they

convert all positive attributes of themselves into negative ones (Dana & Lawrence, 1988).

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This study is a qualitative one, focusing on exploration of bulimic women's experience of sexual abuse. It is intended to explore the participants' experience of sexual abuse and how they interpret their abusive experiences in relation to their bulimic experiences. This study is not intended to verify whether sexual abuse contributes to the development of bulimia but rather to explore the participants' understanding of both of these in their lives, by primarily employing a psychoanalytic theoretical framework to understand the experiences of the participants.

In this chapter the qualitative research framework of the study is described. The use of semi-structured interviews using open-ended questions were used to collect data. The aim of the study will be clarified. The chapter will also focus on the biographical details of the participants.

3.2 AIM OF THE STUDY

The aim of this study is to explore bulimic women's experience of sexual abuse. Theoretical writings by psychoanalysts such as Blume (1990) and Du Zulueta (1996) suggest that women who are bulimic and who were sexually abused often struggle with similar emotions in their lives. The responses given by the participants in remission,

who were bulimic and sexually abused reflected experiences of disempowerment, revictimisation, identifying with the perpetrator of sexual abuse, self-esteem and control (Blume 1990; Du Zulueta 1996 & Mahon et al., 2000). It is possible that an understanding of these women's experiences can facilitate more structured therapeutic methods of providing mental and physical health care facilities for women who have been sexually abused and diagnosed with bulimia.

3.3 QUALITATIVE RESEARCH

3.3.1 Definition and overview of qualitative research

According to Punch (2000), there is not just one definition of qualitative research because it is not a single entity. There are a number of different methods in qualitative research with multidimensional frameworks that pays respect to pluralistic paradigms. Banister, Burman, Parker, Taylor and Tindall (1994) agree with Punch (2000) that there is no single method of qualitative study because the aims of each study will be accompanied by different interpretative approaches. Some of the different approaches in qualitative research include discourse analysis, feminist and postmodernism approaches, grounded theory and thematic content analysis.

In this study thematic content analysis will be used to locate central themes, using the definition of social science researchers Marshall and Rossman (1999) and Miles and Huberman (1994). Marshall and Rossman (1999) have described qualitative research to be subjective, interpretative and grounded in the lived experiences of people. According to Miles and Huberman (1994), 'lived experiences' are described as the

meaning people place on events; processes and the way people structure their lives. 'Lived experiences' also imply perceptions, assumptions, judgments, presuppositions and how these are connected to the social world of people (van Manen 1977, in Miles and Huberman, 1994). According to Banister *et al.* (1994), the process of interpretation in studies of this nature provides a bridge between the researcher and participants. It is important to bear in mind that interpretation occurs along a continuum and is part of a process that continues as people's life circumstances change. As researchers, it is important to acknowledge that there will always be a gap between the things we want to understand and our accounts of what the research presents us with (Banister *et al.*, 1994). The use of interpretation is considered as an opportunity to make clearer meaning of information that is provided by a participant, which could have been presented in a confused or unclear manner. It makes sure that what is presented is not laden with the researcher's meaning (Stevenson, 2000).

Qualitative research should ideally occur in the natural settings of participants so that they can be observed. According to Marshall and Rossman (1999), researchers should not attempt to understand people without understanding the meaning participants attribute towards their own actions, emotions, beliefs and values. It is argued that since people give meaning to their experiences and emotions an objective reality cannot be constructed, rather it is a social reality. The research is also conducted from a particular point of view and cannot assume the neutrality that quantitative researchers claim to adhere to (Banister *et al.*, 1994). Qualitative researchers argue that there is always a moral aspect that should be considered while conducting research. Research is also

conducted from personal and political interests and should be explored as opposed to concealing the experiences of people.

It is the intention of this study to explore the 'lived experiences' of the participants who were not able to openly verbalise their sexually abusive experiences until their admission into the Eating Disorder Unit at Kenilworth Clinic or following their discharge from the Unit.

3.4 THIS STUDY

3.4.1 Introduction

Using qualitative research in this study allowed the participants to tell their stories in their own words and provide an opportunity for the researcher to explore what the participant is relaying. When the participants were narrating their stories, it provided an opportunity for them to explain and describe their experiences of the events and highlight the parts of their life stories that were of particular interest to them (Marshall & Rossman, 1999). In this manner the participants have a-sense of empowerment in that they revealed only what they were comfortable to present.

In the present study there was an opportunity for the researcher to learn from the participants, because they were not only viewed as passive objects of inquiry (Marshall & Rossman, 1999). However, it has been argued by Stroh (2000) that power may be shifted in both directions since the researcher has organized and initiated the interviews

as well as directs the interview. The researcher is also dependent on the participant's response and in this way the power is redirected to the participant.

3.4.2 The participants

The researcher had initially intended to interview five participants for this study, but a fifth participant was not accessible. At least three other women were informed about the study, but indicated that they did not want to speak about their experiences. One of the three women was a grade 12 student and felt that this was an appropriate time for her to be interviewed. Furthermore, the focus of qualitative research is primarily on the quality of data and not on the quantity of data that may be obtained (Brendstrup & Schmidt, 1990) since interaction with the participants is the best manner in which to gain insight into the research question (Breakwell, Hammond & Fife-Schaw, 1997). Therefore the researcher did not attempt to gather more women as possible participants as it was believed that the researcher's interaction and information gathered from the participants would be sufficient to verify the aim of the study.

The participants were four women who were initially inpatients of Kenilworth Clinic. At the time of this interview all four had been discharged after a six-week inpatient programme and continued with outpatient treatment. This entailed regular sessions with their individual therapist, dietitian and a compulsory support group for at least 12 sessions after their discharge from the unit if they were residents of Cape Town.

The participants all met the criteria for bulimia nervosa as mentioned in the Diagnostic And Statistical Manual of Mental Disorders-fourth Revised Edition (APA, 1994) commonly referred to as the DSMIV-R. The DSMIV-R (APA, 1994) is a manual that has been compiled by members of the American Psychiatric Association and is used as an assessment tool in the mental health professional to appropriately make a diagnosis of a person in terms of the symptoms with which the person is presenting. All four participants had disclosed to members of staff or their individual therapists that either a known or an unknown perpetrator had sexually abused them. Only in the sexually abuse experienced by participant one, were the perpetrators not known to her before the abuse occurred. Participants' ages ranged from 16 years old to 23 years old.

The participants were scholars who have part-time work over weekends or half-day work. The scholars however depended on their parents to support them financially. Two of the participants were the youngest members of their family of origin. The age differences of the participants and their siblings ranged from one year to seven years. Participant one described her family as emotionally close; while participant two disclosed that her family was not emotionally close. The third and fourth participants reported that they had good relationships with only certain members of their families.

Three of the participants were sexually abused by at least two different perpetrators. For two of the participants their first sexual abuse occurred before the age of 11 years by known perpetrators. Participant one did not know the perpetrators before the abuse occurred. In the case of participant two, the first perpetrator was a family friend. Sexual abuse by the second perpetrator occurred between the ages of 14 and 17 years of

age and was also known to the participant. The perpetrators in each incident were also known to participant three and four. Participant four disclosed that her first perpetrator physically and verbally abused her before and after the sexual abuse. Participants three and four were in romantic relationships at the time of the abuse. The ages of the perpetrators in all the abusive incidents were over 18 years of age. The sexual abuse experienced by the four participants ranged from inappropriate touching to fondling, forced oral sex and rape.

The four participants had additional sessions to help them process their abusive experiences which were separate from their weekly psychotherapy hour. The unit co-coordinator who is a specialized lay counsellor in sexual abuse and rape provided these sessions.

3.4.3 Procedure and ethical considerations of the study

According to Banister *et al.* (1994), the welfare and protection of participants during a study should take into account mutual respect, and confidence should be established between the researcher and the participants. Researchers should respect the participants as individuals who have basic human rights, dignity and worth. The participants should also leave an interview with their self-esteem intact and have with a sense that they have contributed to valuable research. The participants should be protected against potential harm to their psychological well being (Banister *et al.*, 1994).

The researcher asked the individual therapists, family therapists, nursing staff and the unit co-ordinator to recommended suitable candidates for the study. The participants were told about the study by their individual therapists as well as informed by the Eating Disorder Unit staff during their inpatient admission to the clinic. The names and details of the interested participants were forwarded to the researcher. The researcher made telephonic contact with the participants explaining her rationale for the study, and discussed logistical information with the participants. This included deciding on interview times, and for the participants who were under 18 years old to obtain permission from their parents to participate in the study. The participants who were under the age of 18 were required to have their parents sign consent forms, which allowed the participants to be interviewed (view attached Appendix 3).

The interviews were conducted by the researcher at Kenilworth Clinic. Before the interview the researcher explained the process again. The participants were also requested to complete a social and demographic form (view attached Appendix 2) and sign the consent forms (view attached Appendices 3 and 4). The consent form was a document which ensured that the participants gave their permission to be interviewed for this study and that they would remain anonymous (Miles & Huberman, 1994). The referring therapist addressed the need for consent and anonymity with the participants as well. Two of the participants were under the age of 18, therefore, their parents signed the consent forms before the interview.

On establishing contact with the participants, the researcher made them aware of a 'containment' room, which was made available for their use if they felt emotionally

overwhelmed during or after the interview. The researcher as well as the individual therapists was concerned about the emotional well-being of the participants after the interview. A staff member volunteered to remain with the participant after the interview for support. Of the four women interviewed, none of the participants asked for a staff member to remain with her. One participant asked to remain in the interview room with the researcher and wanted to speak more. Material from the conversation after the interview was not used for analysis as the recording instrument was switched off.

The study used a semi-structured interview format as the main instrument. The questions were open-ended and in-depth as a means of gathering information (view attached Appendix 5). The use of the questions served as a guideline in an attempt to move away from fixed answers so that the participants' perceptions, meanings, definitions of situations and construction of reality could be assessed (Burton, 2000; Punch, 2000).

Other types of interviews in qualitative research are structured and standardized interviews, unstructured and open-ended interview (Punch, 2000). A structured interview is a series of pre-set questions where flexibility is limited and the interviewer attempts to play a neutral role. In unstructured and open-ended interviews, the interview is not pre-planned and standardized; instead it relies on specific questions to emerge as the interview proceeds (Punch, 2000). Semi-structured interviews will be used as they explore the areas where the interviewees perceive gaps, contradictions and difficulties. The usefulness of semi-structured interviews is that the researcher can

have tailored questions but is not bound by the codes of standardization and replicability. Semi-structured interviews are flexible and can be used to empower participants as their views are being validated and publicised (Banister *et al.*, 1994).

3.5 ANALYSIS OF DATA

The aim of the study was to document and contextualise the experiences of bulimic women who have disclosed that they were sexually abused. In writing up the experiences of the participants the researcher tried to remain as objective as possible. Thematic content analysis was used as a method in analysing the recorded information.

Content analysis is a subjective means of interpreting information and places emphasis on the meaning of information gathered. Thematic content analysis is a method employed within the framework of content analysis to analysis data (Breakwell, Hammond & Fife-Schaw, 1997). A thematic analysis is a coherent way of organizing or reading interview material in relation to specific research questions (Banister *et al.*, 1994). The themes which emerge may also reflect the theoretical underpinnings of the research. A thematic analysis further allows the researcher to locate common themes across the different interviews (Washkansky, 2000). Expected themes that may emerge are issues around re-victimisation, identifying with a perpetrator of sexual abuse, feelings of disempowerment and the participants' perceptions of control.

3.6 REFLEXIVITY: THE RESEARCHER AND THE PROCESS

Reflexivity refers to the fact that the researchers become a part of the social study that they are conducting. When entering the life or listening to experiences of participants, researchers construct 'truths' regarding the participants (Steier, 1991). The researcher becomes an instrument as he/she enters the personal life of the participant. This invites a range of strategic, ethical and personal elements to the study (Marshall & Rossman 1999; Punch, 2000). This implies that the researcher may enter into the study with his or her own biases, but needs to maintain a professional boundary in order to document the experiences of the participants as accurately as possible. .

Banister *et al.* (1994) believe that researchers are mistaken in claiming to keep a position of distance between themselves and the participants. Researchers in this manner produce a subjective account of themselves, because a position of distance is still a position. Hence, it is considered to have a negative impact if the researcher underplays his or her presence in the study (Banister *et al.*, 1994). Personal reflexivity is the acknowledgment of who you are and of your individuality as a researcher and how your personal interests and values influence the process of the research. According to Banister et al. (1994), it involves levels of personal participation and engagement from the start of the research. However, there may be implications of this level of engagement because the researcher should be able to remain critical yet able to empathize with the participants and be aware of his or her own experience to be able to achieve a resonance between subjectivity and objectivity (Banister *et al.*, 1994). Researchers also fall on a continuum where some researchers choose to share personal

disclosures with the participants, while other researchers choose to not disclose any personal details about themselves. This is known as revealedness (Marshall & Rossman, 1999).

As the researcher in this study I had already entered into the study with a bias that was influenced by my work at Kenilworth Clinic before engaging in my current occupation. I therefore both formally and informally had interactions with eating disordered patients including bulimic women who were sexually abused. A formal interaction would be when the bulimic patient was referred to me for rape or sexual abuse counselling during her inpatient stay at the clinic. An informal interaction would often be bulimic women who have been sexually abused but would want additional counselling for their abuse or in certain cases would not need additional counselling.

I have disclosed my interest in the study, which arises from my work in the Eating Disorders Unit and the volunteer work I did for a non-governmental organisation Rape Crisis, Cape Town, that dealt with sexual abuse, specifically rape. As a member of Rape Crisis, I received supervision from more senior members of the organisation for the women that I counselled.

The interviews were semi-structured and therefore I had some sense of the type of information that would be elicited in the process, which immediately introduced a power dynamic in the room. This dynamic was established because I had an idea of the type of information that would be elicited from the participants. In addition my novice clinical skills gained during the MPsych training helped me facilitate the interviews. I

was able to listen, empathise and remain open to the material that was presented by the participants. This allowed the participants to share information more freely as well as providing me with insight into interviewing women with sensitive emotions arising from traumas such as the sexual abuse. Mkhonza (1999) in her qualitative study which explored the difficulties that women encounter in preventing sexually transmitted disease within heterosexual relationships documented a similar experience where she relied on her therapeutic skills when interviewing participants.

3.7 RELIABILITY AND VALIDITY OF THE CURRENT RESEARCH

Reliability is defined as a central concept used as a form of measurement which introduces and examines aspects of consistency. This implies that if an instrument is given to a participant on more than one occasion, the results produced will be similar (Burton, 2000; Punch, 2000; Silverman, 2001). Concerns regarding reliability were raised when taking into account whether the findings of a study reflect the participants' and the inquiry itself; or if they reflect a fabrication from the researcher's biases or prejudices (Lincoln & Guba cited in Marshall & Rossman, 1999).

Lincoln and Guba (cited in Marshall& Rossman, 1999) propose four constructs which may accurately reflect the assumptions of qualitative research. The first such construct is credibility in which the aim is to illustrate that the study was structured in such a manner as to ensure that the participant was accurately identified and described. The researcher used the clinical expertise of the participants' individual therapists to accurately identify women for this study. This was accomplished when the participants

fulfilled the criteria for bulimia nervosa as specified in the DSMIV-R (APA, 1994) and when they disclosed their abuse to a staff member of the Eating Disorders Unit. Further descriptions were obtained when they agreed to complete a social and demographic form before the interview started.

Qualitative research operates from a perspective that aims to explore a problem or describe a setting process or interaction. In-depth descriptions of the complexities of the process and interactions will be embedded within data obtained from the participants and in this manner, it becomes valid. Thus the research validity is maintained within the parameters of a setting/population and a theoretical framework accounts for why the research further becomes valid (Punch, 2000).

The second construct considered by Lincoln and Guba (cited in Marshall& Rossman, 1994) is transferability, in which researchers must argue that the findings of their research will be useful in the future in similar situations. The researcher had intended to make recommendations for future treatment plans to mental health professionals who work in inpatients programs where bulimic women who are sexually abused are admitted for therapeutic interventions. The third construct is dependability whereby the researcher attempts to account for 'the changing' conditions in the phenomenon chosen for study and changes in the design created by an increasingly refined understanding of the setting. This represents a set of assumptions that moves away from a more traditional understanding of reliability. A positivist notion of reliability assumes an unchanging universe where inquiry could be replicated. This assumption is in contrast

to the qualitative standpoint that argues the social world is always being constructed and the idea of replication itself is troublesome (Marshall & Rossman, 1994).

The fourth construct is confirmability or objectivity that is needed to make a study valid. Lincoln and Guba (in Marshall & Rossman, 1994) have employed strategies to make studies valid by having a research partner who is able to be critical. Citing previous researchers who have written about the same or similar topics and describing how analysis will include data has been used to compare studies in order to remain critical. Often a process of checking and rechecking the data is a purposeful way of generating possible alternative explanations.

Lastly, Thomas-Bernard (2000) argues that validity in qualitative research is difficult to discuss in participatory research because the research operates from a holistic and evolving process making it difficult to deal with all the phases of research. Thomas-Bernard (2000) questions the notion of 'truth' or validity and. suggests that barriers such as race, gender, class and culture challenge the quest for the truth.

3.8 SUMMARY

It can be concluded that the ethos of qualitative research is rooted in the individual experiences of the participants and their understanding of these experiences. Since the nature of qualitative research is to capture the meanings of the participants' experiences, researchers in the field regard the participants to have gained a sense of empowerment. However it is necessary to bear in mind that researchers may also have

a power dynamic of their own, since the researcher decides on the methods employed for the study as discussed in the introduction section of this study. The use of semi-structured interviews in this study was to allow for flexibility with the participants and not to minimize the empowerment of the participant. Thematic content analysis was used to identify themes that emerge during the interview. Issues of reliability and validity were also considered.

Ethical and diagnostic considerations directed the manner in which participants were selected for the study. The participants had to meet the DSMIV-R (APA, 1994) criteria for bulimia nervosa and have disclosed their sexual abuse prior to the interviews. All four of the women were inpatients at Kenilworth Clinic's Eating Disorders Unit prior to this study. The ages of the women ranged from 16 to 22 years old. They were scholars who had part-time employment. None of the participants asked to use the 'containment' room after the interview.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 INTRODUCTION

The objective of the study was to explore the experiences of women who were diagnosed with bulimia nervosa and who had been sexually abused. The women who agreed to be participants for this study were all inpatients of the Eating Disorders Unit, Cape Town. Their ages ranged from 16 to 22 years. The participants' ages ranged over at least two psychosocial developmental stages, according to the developmental theorist Erik Erikson. At the time of each of their sexual abuse experiences they were at different psychosocial developmental stages. Participant one was in her Initiative versus Guilt stage as described by Erikson. According to him participant one would have a growing sense of her sexual curiosity manifested by playing or touching her own genitalia or those of her peers (Kaplan & Saddock, 1998). Participant two and three's developmental stages at the time of their sexual abuse was in the stage that Erikson would describe as Industry versus Inferiority. This stage is similar to Freud's Latency stage so that it is speculated that both these two participants gained levels of skills and were able to develop a sense of duty (Kaplan & Saddock, 1998). Participant four was in what Erikson would have described as the fifth stage of Identity versus Role Confusion when her first sexual abuse experiences occurred. This stage is focussed on developing a sense of identity which coincides with puberty and adolescence.

In this chapter the themes that emerged will be discussed using thematic content analysis. As part of the discussion regarding the most salient themes, a description of the sexual abuse and the participants' experience of their bulimia will be discussed. The participants' experiences will be located in theoretical frameworks such as psychoanalytic literature and research, predominantly, and will draw on the writings of feminist theorists as well to illustrate and enhance the experiences of the participants. For the purposes of this study, prominent themes, which were considered to be dominant and experienced by the four participants, will be explored. The themes included the following: anger of the participants, the participants' perception of control, entering into abusive relationships after the initial sexual abuse, and feelings of detachment.

4.2 EMERGENT THEMES

4.2.1 Anger

4.2.1.1 Expression of Anger

It is stated by psychoanalysts such as Blume (1990) and Freidrich (1990) that the anger often cannot be expressed by women who have been sexually abused as they tend to repress their feelings of being abused until a precipitant event occurs in which the feelings of anger return for them. For the participants in this study, negative emotions of anger were first verbally expressed against the perpetrators of their sexual abuse either during their inpatient admission into the unit or just shortly after being discharged from the clinic. The following quotes locate the approximate times when the participants first started to speak about their sexual abuse:

P1: when I started eating properly and everything ...and all the feelings in my... and I started remembering

P3: And ja but I guess when I came here I really spoke about it

P4: I spoke about it was about a month ago, after I got out the clinic, I told Tanya, my dietitian first

Participant one disclosed that her ability to articulate her anger emerged when she engaged in a healthy eating pattern and did not use food to distract her from the anger that she was experiencing. Participant three was able to speak about her anger during her admission into the unit, while participant four was able to verbalise her feelings of anger after the admission to unit.

As inpatients of the unit, the participants would have been involved in various activities at the clinic such as individual therapy, psychotherapy groups, family therapy, art therapy and additional counselling for their sexual abuse as part of their treatment plan. All of these therapeutic interventions would have assisted the participants in understanding why they were admitted into the unit as inpatients as well as to start a psychotherapeutic intervention that would have allowed them to process any unresolved psychological trauma of the past such as the sexual abuse. It is assumed that participants were able to engage with their positive and negative emotions such as anger because of the therapeutic structures that were in place for them. This led them to arrive at some levels of resolution regarding their sexual trauma as mentioned in the quotes below by three of the participants:

P1: Em, at this point I sort of calmed down about it you know...

P2: I used to feel very angry and a lot of resentment and guilt and shame and all the normal stuff, but ja, I have been working on it now and it's getting a little bit easier

P3:I dunno, now I'm fine with it, it's still uncomfortable, I don't like it if my boyfriend does ask me about it...

The above quotes are indicative of the participants' reactions when they first started verbalizing their anger. Participant one considered herself to be less anxious since she started speaking about her experiences. Participant two disclosed that she initially felt guilt and resented that she had spoken about her anger, while participant three indicated that she continues to be uncomfortable speaking about her feelings of anger, especially when her boyfriend asks her to speak about it to him. The feelings of anger were directed towards different people for different reasons. Anger was voiced towards the perpetrators of the sexual abuse, the parents of the participants and towards themselves. The main discussion of anger will start by analysing the data regarding participants' anger towards the perpetrators who sexually abused them. This will be followed by exploring the participants' emotions of anger towards themselves.

4.2.1.2 Anger towards perpetrators

Anger towards the perpetrators was a response to how the participants felt regarding the actions of the perpetrators towards them when they were sexually abused. The participants' felt that the perpetrators had violated and taken advantage of their bodies and robbed them of their innocence. Participant two felt angry towards the perpetrator of the sexual abuse and indicated that he should have been aware of what he was doing

to her psychologically and physically. Participant one had the following to say about her anger towards her perpetrator:

> P1: Anger to those men, because they had taken a part of me, and sort of taken my innocence in a way, and ja, em, hatred sometimes as well. I know that is a strong word but...I don't know and I just wanna cry and just let it all go, but it is hard sometimes, so it's always...it just builds up and...

Participant two expressed her anger differently and described behavioural actions to convey her rage towards the first perpetrator who sexually abused her:

> P2: They took advantage of me, especially ...he was the guy that abused me when I was 11, I mean, he should have known better, em....ja, I dunno, just might put a bullet in his head...

She however had a different reaction towards the second perpetrator who sexually abused her and had the following to say:

> P2: I took responsibility as well ... because I felt that I put myself in that position

The following quotes are of participant three who was sexually abused by two perpetrators, both of whom were known to her. The perpetrator of her first sexual abuse experiences was the father of a childhood friend. She subsequently replied to a question during the interview process by saying:

> P3: Cause he's the one carrying on with his family and, or carry on with his daughter which was my best friend

Her response to the second perpetrator with whom she had a romantic relationship at the time he sexually abused her over a period time was:

> P3: Well, towards my boyfriend err, really, I suppose I really hate him.... ja no, if someone mentions that they have seen him then I just go totally em...criticize him and stuff like that, cause then.... after we broke up he used to come back and tell me about his other girlfriends and then he'd make a move on me and its just gross

She was further angered by the fact that the perpetrator whom she considered to be someone who cared for her did not acknowledge her as a person nor did he take into account that she was not emotionally or physically comfortable with being forced into sexual activities in which he wanted her to partake. She also recalls that he laughed during one specific incident and this made her angry as well. The following quote is a recollection of that incident:

> P3: Ja... no it often... I'd be crying and then my nose is not closed but now how I'm supposed to breathe and then often choke and then he'd laugh at me

Her anger was also directed at the fact that this was one of the instances he had forced her to have oral sex and she had felt humiliated and made to feel powerless by him.

The fourth participant responded by saying that her anger towards the perpetrator was because she felt invaded and powerless as illustrated in the quote below:

> P4: I feel like he has invaded me. And its not something I can ever get back, so I hate him for it, it feels like he has got so much power over me, that's what it feels like...it feels like he's got power over me, I feel powerless even though like I'm not with him no, I still feel like he owns me because he was determined like where ever he goes determines where I go, you know or where I don't go because then I won't go where he is, even if my best friend is there

South African researchers Mayekiso and Bhana (1997) argue that sexual abuse is often committed by an individual in power against an individual in a position of weakness. The quotes of the participants imply that the perpetrators were the individuals in the position of power and the participants were in positions where they are weak or not able to defend themselves assertively. According to Mayekiso and Bhana (1997) the perpetrators were in power because of the roles they possessed, such as being the head of a family, being the romantic partner of the survivors, and forcing the survivor to do

as the perpetrator wished. The first perpetrator who abused participant three was the father of a friend. According to feminist theorists such as Burstow (1992) and Walker (1998), fathers are thought to be members of patriarchal cultures and are often idealised by the rest of the cultural group. This creates the illusion that fathers are in positions of power and the rest of the cultural group might be considered to be in positions of weakness. Participant three would form a part of the rest of the cultural group that both she and the perpetrator belonged to but when he had abused her she became the individual who was in the position of weakness. Furthermore, her quote suggests that her anger towards him centres on the belief that he is able to continue functioning as a member of his family, retaining his position of power.

Participant four felt powerless because of the way the perpetrator had violated her body and her privacy and left her feeling powerless. In her quote she indicated that she is also experiencing difficulty in reclaiming her power and individuation from him. This is supported by the work of feminist writers Kuba and Hanchey (1991) who maintain that power is given to men and they are considered to be strong and dominant. The perpetrator's dominant behaviour is evident in his actions of forcing the participant to do as he told her and her response of saying that she feels like she is owned by him.

Participants' three and four were left feeling humiliated and powerless and this angered them, while no anger was expressed towards the second perpetrator who abused participant two. She had felt responsible for the abusive actions that took place. Miller (1986), a psychoanalyst, believes that if a perpetrator was previously known to a survivor of sexual abuse then anger may not always be expressed because the survivor

may have conflicting feelings for the perpetrator such as love and hate, which may occur simultaneously. Although participant two was not in a romantic relationship with the perpetrator she had initially displayed romantic interest in him shortly before the abuse had occurred. She blames herself for her romantic feelings towards him and therefore finds it difficult to express any anger towards him since she decided to enter into a courtship with him.

4.2.1.3 Anger at self

During the interviews the participants expressed anger towards themselves because they remained in the sexually abusive relationships. Participant two was angry because she felt that she lacked the knowledge of what was happening to her because she had a romantic interest with the perpetrator and thought he should have been aware of what he was doing to her. The sexual abuse occurred when she was about 11 years old. However, she took responsibility and blamed herself for being abused by a second perpetrator after she disclosed that she had placed herself in a vulnerable position. Participants one and three considered inflicting pain on themselves as a means of expressing their anger towards themselves. The fourth participant verbalized her anger towards herself for remaining in the relationship for almost a year and was angry that she allowed the perpetrator to dominate her. The following quotes are examples of the participants' anger towards themselves:

> P1: I tried to cut myself; I'd rather feel physical pain than emotional pain
>
> P2: I took responsibility as well...because I felt that I put myself in that position
>
> P3: Em, I think, total feeling of just... need it to get out of my body and I dunno... I suppose hurting myself

P4: When I talk about it now I can feel my face is like, my expression is just one big, like angry. I'm so angry with myself because I sat there for a whole year, and I would even be caught sitting next to him, I would let him touch me, because he doesn't bath, he's so gross, because he would play rugby and he would come back from playing rugby, because he's like this professional rugby player or whatever I don't care but he like, he I dunno, something didn't go right with him in that game or something ... he would take it out on me and then I would have to have sex with him after every game and if I missed any of his rugby games I would get into trouble, if em, I was late for any of his rugby games I would get into trouble, even if I was at a crucial thing that my mother was coming back from America and I had to go see her, he would blame her, he would expect me to be at his game and if I wasn't there he would blame her, and he would blame me and he'd get so angry and then I would have to give him sex after the rugby game or I'd have to do this, I'd have to do that and he wouldn't even wash himself, and I would have to like, and I let that happen...its like, it's like so gross...

P2: Its wrong but I didn't do anything about it

The aforementioned quotes are an illustration of the participants' conceived notion of themselves when the abuse was occurring to them. The participants further voiced that they assumed a level of responsibility for what had happened to them. These quotes corroborate with the literature of psychoanalysts Blume (1990), Grisset and Norvell (1992) and feminist writer Burstow (1992), whose theories suggest that survivors take responsibility for their abusive experiences because they are not able to trust themselves. Since they were not able to trust themselves they denied themselves their own awareness as well as believing that they are expected to meet the needs of the perpetrator. Participants one, two and three have internalised their feelings of anger towards the perpetrators, as they did not trust themselves to verbally express their anger towards the perpetrators. This allowed them to take responsibility for what has happened to them as well as to deny themselves their own awareness, as indicated by participants one and three. They spoke about rather experiencing a physical pain or a physical removal of pain than to emotionally engage with their pain regarding the

sexual abuse. Participant four also denied her own needs and fulfilled the needs of the perpetrator, which in her reflection during the interview angered her.

The participants did not only express anger towards themselves for the influence that the sexual abuse has had on them thus far but also related anger towards themselves for their bulimic behavioural actions. Three of the participants voiced anger towards themselves regarding their bulimia and their relationships with food. The participants expressed anger towards themselves when they discussed certain eating behaviours they were involved in, such as bingeing and purging, not being able to control the bulimia, disgust with food and with their bodies. The following extracts illustrate the participants' feelings towards themselves:

> P2: Because I'm responsible for it, I eat, I put my finger down my throat or whatever it is I do

> P3: I felt disgusted with myself...cause I couldn't control it and it might have been, the way I was eating and behaving and starting to drop in my school work, no interest, not telling anyone, no interest in my friends, not caring to make an effort and just totally consumed me and I became selfish...(P3)

> P4: I felt like I was betraying myself, actually, it felt like ja, gross... food makes me feel disgusted

The anger and rejection of food by the participants is supported by Guntrip's (cited in Dana & Lawrence, 1988) the psychoanalytic theory of on women. He argues that bulimic women reject food as they are afraid of their own rejection and neediness. Their neediness is often the nourishment that food provides but more importantly food represents nurturance from people. The quotes of participants two and three have illustrated their anger via the rejection of food, and therefore their own emotional

needs. While participant two became angry with herself because she could not control herself around food and became selfish.

In addition to the literature of Guntrip (cited in Dana and Lawrence, 1988), self-psychologist Bachar (1997) believes that bulimic women use food to provide them with nurturant qualities such as comfort and calmness. Food is further used as a means of expressing difficult emotions such as anger. Participants three and four spoke about their anger in terms of feeling disgusted with themselves so that consuming food made them perceive themselves negatively, and they disliked themselves when they did eat. Participant two disclosed that eating food did not comfort her; rather it had the opposite effect where she wanted to expel it in an aggressive manner such as purging.

Contrary to the writings of Bachar (1997), psychoanalyst Bruch (cited in Josephson, 1985) argues that food does not necessarily offer nurturing qualities. According to Bruch's theory, parents might have used food as a solace for any emotional injury that occurred to the infant when she was young, often confusing the child regarding her own emotions, since food was provided to the infant for both positive and negative emotions experienced by the infant. Bruch believes that women's reaction such as those of the participants extend form early childhood where their emotional needs were often compensated with food. For women such as the participants, emotions of anger coincided with feelings of hunger (Josephson, 1985).

4.2.2 Control

4.2.2.1 The participants' control

Psychoanalyst Waller (1996) argues that bulimics who have been sexually abused tend to show more external locus of control, i.e. they see themselves as having low levels of control over events in their lives. Sexual abuse incidents are events in the lives of survivors where they had no control, and in situations where the person in authority, namely the perpetrator, could not be questioned. This belief originates from the notion that adults are always right (Chand, 1999). Survivors who maintain this belief develop negative thoughts about themselves such as that their body is the enemy who deserves to be punished.

According to psychoanalyst Chand (1999) eating disorder is a form of punishment or self-injury that the survivors inflict on themselves to create a distorted body image. However eating disorders violate the physical boundaries of the survivors as much as the sexual abuse violated the physical boundaries of the survivors. According to psychoanalyst feminist Kearney-Cooke *et al.* (1994) the survivors who internalize the violation of their bodily integrity and safety interpret this as having no control over their physical space. Thus they tend to react by over controlling elements that are within their power, such as food. Although the survivors resort to food as a means of controlling their environments, destructive eating patterns also present a means of controlling abusive experiences. This leaves them with a perceived sense of control over what happens to them (Chand, 1999).

Aspects of control were important for the participants to verbally engage with during the course of the interview. The participants felt that there had been times when they had different measures of control. When they were been sexually abused, the participants felt they had no control, while at other times the participants considered themselves to be in control of aspects, such as food and their body images. The following quotes illustrate scenarios where all four of the participants had no control over the sexual abuse. The quotes further highlight the physical violation that the participants had to endure when they were abused by a person in authority:

> P1: I was tied up and there were guns and knives and ja, it was, it is quite uncomfortable to talk about...I felt scared because if it had, you know, because it happened to me once before maybe it could happen again...I mean what 4 year old possibly could deserve something like that

> P2: Em, I actually felt very uncomfortable because we actually talking about sex and he said he bought a new place and he wanted to go there and show me, then he wanted to have sex, I said ja okay fine, and I agreed to go to his house and when I got there I didn't want to do that...

> P3: he was very, had a, always wanted to be involved in sex and blah blah and ja, especially oral sex, it was very disgusting, and I had no clue then really what the stuff was about and he... I knew what it was, but I didn't expect I was supposed to be involved in this then already, and even if I said no, he forced me to and even if... I cried, he forced me to ...

> P4: He was forcing me to have sex with him. He drinks a lot okay, and then I em, would sometimes drink with him and he would get me really like drunk and stuff and em, and then those were the times when he used to do like the worst things to me but like, when I'd like be getting sick or something like in the bathroom then he would come in because I'd be all by myself and he would know that, it would be an easy place cause he could lock the door and stuff then he'd hurt me and ja...the night that he raped me and I knew he was angry with me that night and somehow I knew that something was going to happen, and em, I kept on like saying like stop and he said like yeah, what's wrong with you...he started pushing me around

The experiences of the participants are supported by the literature of Waller (1996), who reports that sexually abused bulimics had no control in situations and could not physically defend themselves against the perpetrator. This is evident in the responses of all four participants. The experiences of the participants further support the arguments of Burstow (1992) that women become control orientated when there are emotional issues or events, such as the sexual abuse. The sexual abuse is considered to be explicit events in which the participants had no control because of the physical dangers with which they were faced. Participant one was threatened with weapons, while the perpetrators physically threatened participants three and four. The perpetrator also verbally threatened participant four.

4.2.2.2 Control over food, weight and body image

The participants considered themselves to be in control of themselves and their psychological well-being when they were able to have power over their food, before entering into remission for their bulimia. Control was viewed by the participants in terms of how they were able to make their bodies more attractive by losing weight through purging the food they consumed. Participant one felt that she was in control of her daily happenings, including her food intake, because the hospital staff as well as her parents supervised her meals closely. Participants two and three also felt the feelings and actions that they employed when attempting to gain control became overwhelming for them and were unable to focus on anything else. For participant four who measured her control with food, it was the ability to not eat the food which gave a false sense of

feeling good about herself and she interrupted this to indicate that she was in control. The following remarks highlight these experiences:

> P1: Ja, I hate that sort of thing that I hate not being in control so having people watching what I eat, watching that I don't go to the toilet afterwards, its just so frustrating to me because I feel so out of control when this happens
>
> P2: ja cause it was always about the weight, em, I could make the weight go down, or I could if I wanted to...it was just I wanted to fixate, I just got obsessed about something else...
>
> P3: it was chaotic, it was, I couldn't concentrate at school because I used to think about what I need...it was totally out of control but at times I thought I will, ja I mean later I tried to fight because I knew it was controlling me
>
> P4:I would just distract myself from everything and the only thing that I felt I could control is, em food...because not eating food felt like I was in control even athough I was working with it, you know, starving myself, like the best thing and I'd go home and I'd be so chaffed with myself

When the participants refrained from eating food they were avoiding nourishment or nurturance. This type of action is described by the writings of psychoanalysts Dana and Lawrence (1988), who believe that women reject food as it presents the attention that the women desire. The women reject the food because they believe they are not worthy of attention and nurturance. It is further speculated that actions from participants three and four were in response to not accepting the attention they are receiving, namely the abusive attention from the perpetrators

The participants considered themselves to have control when they limited their daily food intake. They believed if they could accomplish this, it result in them acquiring attractive bodies which would lead them to have improved relationships with men as

compared to relationships that they had in the past. Participants two and three are quoted as saying:

> P3: just, just suppose I wanted to be an attractive girl, I dunno... I just, I really, my body became, I obsessed with being okay for my boyfriends...

> P4: I felt like, you know, guys love that supermodels and girls that are on covers of magazines and stuff like that, maybe I'll get a decent guy that would treat me right and that's what my main aim was

The responses of the participants are corroborated by the literature of psychoanalytic theorist Guntrip (cited in Dana & Lawrence, 1988). According to Gunrtip, control is an attempt to separate bulimic women from experiences or people whom they may have conflict. The measures undertaken by the participants were attempts at controlling the external environment. This provides them with a distraction of having from process uncomfortable emotions which stem from the sexual abuse. According to Lawrence (2001) the ability to create this distraction is a defense against depressive pain.

Self-psychologist Krueger (1998) argues that bulimics further gain control by the knowledge that they hold regarding the dietary value of food. A binge allows the women to believe that she is in control of all the food she is consuming and inevitably can control aspects of her environment. The participants believed the ability to control their environments would lead to them developing better relationships with men.

The response of the participants echoes the feminist writer Burstow (1992) who believes that women are not normally able to demonstrate their ability to control and be powerful in society. For most females control and power are valued only in situations

that are common to them, namely the domestic environment such as the kitchen where a considerable amount of time is spent preparing food. Furthermore the literature of other feminist writers such as Kuba and Hanchey (1991) and Sesan and Katzman (1998) suggest that the idea of being thin and attractive is the ability to control the bulimic's external well-being as well as to meet social and cultural norms. This is illustrated in the quotes of participants three and four who wanted to achieve attractive bodies to receive attention from men. Participant four's quote demonstrates the socio-cultural norm which influences her needs to resemble supermodels that attain the media's portrayal of the ideal woman.

Psychoanalyst researcher Andrews (1997) argues that negative thoughts which bulimic women tend to internalize about themselves are often related to early sexual abuse. She suggests that the women might experience feelings of inferiority and disgust about their femininity and sexuality, which is expressed in their concern with body image, leading to eating disorders like bulimia. Bulimia is considered to be a control-orientated disorder. According to Andrews (1997) it is not surprising that women such as the participants of the study become bulimic, when taking into account their sexual abuse histories.

The negative emotions as mentioned by Andrews (1997) are congruent with psychoanalyst Rose's (1986) definition of 'identify with the aggressor.' Rose (1986), like Andrews, states that sexually abused women have negative emotions such as feeling inferior and consider their femininity to be spoilt. However Rose (1986) argues that when women are experiencing these emotions they are identifying with the

not emotionally well. Thus they do not seem to believe that they are emotionally healthy.

4.2.3 ABUSIVE EXPERIENCES AFTER THE INITIAL ABUSE

A third common theme amongst the participants was their entering into sexually abusive relationships, hurting themselves physically and abusing of substances such as drugs after the initial abusive experiences. For participants two, three and four their subsequent sexual relationships occurred on more than one occasion. They would continuously move from relationship to relationship and be abused while trying to meet the needs of their partners. For participant two the abuse of drugs occurred before the onset of her bulimia while the intention to hurt herself occurred simultaneously with her bulimia. For participant one and participant three hurting themselves implied suicidal ideation and self-mutilation such as cutting of bodily parts.

4.2.3.1 Abusive experiences with perpetrators

Whilst speaking about their subsequent experiences the participants reflected on their initial experiences. All four participants disclosed that they were not aware of the emotional implication that their first sexual abuse experiences had for them, at the time that the abuse occurred. Participant two recalls her being fond of the perpetrator, as he was a well liked family friend and recalls the following regarding the perpetrator:

> P2: I didn't know it was abuse, I thought, cause I had a little bit of a crush on the guy and I saw it as just normal

When the perpetrator stopped abusing her and stopped all contact with her she had the following to say:

> P2: Ja, I felt rejected....

In contrast to participant two who was aware that the abuse was happening, participant one said she had repressed the event, and was only made aware that what happened to her was abuse after therapeutic intervention:

> P1: Em, from debriefing, cause they've told me you know, everything that I've experiences and the details that I've told them so...I sort of put it in my, you know, subconscious that I didn't remember it...

Participants three and four were in romantic relationships with the perpetrators when the sexual abuse started:

> P3: I'd have a loving relationship...well I mean he treated me nice, like I suppose, how a boyfriend is suppose to treat a girlfriend and he took me out and treated me nicely whatever, flowers or...

> P4: I only told her once, I never told her the other times that it happened and everything because it started becoming a routine like, like you know, and I thought like kind of justify it and minimise it and make it like maybe its supposed to happen. I am after all his girlfriend so should be allowing him to do these things to me and all the stuff....

The response of the participants who were able to repress their experiences or rationalised the extent of their sexually abusive experiences supports with the writings of psychoanalysts Sullivan and Winnicott (in Friedrich, 1990). They argue that experiences such as sexual abuse, as in the case of participant one, are too difficult for survivors to hold in their conscious as it was too overwhelming and painful for them to comprehend. Psychoanalyst Miller (1986) suggests that the sexual abuse becomes

repressed and serves as a defense mechanism that allows the survivors to continue to function in their daily routines.

According to Winnicott (cited in Friedrich, 1990) young people divide their experiences into good and bad, but with adequate care and attention from adults, children realise that they cannot always depend on the two polarized ends as a frame of reference and need to find a place in between that does become a frame of reference for them. The incidents of sexual abuse for the participants are bad experiences and may create anxiety in their lives. However, Winnicott (cited in Freidrich, 1990) stated that the experience of the abuse is out of the child's frame of reference, for example participant one's trauma was out of her frame of reference and therefore the event remained in her unconscious.

Alternative object relations theories by Fairburn and Cashdan (cited in Sandberg *et al.*, 1994) suggest that the experience of the sexual abuse may not have been repressed, rather it had to have been reframed for the survivor in order for her to survive. Fairburn and Cashdan (cited in Sandberg *et al.*, 1994) argue that young children such as the survivors of sexual abuse depend on their parents or other objects whom they trust in order to survive. If the survivor is subjected to severe abuse, she will form a negative view of herself, maintaining a positive view of her object with whom she is relating positively as in the experience of participant three who claimed that the perpetrator was a good object who cared for her (Sandberg *et al.*, 1994). She depended on him to make her experience herself positively. This suggests that she fundamentally has introjected a negative view of herself.

Other psychoanalytic writers such as Wakefield and Underwager (2002) also believe that the memories of the sexual abuse get buried along with happy childhood memories. Contrary to Winnicott's belief that children are able to distinguish right from wrong, the quote of participant two indicates that she was not able to do so when the family's friend abused her.

The following quotes are examples of participant four who remembers being continually sexually abused by her boyfriend at the time. She recalls confiding in a friend after the perpetrator first abused her. She however did not tell her friend of any of the incidents that occurred afterwards, as she considered herself to be the perpetrator's girlfriend and that she was expected to offer sex to him:

> P4: Em the first time I ever spoke about it was the day it happened. I told my best friend...I just told her that (perpetrator) did something horrible to me, so I only told her once. I never told her the other times that it happened and everything because it started becoming a routine like...and I thought like kind of justify it and minimize it and make it like its supposed to happen, I am after all his girlfriend and should be allowing him to do these things to me and all that stuff...she was like really disgusted and said that ja, she cant believe he can do that

She also did not confide in anybody as time progressed because the perpetrator had threatened her:

> P4: because he used to threaten me with it, and his friends used to threaten me with it, they used to tell me it's obviously not true, you haven't gone to the police yet, it's not true because (perpetrator) didn't fucking...blah, blah, blah, you bullshit. You would have gone to the police by now, you so pathetic, you so lame, do you think anyone will actually believe you, who are you anyway, you know, how could you ever be with (perpetrator) anyway, look at (perpetrator), look at you. I was like such a joke to them

The quote of participant four supports the literature of psychoanalytic researchers Grisset and Norvell (1992), who state that bulimic women often find it difficult to be honest with people in their surrounding, as they fear they will be rejected. Although participant four started telling her friend after the first incident she did not reveal everything to her, especially since her friend could not believe that the perpetrator was capable of such actions. The researchers further argue that bulimic women such as participant four learn to mistrust people and themselves. This is evident when participant four is quoted in saying that she minimized her experiences of the abuse.

4.2.3.2 Re-entering into abusive relationships

After the participants' initial experiences they entered into relationships with partners where they were emotionally traumatized. Participant two recalls that she had felt rejected after her first abusive encounter and believed she only received attention from men because they were interested in her body. Participant three said that when she entered into a subsequent abusive relationship the perpetrator initially valued her and idealised her and was happy that she received this attention from him because she did not have positive self-esteem at that time. Participant four justified her re-entry into an abusive relationship as a 'use-use' relationship (as defined by her) where sex was a way she felt valued, and where she offered the partner in this relationship a distraction from his own hurt and pain. Participants two, three and four had the following to say about why they have reacted in this manner:

> P2: for starters because no one wanted me and I thought I was rejected and I know no one wanted me and I was only good for my body and all that... after that I tended to go to people that were very abusive, ja I've been raped after that

P3: No I meant somebody liked me and kind of kissed the ground I walked on...in that time I was just glad that somebody liked me cause I didn't like, I wasn't thinking much of myself...

P4: Em, I wasn't like, I had lots of guys interested in me....but I mean I wasn't in a em, it wasn't abusive...yeah it was abusive.... he was with her for a long time but she went overseas and he was all lonely and I was like fucked up and I needed to know that someone cared about me like, you know, and he, I would say to him like you know, what's up with us, he would go em, no, like what do you mean, I dunno, I'm so good for you, so I don't know what I want like all this stuff....like he used me and I used him. He actually needed someone, he needed someone to fill in that gap that he was left with what his girlfriend left him, he's lonely, and I was easy because I was vulnerable. I needed to feel that someone cared about me and I thought the only way I could do it was if I had sex with him

The quotes from the participants support with the writings of psychoanalysts Dana and Lawrence (1988) who indicate that re-entering into abusive relationships is a common phenomenon which occurs amongst bulimic women. Choosing abusive partners is an unconscious decision in which the women, such as the participants, seek violent partners for themselves where they will be hurt emotionally and possibly physically. However, according to the fourth participant entering into a subsequent abusive relationship was not necessarily unconscious as she was aware she needed to provide her partner with sex to feel valued. Furthermore her actions might be motivated by her attempts to gain mastery and to understand her initial traumatic experience. According to Sandberg *et al.* (1994), when a woman such as participant four engages in subsequent relationships that are potentially abusive to her, she is attempting to gain control and mastery of a situation in which she had none. Unfortunately women like herself make themselves vulnerable to revictimisation. It is important to further understand that while participant four acknowledged why she entered into a subsequent

abusive relationship, Sandberg *et al.* (1994) argue that it is important to remember that survivors of sexual abuse do not want to be revictimised again. It is further suggested by psychoanalyst Blume (1990) that entry into these relationships would have reproduced similar feelings as the initial abuse.

A common experience that existed amongst the participants was the inability to trust themselves in the relationships that they entered into after the initial sexual abuse. Since the participants are not able to trust themselves in their environments, they are not able to value or trust others and believe that men were only interested in them for their bodies. This corroborates psychoanalyst Blume's theory that women often think they are desired because of their bodies (Blume, 1990). She further argues that re-entering into sexually abusive relationships with partners in not conceivable unless sex is an integral part of their experience with that particular partner (Blume, 1990). The responses of the participants also support the research findings of Mahon *et al,* (2000) that bulimic women are unable to commit to secure relationships and this is indicative of their traumatic childhood experiences.

4.2.3.3 The use of drugs and other self-destructive behaviours

All four of the participants were involved in subsequent abusive experiences whereby they inflicted pain onto themselves. These experiences include abusing substances such as drugs as well as inflicting physical pain on themselves by attempting suicide. Participant one attempted to commit suicide approximately nine to ten years after the initial sexual abuse occurred. Participant two abused drugs after the initial abuse

occurred and stopped using drugs before the second abusive incident. At the time of the second incident she was actively engaging in binge and purging eating behaviours. Participant three felt that physically hurting her body was one way in which she could expel from herself the uncomfortable emotions that the abuse evoked in her. Participant four was abusing drugs while she was in a relationship with the second perpetrator. She was also abusing alcohol whilst in a relationship with the first perpetrator. Participant two concludes that she found comfort in abusing substances, as it was easier for her to cope with the physical pain than it was to emotionally engage with her pain. The participants had the following to say regarding their addictions and self-destructive behaviours:

> P1: I tried to kill myself, first OD and then the doctors, my doctors said no, I have to go now; they have to put me in hospital...
>
> P2: I think basically just wanting to let go, and ja, not feel...ja because when you're high you don't really think about anything so...
>
> P4: we used to like do drugs together cause just like me and him, he's girlfriend had just moved away, he was with her for a long time, but she went overseas and he was all lonely and I was fucked up...
>
> P4: he drinks a lot, okay and then sometimes I would drink with him and he would get me really drunk and I needed to know that someone cared about me...

The above quotes of the participants abusing substances supports the literature provided by psychoanalyst Nash (1999). According to her, sexual abuse is more commonly found in women who are bulimic, especially if they have histories of substance abuse as well (Nash, 1999). Extending Nash's theory, Blume (1990) suggests that women like the participants would move from one detrimental addiction to another to avoid the emotions associated with the abuse. Participants two and three moved from abusing

drugs to bulimia as a means of avoiding the emotional trauma that was related to the sexual abuse.

The participants' intent of hurting themselves either with the use of drugs or suicide suggests that it is a manner in which the participants were 'identifying with the aggressor' (Anna Freud, in Du Zulueta, 1996). According to Anna Freud 'identifying with the aggressor' is an unconscious manifestation in women such as the participants, where attempts are made by the survivors to acquire control and power which was involuntarily taken away from them. The participants believed that engaging in drugs and attempts to commit suicide are decisions that they made and were not forced by the perpetrators. However Du Zulueta (1996) argues that the need to inflict pain on oneself in the manner that the participants had implies that survivors such as themselves believe that they are bad and should be punished. This provides them with the perception that they are in control of the choices they are making for themselves.

Contrary to Du Zulueta (1996), Herman (1997) believes that for the survivors of abuse, such as the participants who inflict pain onto themselves, this can be understood as a symbolic or literal re-enactment of the initial abuse. According to Herman (1997) attempts at suicide or abusing drugs by women such as the participants serve the function of regulating intolerable negative emotions. This could occur because the participants lack alternative or more adaptive self-soothing strategies or emotions to help them relieve the sexual trauma that they have experienced.

4.2.4 Emotional detachment

4.2.4.1 Defense and coping mechanisms

The last theme to be discussed is detachment. The detachment of participants' emotional or psychical experiences is a defense mechanism that is employed to protect the individual from painful emotions and may be considered as Sullivan's (cited in Freidrich, 1990) theory of 'not me' to defend against the trauma incurred. Participants one, three and four describe their detachment as an act of intention by them to avoid or suppress the emotional feelings that were too difficult for them. For the participants their physical bulimic behaviour, for example their bingeing and purging, was the most significant metaphor employed by them to externalize their emotions. The bulimia could also be considered as a way of consciously making sense of the sexual abuse. The bulimia not only served as an emotional detachment for the participants, but also as a physical detachment from the actual sexual abuse that occurred to them, as is mentioned in the following quotes:

> P1: for instance when I put food in my mouth I sort of think about, back then when something was put into me, how I didn't like it so....every time that happens I just immediately try to get rid of everything and for a minute I feel relief, but then it just feels shit again...

> P3: .I want to get whatever was in me out of me again...he often forced me to have oral sex and maybe he, I just wanted to get it out of me...

> P4: Food makes me feel disgusted and (perpetrator) makes me feel disgusted, thinking about it makes me feel disgusted and then getting rid of it, I feel better...

From the psychoanalytic perspective of Lawrence (2001), the aforesaid experiences of participants one, three and four are attempts to control internal processes. She argues

that the bulimia is a symbol of an attempt to control internal psychic processes and the bulimia becomes a defense mechanism used to defend against painful experiences. Lawrence (2001) continues her argument by stating that active states of bulimia such as the bingeing and purging are attempts to kill internal objects. For the three participants who forcibly and physically had to internalize the perpetrators, this was done through the vaginal and oral penetration that the participants had to endure. Their purging becomes a manner in which they can expel violently the penetrating penis, in the hopes that they had killed their internalized object, as quoted by participant three. However Lawrence (2001) argues that the survivors are not able to kill off their internalized object and continual bingeing and purging episodes, as in the case of the participants, demonstrate that the women need to continue their bulimic behaviour to detach themselves from their perpetrators. Self-psychologist, Krueger (1998), similar to Lawrence, believes that the incessant bulimic behaviour of the participants represents the ability that they have to remove the 'bad objects' such as the perpetrators from themselves.

All four of the participants reported that their bulimia served as a manner in which they detached from the emotional experiences that resulted from the sexual abuse. Anger, pain, not wanting to be emotionally connected with their feelings, wanting to be removed from their bodies and being isolated from themselves and others around them emerged from the interview. The participants disclosed their detachment by saying the following:

> P1: What I like about it is it hides, or I hide behind it you know, all my feelings that I get so numb that I don't have to feel ...pain and anger and, I just, just feeling anything...ja it feels better to be numb than having to feel

everything...after I feel sick you feel better, but I think it's just that numbing out that I miss...

P2: I think the fact I was not dealing with my feelings and stuff like that, I've taken it out on food and whenever I throw up or purge or whatever it always makes me feel better so...em I think basically just wanting to let go, and ja not feel...wanting to run away or whatever I got that through bulimia, through drugs, through all sorts of stuff...

P3: Em, I think total feeling of just need it to get out of my body and I dunno, I suppose hurting myself with food and stuff...just dead inside, I dunno, I dunno how to answer that...sleep it away or maybe eat...

P4: I isolated myself even more because I didn't have him isolating me, so I isolated myself from everyone you know, because that is what I was used to and stayed at home and felt like everything else around me was out of control...or if I'm vomiting up my food and stuff, I don't feel anything, I feel like you know, I'm sitting in the room but I'm not really there and for me its nice because I feel safe, because I'm disconnected, its cool. Because then its like you know, you can do whatever he hell you want to me, because I'm not really there...now I know what it feels like to speak to someone that is disconnected...

The participants used detachment as a defense mechanism from their painful and traumatic experiences of the abuse. This was evident since they were not taken into account by the perpetrators when being abused, as mentioned in the above quotes by the participants who were physically and sexually violated. When the participants were detached from their own needs, they sought to fulfil the needs of others; this might further result in them landing in more abusive relationships. According to Blume (1990) the detachment allows women who are in similar situations to the participants to mask their feelings of hurt and pain. The participants managed to remain detached and repressed their negative emotions until they were admitted into the unit to help them enter into remission (Blume, 1990).

Psychoanalysts Sandberg *et al.* (1994) agree with Blume (1990) that dissociation is a defense mechanism that is used to protect the sexual abuse survivors, against any negative emotions of hurt and pain and where they possibly could have felt helpless. Sandberg *et al.* (1994) further highlight that although dissociation is a defense against traumatic experiences, it may ultimately become a maladaptive coping mechanism, often making survivors lack awareness of themselves and their environments. This is evident in the aforementioned quotes of participant one, two and three, who needed to physically dissociate from their food in order to dissociate from their negative emotions. Participant four also describes her dissociation from people in her environment by isolating herself, thus demonstrating that her coping mechanism is no longer protecting her in the manner that is was supposed to, since defense and coping mechanisms initially allow survivors of trauma to continue their daily functioning as if nothing painful has happened to them.

4.2.4.2 Isolation

The desire to isolate oneself from the external world is also considered to be a form of detachment. Blume (1990) argues that detachment could provide the women with the comfort of not wanting to attach themselves intimately with another person (Blume, 1990). The thought of intimacy with another person propagates ambivalent emotions and isolating themselves, as the participants were able to do, is one way of not needing to be confronted with those emotions (Mahon *et al.*, 2000). The ability to detach from their painful feelings is also a way in which the participants were able to continue their relationships with the perpetrators, especially for the participants who were in romantic

relationships or had previous established bonds with the perpetrators. This is consistent with the writings of psychoanalytic feminist writer Walker (1998) who argues that it is not easy for survivors to separate psychologically from the perpetrator, because the survivor cannot accept the reality of the abuse that has been inflicted on her. The participants suggest the following reasons why they were not able to separate from the perpetrators:

> P2: I didn't know it was abuse, I thought, cause I had a little crush on the guy and I just saw it as normal...
>
> P3: In that time I was just glad that somebody liked me cause I didn't, I wasn't, think much of myself, much confidence and someone actually liked me...
>
> P4: I thought like kind of like justify it and minimize it and make it like maybe its supposed to happen, I am after all his girlfriend so should be allowing him to do these things to me...

4.3. SUMMARY

The overall findings of this study indicate that the participants struggled to express their anger directly towards the perpetrators of the sexual abuse, and often expressed anger towards themselves. Their inability to express their anger and lack of appropriate therapeutic intervention lead to their anger being expressed through the manifestation of the bulimia. The experience of the bulimia gave expression to the salient themes presented by the participants. The four themes are anger, control, abusive relationships and detachment.

The common experience of the participants was their disempowerment during the sexual abuse, which evoked anger and inability to control their environments. Anger towards the perpetrators was not verbally acknowledged to any one in the mental health profession prior to their admission into Kenilworth Clinic's Eating Disorders Unit or individual psychotherapy. Anger was expressed by the participants through their bulimic behaviour, such as bingeing and purging, to rid themselves of the physical violence of the sexual abuse as well as the emotional turmoil they were experiencing. Anger was directed at themselves for remaining in the abusive relationships with the perpetrators, as well as for being actively bulimic, and they also felt negatively about their bodies.

The participants further entered into subsequent relationships with abusive partners. The work of psychoanalysts such as Dana and Lawrence (1998) suggests that women, such as the participants, who have been sexually abused and re-enter into abusive relationships, do so unconsciously. Often the repressed and forgotten feelings of the initial abuse will be aroused again for the participants. Re-entry into abusive relationships are also indicative of women who enter into subsequent relationships without considering their own needs whilst trying to fulfil the needs of the perpetrators, as clearly illustrated in the case of the participant four. This becomes another manner in which they detach from their emotional experiences. The participants further engaged in abusive behaviours to help them intervene with their pain and resorted to drugs as described by participants two and four, as well as harming themselves physically by attempting suicide as described by participant's one, two and three.

The themes of control and detachment suggest that the participants needed to have external measures in place be able to contain themselves from internal processes that were too painful for them. Their attempts at control served as a means of remaining detached from their internal psychological processes, as all their energy and concentration was focussed on an external reality. The external reality for them was achieving good looking or thin bodies which would assist them in feeling better about themselves as well as being, indicative of them regaining power over their lives.

From the interviews it can be deduced that the participants continue to struggle from time to time with both issues around their bulimia and the sexual abuse. They consider themselves to experience similar emotions regarding their bulimia and sexual abuse. However with their inpatient stay at the clinic, individual psychotherapy and the additional counselling they received regarding the sexual abuse and bulimia, the participants have been able to start a therapeutic intervention to help them come to terms with their traumatic experiences, of the abuse as well as to consider additional predisposing and perpetuating factors that could have contributed to the reasons they become eating disordered.

CHAPTER FIVE

CONCLUSION

5.1 SUMMARY OF THE FINDINGS

This exploratory study reflects the experiences of women who meet the diagnostic criteria for bulimia nervosa as specified in the DSMIV-R (APA, 1994) and who were sexually abused by either known or unknown perpetrators. The researcher interviewed four women who were diagnosed with bulimia nervosa and who had disclosed to a member of staff at the Kenilworth Clinic Eating Disorder Unit that they had been sexually abused. In a qualitative analysis of the interviews, four dominant themes emerged, namely, anger, the participants' perceptions of control, abusive relationships and detachment. Each of these themes will be addressed in turn.

All four participants disclosed that they had experienced anger towards the perpetrators, themselves and members of their family. Anger towards the perpetrators and themselves was expressed more openly while the participants struggled to reveal their anger towards their parents. Anger towards the perpetrators indicated that the participants were upset because they had to engage in sexual activities without their consent and were left with negative emotions that they were not able to process successfully without the assistance of a psychotherapist. Participant one reported that she had repressed her sexual abuse and the emotions she had experienced. The other participants do not report the same experiences. The emotions and actual events had

been repressed but manifested later in terms of their bulimia and other addictions such as substance abuse.

The opportunity to participate in the study gave the participants a chance to critically examine issues of control, and how controlling their environment had become a coping and defense mechanism for them. Ideas of control extended to irrational thinking, where the participants created situations for themselves whereby external validation was needed from others, such as believing that men in future relationships wanted women who were thin and had good looking bodies. Exerting control became a way in which the participants distracted themselves from their emotional distress and internal psychical processes and allowed them to feel mastery in their environments. The participants further came to realise that their need for control was an attempt to regain a certain level of power. The ability to make choices was taken away from them by the perpetrators of the sexual abuse.

Participants spoke about their re-entry into abusive relationships after they had forgotten their initial sexual abuse or sought relationships in which they could feel validated. Two of the participants had buried the experiences in their unconscious as described in the writings of Sullivan and Winnicott (Friedrich, 1990). The sexual abusive experiences became repressed in order to help the participants emotionally survive in their surroundings. For the participants who were aware of their initial abusive relationships, re-entry into abusive situations provided an opportunity to better themselves for their partners, believing they were the ones who needed to change. The most challenging change that participants engaged in was to try and achieve better-looking bodies by engaging in self-starvation, bingeing and purging behaviours and

excessive exercise. This type of behaviour gave rise to other self-induced abusive activities such as their participation in using drugs and attempting to commit suicide.

The theme of detachment is indirectly raised in most of the previously mentioned themes and suggested by the participants not expressing their anger directly because of the consequences it had for them. This was evident in the case of participant three who felt that her boyfriend treated her well by spoiling her with material objects such as flowers and making her feel special. The ability to detach, like the ability to control events in their environments, is a defense mechanism that allowed the participants to mask their painful physical and emotional experiences. Adopting an attitude of detachment allowed the participants to enter into subsequent abusive relationships, in which they detach from their emotional well being in order to protect themselves. The need to do this derives from the idea that becoming attached to others would evoke feelings of the previous abuses, which may potentially be hurtful to them (Mahon *et al.*, 2000).

5.2 INTEGRATION OF THE THEMES

The themes discussed were reflective of the physical and emotional experiences the participants have encountered since the sexual abuse began up to the point of and through the active phase of their bulimia.

Whereas the abovementioned themes suggest four different themes, the participants' experiences did not mirror these distinct categories. During the course of the interviews it was evident that the participants were not able to single out the themes that emerged.

For the participants the themes could not be separated as the emotions they had experienced, as well as some of the physical processes that were occurring, happened simultaneously. The dominant theme that emerged was anger. The participants would for example experience anger towards themselves while at the same time being angry with the perpetrators and their parents. It could be argued that themes such as detachment and control, especially regarding self destructive behaviour and not eating correctly, by either starving themselves or by binging and purging, were indirect ways of turning their anger inwards.

The interviews with the participants further indicate that there is a link between the participants' experiences when considering the themes of control and detachment. This was highlighted in the theme of control, when the participants refused food as a source of nourishment, and nurturance or considering their emotional well-being.

The participants' experiences also demonstrated that they engaged in activities such as abusing drugs or attempting to commit suicide as a way of detaching from their emotions. They needed to react in this manner to avoid emotions that were too painful and events such as the actual sexual abuse that were too traumatic for them. Furthermore the participants exerted control in their environments as a means to deflect emotions that were too hurtful for them. For the participants, control was measured by their ability to control their body weight and physical forms. Their preoccupation allowed them to remain detached from their abusive incidents of the past.

From the material gathered in the interviews with the participants it appears that for the participants, although their experiences of the sexual abuse and bulimia were two different entities they evoked similar emotions for them. For all four participants some of their emotional experiences continue to exist, which makes remission difficult for them from time to time, as demonstrated in the following quotes:

> P1: I just wanna, sometimes just get sick again; I just want to get rid of it all
>
> P2: Ja, its, I dunno, I still binge every now and then, but I refrain from purging em, I can't find like, ja, I can't say that I'm never gonna do it again, because...when I just finished therapy, ja or I've just fight with someone
>
> P3: Its uncomfortable sometimes it will...but it doesn't get higher up anymore
>
> P4: Its weird thing, because it's like I don't ever had control over anything in my life, even now, I still don't have control over myself. I mean I'm...I haven't gone on a starving strike or started vomiting like that, vomiting you know, em, but I'm still not being good to myself, I'm still isolating myself, still, dealing with it...

5.3 LIMITATIONS OF THE STUDY

The first limitation of this study is reflected in the fieldwork, where an expected number of participants could not be guaranteed. Due to the closing of the Eating Disorder Unit a large sample could not be obtained, as most of their in-patients were from areas outside of Cape Town. These women would have liked to participate in the study but were not able to do so, due to logistical reasons such as travelling out of the city, academic and work commitments.

5.4 RECOMMENDATIONS FOR FUTURE RESEARCH

The aim of qualitative research is to highlight the 'lived experiences' of the participants and allow them to tell their stories. The researcher encouraged participants to disclose as much as they were comfortable with sharing and valued their contribution. However it would be beneficial to assess whether the findings of research of this nature would be similar if more participants were included. Participants should have been included from a large range of ages, racial categories and socio-economic status differences. It is also recommended that future research is conducted amongst participants who were abused by family members such as their fathers. This will allow for comparisons to be made between incestuous abuse and the experiences of the current participants who were abused by either friends of the family or their boyfriends.

5.5 RECOMMENDATIONS FOR FUTURE INTERVENTION

The findings of this study suggest that future psychotherapeutic intervention should consider a more holistic view, such as looking more closely at family dynamics and interpersonal dynamics that manifest outside partner or love relationships. The intention would be to examine if the participants enter into friendships in which they set themselves up to be abused emotionally. This would be evident in their social networks such as work and with their friends, and their behaviour during groups and other activities while they were at the clinic. It is further recommended that participants from the same developmental stages be interviewed to gain insight into the interpersonal dynamics of sexually abused women at a specific developmental stage. Whereas this

research focused on sexual abuse of women before age 16, future research should be conducted with women who are abused in the adult stages of their lives.

It is recommended that eating disorder units need to adopt a more structured management approach to sexually abused women who also have an eating disorder. This would include providing the patients with additional counselling for their sexual abuse and creating a support group for women with similar experiences. The intention would be to help them break the silence and move away from being stigmatised.

5.6 THEORETICAL IMPLICATIONS

This study drew on the psychoanalytical writings of authors like Dana and Lawrence (1988), Bachar (1997); Miller (1986), Blume (1990) and Winnicott (cited in Friedrich, 1990) to conceptualise the participants' understanding of their bulimia and sexual abuse. A strength of the theory is that it enabled an adequate description and contextualisation of the participants' intrapsychic experiences of bulimia and sexual abuse. Psychoanalytic theory further assumes that the actions such as binge eating and self-injury are the signs of basic underlying problems (Herman, 1997). However most of the theory used in this study discussed bulimia and sexual abuse separately, with very few studies discussing the two phenomena simultaneously. The literature on bulimia further focuses on early interactions of an infant with her mother, and suggests that inadequate mothering or care giving may be a consequence of bulimia (Guntrip, in Dana & Lawrence, 1988). Using this as a basis for many of the arguments in the results

and discussion chapter, literature, which considers the development of bulimia in later developmental stages was not considered.

The psychoanalytic theory used by theorists such as Dana and Lawrence (1988), Bachar (1997) and Krueger (1998) did not consider the power and gender dynamics regarding sexual abuse and bulimia. The study by Mayekiso and Bhana (1997) was the only article used to substantiate the relationship of power and sexually harassed females. In this study the power dynamics were discussed especially where participants felt that they could not voice their emotions to anyone what has happened to them and would often be physically threatened by the perpetrator as in the experiences of participant four. Participants also felt powerless because their remaining silent about their experiences contributed to the perpetrators retaining his position of power.

By using a qualitative approach as the research method in this study, the researcher was able to use the theories provided on bulimia and sexual abuse on a small sample of women. The researcher therefore considers that this research has contributed to literature and studies in this and related fields. Furthermore this study concurs with writings of psychoanalysts such as Blume (1990), Freidrich (1990) who argue that women who were sexually abused and who could not verbally express their emotions repress their emotions as a defense against the emotional hurt and pain they experienced. Other defense used by survivors such as the four who participated in this study is the need to control their external environments, physically hurting themselves and often unconsciously entering into subsequent abusive relationships.

The experiences of the four participants contributed to understanding the psychodynamics of bulimia nervosa and sexual abuse as one entity as opposed to considering them as separate. This was reflected in the themes that emerged during the interviews when participants would often disclose that they had similar emotional experiences regarding their sexual abuse and bulimia.

5.7 SUMMARY

This research suggests that sexual abuse remains a topic that is not openly disclosed or discussed within current communities and societal structures. This has resulted in a situation where women, either as adults or children survivors of sexual abuse, cannot openly speak about their abusive experiences to known or unknown social support structures. This makes 'breaking the silence' difficult for women such as the participants, especially not knowing how they will be received on disclosing such information. When the participants remain silent about their sexual abuse, perpetrators are protected by the participants and continue to remain in positions of abusive power. Bulimia nervosa has become a way in which the participants have processed their feelings regarding the sexual abuse, shifting the responsibility away from the perpetrator toward harming and punishing themselves.

Through a multi-disciplinary intervention such as individual therapy, psychotherapy groups, intervention from the dietitian and the additional counselling received at the clinic the participants were encouraged to share their 'lived experiences' and were supported in 'breaking the silence.' For the participants it was the beginning of years of uncovering trauma and reclaiming the power and control in their lives. It is hoped

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APPENDICES

APPENDIX 1

University of the Western Cape

Psychology Department

Private Bag X17 **Bellville 7535** South Africa Telephone: (021) 959-2283/2453
Fax: (021) 959-3515 Telex: 52 6661

To Whom It May Concern:

Thank you for your participation in my research project. Due to the nature of the research project I need your permission to have contact with your individual therapist to ensure your emotional well-being before and after the interview. I have further asked the staff at Kenilworth Clinic to provide you with the most suitable 'containment' place after the interview, should you require this. A staff member will remain with you during your time in the 'containment' room.

Thank you for your co-operation

Yours sincerely

_____

Gadija Roshan (MPsych student)

University of the Western Cape

Psychology Department

Private Bag X17 Bellville 7535 South Africa Telephone: (021) 959-2283/2453
Fax: (021) 959-3515 Telex: 52 6661

COVERING LETTER

91 Plettenberg Road
Rylands Estate
7764
Athlone
Tel: (021) 691 2311-home
: 082 786 7508- cell

Dear _____

Thank you for agreeing to participate in my research project which forms a part of my M.Psych degree programme. The aim of my research is an explorative study of bulimic women's experience of sexual abuse. The research aims to gather a better understanding of women who have undergone such experiences and to contextaulise their experiences so that therapists will be able to construct future management plans to suit that of the client.

Please find an attached letter of consent that ensures confidentiality between participant and the researcher. The consent letter further allows you to withdraw from the research. The signed consent letter must please be returned to the researcher.

Thank you,

Yours sincerely

Gadija Roshan (MPsych student)

APPENDIX 2

University of the Western Cape

Psychology Department

Private Bag X17 **Bellville 7535** South Africa Telephone: (021) 959-2283/2453
Fax: (021) 959-3515 Telex: 52 6661

SOCIAL AND DEMOGRAPHIC DETAILS

Participant no: _____

Age: _____

Current Residential Address: _____

A. Preferred language

English	Afrikaans	Xhosa	Others: please specify

B. Marital Status and Living Arrangements

Single	Married	Divorced	Living with partner	Widowed	Living with parents	Living with other family members/ friends	Living at boarding school/ hostel	Any other living arrangement: (specify)

C.1. Do you have any siblings: _____

C.2. How many brothers do you have? _____

C.3. How many sisters do you have? _____

C.4.Which sibling position do you occupy _____

C.5.What is the age differences between you and your siblings? _____

C.6.Are there other family and friends are permanent residents in your home? Please specify

_____

D. Please tick the appropriate responses that best describe your family

Our family is a close-knit family	
It is easy to share or talk about our emotions in the family	
We are not a close-knit family	
We hardly speak about our emotions to each other in our family	

E. Please tick the appropriate responses that best describe your parents.

My parents are still married to each other	
My parents are divorced from each other	
My parents have/had a good relationship with each other	
My parents do not/ did not have a good relationship with each other	

F. Specify your current status

Student and financially dependent on parents or others	Student and independent of parents or others	Employed	Unemployed	Other (Please specify)

G. Please tick the appropriate column that describes your monthly household income.

R0.00 to R1500 per month	R1500 to R3000 per month	R3000 to R4500 per month	R4500 to R6000 per month	R6000 and above per month

H.1. Do you receive any other financial income other than those identified in the above column? Please tick the appropriate one

Yes	No

H.2. Who provides this additional income for you? _____

I.1 If you are contributing towards the monthly household expenditure, please specify your monthly expenses such as rent, food, transportation costs, medical accounts or any other accounts that you are liable for. Provide an indication of how much you contribute to each of these on a monthly basis for example:

Rent : R1000 per month
Medical Accounts : R600 per month
_____ : _____
_____ : _____
_____ : _____
_____ : _____
_____ : _____
_____ : _____

I.2. If you are financially dependent on your parents or others, do you receive a monthly allowance. If so, how much? _____

APPENDIX 3

University of the Western Cape

Psychology Department

Private Bag X17 Bellville 7535 South Africa Telephone: (021) 959-2283/2453
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INFORMED CONSENT FOR PARTICIPANTS UNDER THE AGE OF 18 YEARS

I _____, parent/ legal guardian of _____ hereby give consent for my daughter/daughter in my care as guardian to participate in a research study that is being conducted by Gadija Roshan as part of her Masters Degree Programme. I am aware that the focus of the research is an explorative study of female bulimic's experience of sexual abuse.

I understand that my daughter/ legal child will remain anonymous and that she is a voluntary participant in this study. Furthermore I understand that she may withdraw from the study at any point.

_____ _____

Parent/ Guardian's Signature Date of interview

APPENDIX 4

University of the Western Cape

Psychology Department

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INFORMED CONSENT

I _____ hereby agree to participate in a research study that is being conducted by Gadija Roshan as part of her Masters Degree Programme. I am aware that the focus of the research is an explorative study of bulimic women's experience of sexual abuse.

I understand that the information that I provide will be kept in the strictest confidence and that I will remain anonymous in the research report. I am a voluntary participant in this research and understand that I may withdraw from the study at any point.

_____ _____

Participant Signature Date of interview

APPENDIX 5