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# The Relationship Between Sexual Abuse and Disordered Eating: Applications of Narrative Therapy

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# The Relationship Between Sexual Abuse and Disordered Eating: Applications of Narrative Therapy

## Abstract

While research has demonstrated a significant relationship between sexual abuse and the development of disordered eating behaviors, research on techniques to address disordered eating formed in this manner remains limited. Posttraumatic stress as well as internalized feelings of guilt, shame, and blame all contribute to the development of disordered eating in those who have experienced sexual violence. Narrative Therapy focuses on restorying an individual's experienced and lived themes to make the creation of a new, healthy interpretation of trauma. Limited research has explored the potential application of restorying to populations experiencing disordered eating and sexual abuse trauma, independently. This conceptual article explores the potential application of Narrative Therapy with clients who have experienced sexual abuse and developed disordered eating behaviors. Implications in clinical practice as well as future research directions are presented.

Keywords

disordered eating, sexual abuse, narrative therapy, mental health, bulimia

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Research has consistently demonstrated a significant relationship between sexual abuse and the development of diagnosable eating disorders and other disordered eating behaviors (Dubosc et al., 2012; Dworkin et al., 2017). Despite this finding, there has been little research done regarding counseling techniques that address this unique relationship. Much of the existing literature explores treatment approaches that focus on one dimension of this relationship, (i.e., either sexual abuse or disordered eating), but fail to sufficiently consider the significance of the relationship between these two phenomena (Calugi et al., 2017; Costin, 2018). Due to the unique needs of this population, more positive treatment outcomes are seen when sexual abuse trauma and disordered eating symptoms are addressed relationally as opposed to independently (Mitchell et al., 2012). Additionally, clients demonstrate significantly more positive treatment outcomes when counseling interventions address the role of emotional dysregulation symptoms, which act as a mediator between sexual abuse and disordered eating (Mitchell & Wolf, 2016). Because disordered eating behaviors involve a physical harm component that can place individuals in immediate danger, comprehensive interventions are particularly crucial when working with this population (Fox et al., 2019).

## Eating Disorders and Disordered Eating

Eating disorders are characterized by a pattern of maladaptive eating behaviors and related thoughts and emotions. Specified and unspecified eating disorders are mental disorders that are diagnosable by a mental health professional according to diagnostic criteria listed in the DSM-V (Shaw & Homewood, 2015). These disorders include but are not limited to: anorexia nervosa, bulimia nervosa, and binge-eating disorder. However, many individuals engage in disordered eating behaviors that do not meet the diagnostic criteria for a specified or unspecified eating disorder. These individuals often experience less frequent or less intense maladaptive

thoughts and emotions related to their eating behaviors, but may still experience them (Vestuyf et al., 2016). Disordered eating behaviors include but are not limited to: restriction of food intake, periods of binge-eating, and purging behaviors such as self-induced vomiting and excessive exercise. Because eating disorders produce high mortality rates (Shaw & Homewood, 2015), effective treatment interventions are crucial. Additionally, individuals who engage in disordered eating behaviors but do not meet the diagnostic criteria for a specified or unspecified eating disorder need and deserve effective treatment interventions in order to minimize the risk for physical and mental harm.

## The Role of Post-Traumatic Stress

Although individuals develop disordered eating behaviors and body image issues for a variety of reasons, research consistently demonstrates a relationship between this symptomatology and past experiences with sexual abuse (Caslini et al., 2016; Dubosc et al., 2012). In fact, a majority of women with eating disorders report at least one instance of being a victim of sexual assault (Dubosc et al., 2012). Individuals who have survived at least one instance of sexual abuse are at a heightened risk for developing an eating disorder or otherwise engaging in disordered eating behaviors (Breland et al., 2018). Following these instances of sexual abuse, many individuals experience difficulty coping with feelings of mental, emotional, and physiological distress (Calugi et al., 2018). It is common for individuals to experience feelings of shock and confusion following the abuse, and they may feel uncertain about how to effectively cope with this trauma in an adaptive way. Survivors of sexual abuse who experience difficulty coping with this distress are at an increased risk for developing post-traumatic stress disorder, or PTSD (Breland et al., 2018; McTavish et al., 2019)

PTSD is a mental disorder characterized by mental and emotional distress following an

intimate experience with a traumatic event, such as sexual abuse. According to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), common symptoms of post-traumatic stress include but are not limited to:

- Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
- Dissociative reactions in which the individual feels or acts as if the traumatic event(s) were recurring
- Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
- Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
- Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world
- Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame themselves or others
- Persistent negative emotional state
- Feelings of detachment or estrangement from others
- Reckless or self-destructive behavior. (American Psychiatric Association, 2013, p. 271)

While post-traumatic stress following various types of traumatic events has been found to act as a predictor for disordered eating behaviors, post-traumatic stress following sexual abuse has been found to be especially impactful (Calugi et al., 2018; McTavish et al., 2019). Among adult women who have experienced sexual assault, those who experience post-traumatic stress are at a heightened risk for developing diagnosable eating disorders (Dubosc et al., 2012). This may be related to an increased need for the individual to cope with various

distressful symptoms of post-traumatic stress (Dunkley et al., 2010). Post-traumatic stress, particularly that related to sexual abuse, mediates the relationship between sexual abuse and disordered eating (Dubosc et al., 2012). In fact, many individuals with eating disorders and a history of sexual abuse self-report that they engage in disordered eating behaviors as a direct means of coping with post-traumatic stress (Moulding, 2015). In other words, individuals often engage in disordered eating behaviors as a direct response to sexual abuse trauma.

## The Roles of Guilt, Shame, and Self-Blame

Although each individual who copes with sexual abuse trauma using disordered eating behaviors does so for different reasons and in different manners, there are several common motivations behind this unique relationship. Disordered eating behaviors among survivors of sexual abuse may be related to feelings of guilt, shame, and self-blame (Moulding, 2015, 2016). Individuals who experience post-traumatic stress from childhood or adulthood sexual abuse are at a heightened risk for feeling as if they are to blame for the abuse that occurred (Ullman et al., 2014). Although sexual abuse is never the fault of the victim, survivors of sexual abuse may feel as if they somehow contributed to the unfolding of the traumatic event(s). Individuals who engage in self-blame are also more likely to experience feelings of low self- worth and a tendency to withdraw from others, including mental health professionals (Ullman et al., 2014). This poses a risk for individuals either not receiving or not completing the treatment they need to minimize physical and emotional harm.

While each case is different, this phenomenon is sometimes related to a societal atmosphere in which survivors of sexual abuse are often disbelieved or blamed for the abuse (Stillar, et al., 2016; Ullman et al., 2014). Statistically, most survivors of both childhood and adulthood sexual abuse were victimized by someone with whom they were acquainted in some

way (Hammond et al., 2011). These individuals are at a heightened risk for experiencing feelings of self-blame and other post-traumatic stress symptoms, as well as engaging in maladaptive coping behaviors, such as disordered eating. In other words, these individuals may engage in behavioral forms of self-blame. This is significant, as these behaviors often pose a risk for physical harm and are associated with greater difficulty during recovery from post-traumatic stress (Ullman & Siguryinsdottir, 2014).

Male survivors of sexual abuse are particularly prone to experiencing feelings of guilt, shame, and self-blame regarding the abuse (Dorahy & Clearwater, 2012). It is important to note that while feelings of guilt and shame are often related to thoughts of self-blame, guilt and shame are sometimes experienced independently from self-blame as well. For example, both (cisgender) heterosexual and homosexual survivors of childhood sexual abuse frequently report feeling guilt and shame related to a sense of emasculation (Feldman & Meyer, 2007). More research is needed to explore how guilt and shame may uniquely affect transgender survivors. Oftentimes, these feelings vary according to demographic and identity characteristics, as well as multicultural variables. Furthermore, guilt, shame, and self-blame following sexual abuse are often self-reported as triggers among individuals with eating disorders (Ullman et al., 2014). Some individuals with eating disorders report that they engage in disordered eating behaviors as a means of punishing themselves for their perceived roles in the abuse they endured . Additionally, it is common for survivors of sexual abuse to begin to believe that they and their bodies “deserve” bad treatment (Moulding, 2015, 2016).

**The Role of Body Image**

In addition to the influences of guilt and shame, existing research suggests that issues related to body image may also contribute to disordered eating behaviors being utilized as a

coping mechanism for post-traumatic stress. Survivors of both childhood and adulthood sexual abuse who experience post-traumatic stress are significantly more likely than their peers to experience body image disturbances (Dyer et al., 2013). These disturbances in body image, both independently as well as in conjunction with post-traumatic stress, act as a strong predictor for disordered eating symptoms (Dunkley et al., 2010). Although a variety of body image disturbances have been recorded, disturbances among this population frequently involve themes of perceived attractiveness and sexuality. Individuals with a history of childhood sexual abuse and disordered eating behaviors are more likely than their peers to perceive themselves as unfit or unattractive (Dyer et al., 2015; Dyer et al., 2013). This is associated with feelings of low self-worth and low self-esteem (Calugi et al., 2018).

Additionally, post-traumatic stress following sexual abuse introduces a unique set of experiences related to body image. This may be partially because sexual abuse involves a violation of one's physical body, sometimes leading to a strained relationship with one's post-trauma body (Dyer et al., 2013). Female survivors of sexual abuse who meet the diagnostic criteria for an eating disorder often report that they engage in disordered eating behaviors in attempt to strip their bodies of their perceived sexuality. Related to feelings of shame and self-blame, it is common for female survivors of sexual abuse to believe that the abuse happened as a result of the perceived sexual nature of their bodies (Moulding, 2015, 2016). In turn, as an attempt to prevent future sexual abuse and maintain a feeling of safety, individuals may engage in disordered eating in hopes to lessen the perceived sexual appeal of their bodies. As detailed by a young woman in a case interview regarding this phenomenon, "I wanted to cut my breasts off… [the abuse] was my fault because he found me attractive. So I then developed an eating disorder" (Moulding, 2015, p. 1466). This is significant, as it suggests that some individuals

may engage in disordered eating behaviors as a means of establishing a sense of perceived protection from sexual abuse.

Because sexual abuse involves a physical violation of one's body, it is common for survivors of sexual abuse – particularly those who experience post-traumatic stress – to experience persistent feelings of violation (DiTullio & Sullivan, 2019). Following the abuse, individuals may feel as if their bodily autonomy is continuously being taken away from them (Moulding, 2015). This experience is especially prevalent in individuals who experience dissociative and intrusive memory symptoms (Hund & Espelage, 2005). These experiences may provide a pathway through which disordered eating behaviors to manifest. Survivors of sexual abuse may engage in disordered eating behaviors as a means of regaining a sense of bodily autonomy and control. Although disordered eating behaviors only provide the *illusion* of control, it is a particularly powerful influence in the maintenance of these behaviors. When engaging in disordered eating, survivors of sexual abuse can feel as if they are demonstrating some degree of control over their bodies by controlling their eating behaviors (Arthur-Camessle et al., 2011; Moulding, 2015).

**The Role of Emotional Dysregulation**

Contrary to popular belief, diagnosable eating disorders and disordered eating behaviors are not always characterized by a fixation on weight. Particularly within the context of post-traumatic stress following sexual abuse, disordered eating behaviors are more likely to be characterized by conscious or unconscious emotional suppression (Collins et al., 2014). Although each individual experiences post-traumatic stress and disordered eating symptoms differently, emotional (dys)regulation has been found to act as a mediator for this relationship (Mitchell & Wolf, 2016). It is not uncommon for survivors of sexual abuse – particularly those

who experience post-traumatic stress -- to experience difficulty processing and regulating their emotions (Collins et al., 2014). Additionally, post-traumatic stress -- particularly that related to sexual abuse -- is often characterized by emotional avoidance or dissociation in regards to the traumatic event(s). It is not uncommon for survivors of sexual abuse to over- regulate their emotions in order to avoid distressful emotions, consciously or unconsciously (Mitchell et al., 2012). This type of emotional avoidance and suppression has been found to increase the risk for disordered eating behaviors among adult survivors of sexual abuse (Collins et al., 2014).

Because emotional avoidance has been shown to play a significant role in both sets of symptoms, it has been theorized that co-occurring post-traumatic stress and disordered eating behaviors fuel one another through this common feature (Mitchell et al., 2012). Based on this information, it can be argued that interventions for individuals experiencing both post-traumatic stress and disordered eating symptoms must address emotional regulation in order to minimize this reciprocal relationship of symptoms. Furthermore, individuals who experience post-traumatic stress following sexual abuse often experience emotional dysregulation and avoidance, as well as other emotional symptoms, prior to any behavioral symptoms they may experience (Collins et al., 2014; Trottier & MacDonald, 2017).

Behavioral symptoms related to post- traumatic stress frequently include maladaptive coping behaviors, including disordered eating behaviors. In other words, it is not uncommon for emotional dysregulation symptoms related to post-traumatic stress to act as a predictor for disordered eating behaviors related to the trauma (Collins et al., 2014; Trottier & MacDonald, 2017). This is not to say that this is always the case, as each individual experiences each of these symptoms in unique ways. However, research has consistently demonstrated that emotional dysregulation and avoidance symptoms related to post- traumatic stress play a significant role

in the *maintenance* of disordered eating behaviors (Collins et al., 2014).

**The Role of Alexithymia**

In addition to emotional avoidance and over-regulation of trauma-related emotions, alexithymia has been found to mediate the relationship between sexual abuse and disordered eating behaviors (Mitchell et al., 2012). Alexithymia is characterized by a difficulty identifying and describing one's emotional experiences – particularly those that are distressful. Independently, research has consistently demonstrated a significant relationship between sexual abuse and alexithymia, as well as between disordered eating and alexithymia (Hund & Espelage, 2005). It is common for survivors of sexual abuse, particularly those who experience post-traumatic stress, to experience difficulty identifying their emotions in the wake of trauma; this is especially true of those who have survived childhood sexual abuse (Becker, 2015).

Because trauma is a unique and personal experience, it is not probable to predict each possible explanation for this phenomenon. However, research suggests that this could be partially due to the often-foreign nature of these emotional experiences (Mitchell et al., 2012); sexual abuse is generally not something for which one can emotionally prepare, and the distressful emotions that follow the abuse are often shocking and overwhelming for this reason. Many survivors of sexual abuse may feel trauma-specific emotions that they have not previously felt, making it difficult to identify their emotions using words. This is especially true for cases of childhood sexual abuse, in which the child victim has a more limited emotional frame of reference (Hund & Espelage, 2005).

Alexithymia in individuals with a history of sexual abuse may also be related to the widespread taboo nature of this type of abuse (Dorahy & Clearwater, 2012). Societally, sexual abuse is rarely discussed in a way that allows for survivors of this abuse to be honest about the

range of emotions they experience. This may contribute to survivors of sexual abuse experiencing difficulty identifying the foreign emotions they experience following the abuse (Hammond et al., 2011). Alexithymia also frequently plays a role in eating disorders and disordered eating behaviors (Collins et al., 2014). Because disordered eating behaviors are often used by individuals as a means of coping with sexual abuse trauma, it is not surprising that these behaviors are often associated with alexithymia. Individuals who engage in disordered eating behaviors generally experience greater difficulty identifying their emotions than individuals who engage in adaptive eating behaviors. These alexithymia symptoms are heightened when the individual who is experiencing disordered eating symptoms also has a history of childhood sexual abuse (Hund & Espelage, 2005).

Individuals who have a history of sexual abuse and engage in disordered eating behaviors are at a heightened risk for experiencing difficulty recognizing their emotions (Collins et al., 2014; Hund & Espelage, 2005). Although each individual experiences disordered eating symptoms differently, individuals may often engage in disordered eating behaviors in response to alexithymia symptoms (Mitchell et al., 2012). Alexithymia symptoms often include a difficulty distinguishing emotional experiences from physical experiences (Hund & Espelage, 2005). This is an important finding, as disordered eating behaviors, which are often used to cope with difficult emotions following abuse, involve a physical component. In other words, disordered eating behaviors often combine both emotional and physical experiences, allowing a pathway through which this alexithymia symptom to be manifested and maintained. Women with comorbid bulimia nervosa and post-traumatic stress following sexual abuse have self- reported that the physical act of purging (specifically self-induced vomiting, in this case) allows for an emotional expression that is otherwise difficult. This is

consistent with alexithymia symptomatology in which the individual has trouble distinguishing emotional sensations from physical sensations, sometimes leading to emotionally-driven coping behaviors. Additionally, women with comorbid binge-eating disorder and a history of sexual abuse have self-reported that binge-eating provides an emotional release that is otherwise difficult to navigate (Moulding, 2015). Ultimately, individuals with eating disorders and a history of sexual abuse may engage in disordered eating behaviors as a means of behaviorally "describing" or expressing emotions that they experience difficulty describing using words.

When considering the role of emotional (dys)regulation symptoms within the context of a population experiencing both sexual abuse trauma and disordered eating behaviors, it is important to remember that these behaviors are functional. This is not to say that these behaviors are adaptive or do not need to be targeted within a treatment plan. However, when targeting these behaviors, the clinician must be aware that although maladaptive, they provide some form of emotional expression for the individual. Those who experience alexithymia symptoms generally find it difficult to achieve this emotional expression in other, more adaptive ways (Collins et al., 2014). In order to effectively lessen the severity of these risky maladaptive behaviors, clinicians must directly address the potential role of emotional regulation symptoms in the maintenance of comorbid sexual abuse trauma and disordered eating symptomatology (Costin, 2018). More positive treatment outcomes are seen in this population when interventions directly address the influences of any mediating factors within the relationship between sexual abuse and disordered eating (Calugi et al., 2018). Ultimately, although there are many factors that mediate the relationship between sexual abuse and disordered eating, emotional regulation and alexithymia have consistently been found to be of the most salient.

## Narrative Therapy

Narrative therapy centers the notion that an individual's life experiences can be thought of as a story Each of an individual's experiences – including those that are traumatic – contribute to that individual's ongoing story. While the specific goals of narrative therapy differ according to individual client needs, the primary goal of narrative therapy is for the client to express themselves through their unique story; this therapeutic form of self-expression is also known as "storying" (Rei Solas, 2015). This expression often occurs through written means, such as the construction of a memoir, in both individual and group settings.

However, clients can also experience storying through other forms of expression depending on their needs and limitations (Shaw & Homewood, 2015). Additionally, narrative therapy sometimes utilizes the technique of restorying – creating alternate plots to one's story for therapeutic purposes (Rei Solas, 2015). In many ways, narrative therapy centers the same goals as some forms of art therapy, and they are often utilized together (Becker, 2015). For example, similar to the mapping of one's experiences through physical art forms in art therapy, narrative therapy sometimes involves clients mapping their stories through written means. The intent of this technique is to provide clients with a concrete storybook of sorts to which to refer and begin to analyze (Rei Solas, 2015). While there are many other techniques and activities involved in narrative therapy, its main goal is to empower clients to take ownership of their stories through self-expression.

## Narrative Therapy and Sexual Abuse

Narrative therapy has been found to be uniquely effective with individuals who have a

history with sexual abuse. Because of its similarities to some forms of art therapy, narrative therapy has often been used in conjunction with art therapy techniques with this population (Becker, 2015). This type of therapy is often used to help survivors of sexual abuse to construct cohesive memories and to transition these memories into verbal or written forms of expression (Becker, 2015). Because post-traumatic stress frequently involves disturbances in memory, the construction of cohesive memories can be crucial to growth and healing. This form of therapy has been found to be particularly effective in the construction of cohesive trauma-related memories, as it generally involves a concrete written component to which clients can refer (Saha et al., 2011). Furthermore, through the process of storying and restorying, survivors of sexual abuse often experience a narrative form of exposure therapy (Becker, 2015). In other words, when an individual is exposed to their own story through the construction and expression of cohesive narratives surrounding their experiences with abuse, they are likely to experience reduced distress about expressing trauma-related feelings (Becker, 2015). This development can be crucial to the growth and recovery process.

## Narrative Therapy and Disordered Eating

While other forms of psychotherapy, such as cognitive-behavioral therapy, are prevalent among individuals who engage in disordered eating, narrative therapy has been shown to be effective with this population. This form of therapy, in contrast to others, focuses on externalizing the eating disorder or the disordered eating behaviors (Scott et al., 2013). This means that the presenting problem – the disordered eating behaviors – is separated from the client and discussed as if were a third party. This narrative tactic has been found to reduce cognitive and emotional symptoms related to disordered eating, such as self-blame (Scott et al., 2013; Saha et al., 2011). Similar to the success seen among survivors of sexual abuse, there is

limited research to show that this process can increase the capacity for emotional self-expression among individuals with eating disorders. Furthermore, restorying techniques have been shown to help individuals to recognize alternate "storylines" to their experiences with disordered eating behaviors (Scott et al., 2013). This is notable, as it suggests there is potential for this technique to help individuals recognize alternate coping behaviors.

## Bridging the Gap: Implications for Treatment

While narrative therapeutic techniques have produced positive treatment outcomes among survivors of sexual abuse and among individuals who engage in disordered eating behaviors, there is little research into utilizing narrative therapy to address this unique relationship. Among individuals who experience comorbid disordered eating behaviors and trauma from sexual abuse, more positive treatment outcomes are seen when interventions address any and all factors that mediate this relationship . In this case, more positive treatment outcomes are indicated by a reduction in both post-traumatic stress and disordered eating symptoms (Calugi et al., 2018). In other words, clients experience more significant developments in recovery when sexual abuse trauma and disordered eating behaviors are targeted relationally as opposed to independently. Furthermore, when an individual engages in disordered eating behaviors as a means of coping with trauma, and the underlying trauma is not properly addressed, the need to cope with this trauma may persist. This may pose a risk for a shift from using disordered eating behaviors to cope, to using an alternate maladaptive behavior to cope, although more research is needed to establish this. Because existing research demonstrates the need to address these symptoms relationally, however, the use of comprehensive treatment techniques is crucial.

More research is needed into the utilization of narrative therapeutic techniques to address the complex relationship between sexual abuse and disordered eating behaviors. However, based

on the success of narrative therapy that targets sexual abuse and disordered eating independently, there is strong potential for positive outcomes. Additionally, the primary goal of self-expression of one's "story" in narrative therapy is reflective of the emotional dysregulation and alexithymia symptoms that mediate this unique relationship. Because it is common for individuals to engage in disordered eating behaviors as a means of expressing trauma from sexual abuse (Moulding, 2015), it is crucial for these individuals to develop more adaptive forms of expression. For these individuals, disordered eating behaviors are functional; it is therefore necessary for clinicians to help individuals to identify alternate, adaptive forms of self-expression to fill the void that may appear without the presence of maladaptive yet functional behaviors. This development of adaptive forms of self-expression has the potential to reduce the risk for symptom reoccurrence. Narrative therapy provides an opportunity for individuals to develop cohesive forms of self-expression through the ongoing process of storying.

The process of storying empowers individuals to assign words – through written or verbal means – to feelings and experiences that they may otherwise experience difficulty identifying. Storying techniques, such as the written mapping of one's life story, have been shown to be particularly effective in helping clients to assign feeling words to post-traumatic stress symptoms following sexual abuse (Rei Solas, 2015). This finding is particularly pertinent to individuals whose disordered eating behaviors are triggered or maintained by a persistent difficulty describing sexual abuse trauma using words. When individuals are able to describe their experiences with trauma using written or verbal words, they may have an increased capacity to seek support from loved ones and mental health professionals. Decreasing isolative tendencies among this population is crucial, as more positive recovery outcomes are seen when individuals receive external support (Rei Solas, 2015). Narrative

therapy may provide individuals of this population with a pathway through which to receive this crucial support.

Because individuals among this population often experience feelings of disempowerment related to trauma from sexual abuse (Moulding, 2015), narrative therapy may be helpful in restoring a sense of power over one's story. During the narrative therapeutic process, individuals often learn to build upon their personal power and senses of self (Saha et al., 2011). Restorying, or re-authoring techniques, have the potential to help restore a sense of power to clients experiencing post-traumatic stress following sexual abuse. This is of particular note for cases in which individuals engage in disordered eating behaviors as a means of demonstrating a sense of control and power following sexual abuse. Ultimately, by restoring a sense of power and control to individuals, narrative therapy may, in turn, lessen the perceived need for these behaviors. However, more research is needed to support this theory.

Narrative therapeutic techniques may also help to lessen feelings of self-blame, shame, and guilt among this population. Externalization of the problem has been found to minimize feelings of shame and guilt among individuals with eating disorders and among individuals who experience post-traumatic stress following sexual abuse, independently (Saha et al., 2011; Scott et al., 2013). Additionally, individuals learn, through restorying and other narrative techniques, to gradually change persistent narratives of self-blame by literally or verbally rewriting their stories according to their needs (Saha et al., 2011). For example, an individual who feels as if they are to blame for sexual abuse they endured can work with a clinician to "rewrite" their story to assert that the perpetrator alone caused the abuse. This may involve the therapeutic creation and expression of alternate storylines that challenge specific narratives of self-blame; if the individual's narrative of self-blame reflects a belief that they caused the

abuse by drinking alcohol, an alternate storyline might reframe this to assert that the perpetrator unfairly took advantage of them while they were in a vulnerable state. Similar restorying techniques can be used to challenge a variety distressful narratives. While the recorded outcomes of narrative therapy for disordered eating and post-traumatic stress are individually promising, better treatment outcomes are seen when interventions address symptoms shared by both post- traumatic stress and disordered eating (Mitchell et al., 2012).

## Implications for Future Research

While narrative therapeutic techniques have produced positive treatment outcomes among individuals who experience sexual abuse trauma and disordered eating symptoms independently, significantly more research is needed to explore its use with individuals who experience these issues comorbidly. This might include research regarding how narrative therapeutic techniques may need to be adapted to this specific client population. Their needs and limitations within this form of therapy may differ from those of individuals who experience these symptoms independently. Future research is also needed to explore any potential differences in treatment effectiveness or treatment needs between individuals who meet the diagnostic criteria for an eating disorder and individuals who engage in disordered eating behaviors but do not meet any diagnostic criteria. Similarly, more research is necessary to explore potential differences in treatment needs among individuals with different eating disorder diagnoses or types of disordered eating behaviors (restriction, binge-eating, purging behaviors, etc.). For some individuals who engage in more frequent or severe disordered eating behaviors, more intensive treatment may be necessary to minimize the risk for immediate physical harm. Additional research will help mental health professionals to better know when narrative therapy is appropriate for this population and when other forms of treatment may be more appropriate.

Additionally, because emotional dysregulation and expression symptoms are strong mediators of this relationship, more research is warranted into the effectiveness of narrative therapeutic techniques in specifically targeting these symptoms. Future research may also focus on the use of narrative therapy in combination with art therapy with this population. This combination of therapeutic techniques is common among interventions for individuals experiencing post-traumatic stress and disordered eating independently and has produced positive treatment outcomes (Becker, 2015; Hodge & Simpson, 2016). More research is necessary to determine which types of treatment techniques are compatible with narrative techniques within the context of this specific population. Finally, narrative group therapy has produced positive treatment outcomes among individuals with a history of sexual abuse (Rei Solas, 2015); future research into the use of narrative therapy in a group setting with this client population will help to better inform clinicians of a wider variety of treatment options. In conclusion, further research is needed to best familiarize mental health professionals with the unique needs of individuals who experience comorbid sexual abuse trauma and disordered eating symptoms within a narrative therapeutic setting.

## Conclusion

Although each individual's experience is unique, there is a significant relationship between disordered eating behaviors and symptoms of trauma following sexual abuse (Dubosc et al., 2012). Individuals who experience these symptoms comorbidly belong to a client population with a unique set of needs and challenges. These unique characteristics include symptoms of emotional dysregulation and alexithymia, which is marked by a difficulty identifying or describing emotions in communication with oneself or others (Mitchell et al., 2012). These symptoms, which often occur alongside post-traumatic stress symptoms, have

consistently been found to be the most salient mediators of this relationship (Hund & Espelage, 2005). Individuals who experience this unique set of symptoms often engage in disordered eating behaviors as a means of behaviorally describing or expressing emotions related to sexual abuse trauma. While the nature of these emotions varies from person-to-person, they are often related to feelings of guilt, self-blame, and disturbances in body image following instances of abuse (Moulding, 2015, 2016).

Due to its focus on the expression of emotions related to one's story, narrative therapy may appropriately match the unique needs of this population. Narrative therapy has produced positive treatment outcomes among individuals with a history of sexual abuse and individuals who engage in disordered eating behaviors, independently (Saha et al., 2011; Scott et al., 2013). However, further research is needed to establish the effectiveness of narrative therapy and its techniques with a population that experiences these symptoms comorbidly. This future research will help to better inform mental health professionals of a form of treatment that can potentially target the emotional dysregulation and alexithymia symptoms that mediate the relationship between sexual abuse and disordered eating behaviors. This cohesive form of treatment is crucial for this population, as more positive outcomes are seen when treatment addresses sexual abuse trauma relationally as opposed to independently.

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