Psychodynamics of Eating Disorder Behavior in Sexual Abuse Survivors

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The author reviews the psychodynamics of eating disorder behaviors in women with childhood sexual abuse histories, with a focus on anorexia, bingeing, purging, and overeating. The various defenses and behaviors interact with each other through numerous different feedback loops. The same behavior can have multiple defensive functions and the same defensive function can be served by different behaviors. None of the behaviors is specific to childhood sexual abuse, but the abuse history modifies the content, heightens the intensity of the feelings being defended against, and should be taken into account in the therapy. Several examples of therapeutic strategies are also provided.

KEYWORDS: sexual abuse survivors; eating disorders; behavior; psychodynamics

PSYCHODYNAMICS OF EATING DISORDER BEHAVIOR IN SEXUAL ABUSE SURVIVORS

My goal in this paper is to describe the psychodynamics of eating disorder behaviors in women with childhood sexual abuse histories. Most, if not all, of these dynamics are equally relevant for understanding men with severe body image distortions, eating disorders, and sexual abuse histories (Feldman & Meyer, 2007). I will not attempt to review the literature comprehensively because this is a clinical summary of my experience and understanding as a psychotherapist, which is summarized in a series of books (Ross, 1994; 1995, 1997; 2004; 2007; Ross and Halpern, in press).

I first began to study eating disorders in 1984 as a psychiatry resident in a half–time, six–month rotation in an eating disorders program. Since 1991, I have been operating an inpatient trauma program that has admitted thousands of women with childhood sexual abuse histories: of these,

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slightly fewer than 40% have an eating disorder as classically defined by DSM (Ellason and Ross, 1996). Of the remainder, many have pathological eating patterns that could be classified as an eating disorder not otherwise specified. These include extreme overeating with morbid obesity, phobic avoidance of certain foods based on childhood sexual abuse, and extremely unhealthy diets with normal weight.

As reported throughout the literature, only a subset of individuals with eating disorders reports a history of childhood sexual abuse (Costin, 2007; Feldman & Meyer, 2007; Schwartz and Cohen, 1996; Vanderlinden, 1993); the same psychodynamics operate in people with eating disorders but no sexual abuse histories. Nothing in my analysis is unique or specific to sexual abuse. Childhood sexual abuse rarely, if ever, occurs in isolation and is almost always accompanied by varying combinations of emotional, physical and verbal abuse, family violence, loss of primary caretakers, and failures of bonding, nurturing, and attachment by the parents. A variety of forms of trauma are likely relevant to the understanding and treatment of eating disorders in women (Mangweth–Matzek, Rupp, Hausman, Kemmler, & Biebl, 2007; Striegel–Moore, Dohn, Kraemer, Schreiber, Taylor, & Daniels, 2007; Smyth, Heron, Wonderlich, Crosby, & Thompson, 2008; Wade, Gillespie, & Martin, 2007) and men (Feldman & Meyer, 2007). Although I am focusing on childhood sexual abuse in my analysis, these other forms of conflict also contribute to the cognitive errors, conflicts and defensive functions of eating disorder behavior.

The relationship between trauma and eating disorders was the subject of a recent special issue of the *International Journal of Eating Disorders* (Levitt & Sansone, 2007). The authors of papers in that issue discussed epidemiology, diagnosis and assessment (Brewerton, 2007; Briere & Scott, 2007; Clae & Vandereycken, 2007; Waller, Corstorphine & Mountford, 2007; Sansone & Sansone, 2007) and treatment (Berrtett, Harlman, O'Grady & Richards, 2007; Levitt, 2007). All authors commenting on the relationship between trauma and eating disorders agree that it is complex and that no form of abuse is a specific risk factor for eating disorders (Baker, Mazzeo & Kendler, 2007; Bardone–Cone, Maldonado, Crosby, Mitchell, Wonderlich, Joiner, Crow, Peterson, Klein & Grange, 2008; Calam & Slade, 1989; Miller & McCluskey–Fawcett, 1993; Sansone & Schumacher, 2008; Steiger & Zankor, 1990; Zlotnick, Hohlstein, Shea, Pearlstein, Recupero & Bidadi, 1996).

Likewise, all authors agree that eating disorders arise from a complex interaction of multiple genetic and environmental factors, of which childhood sexual abuse is one, although the relative contribution of genetics is

often overestimated, in my opinion (Ross, 2006). No author has proposed a linear or simple direct causal relationship between childhood sexual abuse and eating disorder behaviors. Consistent with this literature, the analysis outlined below assumes a complex field of interactions with multiple feedback loops, in other words, a cybernetic model of the role of childhood sexual abuse in eating disorders. The analysis is presented in non–technical language that captures the clinical reality of eating disorders better than could more academic prose.

PSYCHODYNAMICS OF ANOREXIA

Maintaining an Illusion of Control

Maintaining an illusion of control is a core defensive function at the root of eating disorders of all kinds. The individual with anorexia may use a thought pattern something like this:

> *The Titanic may be going down, and other passengers may seem to be perturbed by that fact, but if I can count the peas on my plate, push the mashed potatoes over to the left, and slowly cut the meat into smaller and smaller pieces, I need not be distracted by the general pandemonium. Life is good because I am in charge and in control.*

The "need" for an eating disorder arises from a combination of two factors: too much is out of control; and the other available coping strategies are not up to the challenge. Survivors of childhood sexual abuse had childhoods that were out of control to an extreme degree, and many of these individuals were, in a sense, betrayed by their bodies when the abuse triggered physiologically normal arousal. The horrible, disgusting, depraved body needs to be punished, starved into an asexual, prepubescent state, and disconnected from the head so that no physiological arousal of any kind enters consciousness, whether it be fear or sexual arousal.

> *I could not control my perpetrator or my body back then, reasons the person with anorexia nervosa, but I sure can control both now. Now, I'm the boss, and nobody can take that away from me.*

Phobias Related to Fellatio

I was taught in my psychiatry residency that bulimia in a woman is caused by an unconscious attempt to vomit up her baby, or alternatively, that bulimia is a nausea–anxiety reaction to fantasies of oral impregnation. Anorexia, I was taught, is also due to a fear of oral impregnation, which is a displaced fear of vaginal impregnation. Rather than being symbolic of postulated intrapsychic conflicts, however, food phobias in women with

anorexia can be based on actual childhood sexual abuse in the form of forced fellatio.

I remember a young woman I saw for a number of sessions during my psychiatry residency who received no therapeutic benefit to her of any kind (my supervisor on the case was a strict behaviorist). Despite my proposal to set up a desensitization hierarchy for her food phobia of several years duration, she dropped out of "therapy," if I could call it that.

This young woman ate only one specific brand of canned tomato soup. She ate no solids of any kind. She said she just could not stand the texture. She lived with her parents and slept in the attic with the trap door secured from the inside by a deadbolt. When I asked her why she slept there instead of in her bedroom, she said that it was the only place she could fall asleep.

At the time, in 1984, I had no idea what was going on with this woman. Today, my leading hypothesis would be that she was a victim of paternal incest. Since 1984, I have spoken with many women who have explained that they consciously avoid any foods that remind them of semen or a penis: when this is generalized to the maximum degree, severe anorexic restriction ensues.

Starving Off Secondary Sexual Characteristics

Starving off secondary sexual characteristics occurs whenever there is severe food restriction and weight loss. Commonly, the restricting is caused by a drive to thinness, distorted body image, and disgust with fat. For survivors of childhood sexual abuse, however, additional motives come into play. One of these is to make the body prepubertal in appearance so that it will not be attractive to perpetrators. This strategy ignores the fact that when the sexual abuse took place she was a prepubertal child. The desperation for control of perpetrators and their future acts is so great in the abused individual that even the testimony of one's own experience is ignored.

Another motive is to make the body so thin that it becomes "invisible" to perpetrators. One gaunt woman explained to me that if she could become thin enough, then she would literally become invisible to men if she stood sideways. It was clear to me that this was the thinking of a wounded child and not a person functioning cognitively as an adult. Such magical thinking about the body can exist in parallel with normal, rational thinking in other spheres of life, due to a profound dissociation between subsystems of thought and belief.

Suicide by Starvation

Suicide by starvation is a common motive in severe cases of anorexia. The ultimate control over an uncontrollable life is to be in charge of one's exit. In survivors of childhood sexual abuse, the same generic motive can operate, but the conflicts and feelings behind it include bad feelings about self and others arising from the sexual abuse. The generic problem (intolerable feelings) is the same, and the coping strategy of suicide by starvation is the same, but the content is different. Treating the behavior successfully entails paying attention to the specifics of the content.

This is the same logic as that employed in desensitization of a simple phobia: The content of the phobia determines the content of the therapeutic work; however, in all types of simple phobia, the rationale, vocabulary, procedures, structure and tasks of therapy are the same, but it is no good talking about spiders with a person who has a snake phobia, and vice versa. The content of the phobia determines the content of the therapy, but the structure of treatment is generic to all simple phobias.

Not talking to a victim of childhood sexual abuse about the specifics of her conflicts would be like not mentioning spiders while treating a person with a spider phobia.

Suppression of Menstruation

Suppression of menstruation is an unintended benefit of extreme thinness in some women with anorexia nervosa. The absence of menses reinforces the sense of control, but is not an end in and of itself. In the survivor of childhood sexual abuse, however, shutting off the menstrual cycle can be a conscious goal of starvation. This is so because menstruation is a traumatic trigger for memories of childhood rape.

In this permutation of the themes, the behavior of restricting is the same as in all cases of anorexia nervosa, there is the same drive to thinness, and the same illusion of control, but there is an additional element to the psychodynamics. The anorexia can be more severe and entrenched in survivors of childhood sexual abuse because of the additional pain that is absent in women without such histories.

Punishment of Other Ego States

A subgroup of individuals with eating disorders meets criteria for dissociative identity disorder (DID) or partial forms of DID classified as dissociative disorder not otherwise specified (DDNOS) in DSM–IV–TR (American Psychiatric Association, 2000). The structural model of dissociation (van der Hart, Nijenhuis, & Steele, 2006) applies to this subgroup.

These individuals have dissociated identity states that can range from elaborated "inner children" to full altered personalities.

There is a spectrum of structural dissociation; at the left–hand end, individuals have inner children but the term is a metaphor, no more than that. At the right–hand end of the spectrum, the inner child may take executive control of the body, identify herself by age and name, and converse with the therapist. When the adult executive self returns, she has amnesia for the child's conversation.

In one sense, then, DID is simply an extension of normal on a continuum and everyone is a little bit multiple. On the other hand, DID is a discrete psychopathology and people with DID belong to a dissociative taxon (Waller, Putnam, & Carlson, 1996; Waller & Ross, 1997). People with DID have experiences most people never have, such as arriving at a far away location with complete amnesia for the period of travel, not recognizing oneself in the mirror, command hallucinations, and finding clothes in the closet one cannot remember buying the previous day.

Many people with eating disorders possess more than a purely metaphorical inner child; they have a form of DID with a less elaborated psychological structure. They have ego states somewhere in the middle third of the DID continuum, with dissociated ego states that are not fully crystallized and personified, that do not take executive control, that are not separated from each other by full amnesia barriers, or that combine some of these features.

In such individuals, the motive for the eating disorder may be one ego state punishing another ego state by withholding food. The adult self may punish the inner child because she believes that the childhood sexual abuse was the child's fault. This could be stated as, "I don't deserve to eat," or, "She doesn't deserve to eat," depending on the degree of dissociation and personification of the child ego state. If the person is at the left–hand, normative end of the spectrum but has a sexual abuse history, then the therapy involves working with the inner child as a metaphor. At the right–hand end of the spectrum, therapy involves repairing the relationship between different "people," keeping in mind that these are fragmented components of one person, not literally separate people.

Internal Negotiation with Other Ego States

In a similar vein, starvation can be a negotiation tactic between ego states. One ego state may starve another, not to punish it, but to force it to comply with the restrictor's wishes before it can be rewarded with food.

Starvation, in this instance, is not an end in itself. Weight or fat phobias or body image distortions do not drive it; therefore, generic eating disorder interventions will have no effect on this motive for anorexia nervosa.

Reenactment of Childhood Trauma

In some cases, starvation can be a reenactment or an undoing of childhood trauma. For example, if an individual as a child was rewarded with food or candy by a sexual abuse perpetrator, as an adult the individual may restrict food to prove to herself that she was not bad and did not want the candy or the sex: this is an undoing defense. Alternatively, starvation and sexual abuse in childhood may have been intertwined and, in adulthood, starvation rituals may be a reenactment instead of an undoing. The reenactment may have multiple purposes:

to punish the self by replaying the tape of the abuse in the hope that "enough" punishment will make up for the "badness" of the child victim;

to create an illusion that the self is in charge of the reenactment and is now perpetrator rather than victim, which is therefore both reenactment and undoing;

to search for *omens* (Terr, 1992) of the abuse, which are predictors of the abuse the child failed to notice—if the adult acquires a complete inventory of omens, she can remain hypervigilant for them in the present and avoid future abuse;

and, in some cases, the reenactment becomes autonomous and is replayed for no defensive purpose.

In other cases, the father sexually abused the child at night. During the day, there was a separate set of family pathologies concerning food and rules at the dinner table. In these cases, the reenactment and undoing of disturbed food–related family dynamics is not directly linked to the sexual abuse. Therapy must account for this, and the therapist must not assume that all motives for anorexia nervosa are tied into the sexual abuse. This is the opposite therapeutic error (a false positive) of failing to recognize the motives connected to the sexual abuse (a false negative).

All such attributions by both therapist and client are judgment calls and prone to error. They should, therefore, be advanced as hypotheses, not as facts.

Cleansing the Body

Cleansing the body of fat and bad feelings is a generic goal in anorexia nervosa. For the survivor of childhood sexual abuse, the body needs to be cleansed of two things: bad feelings and semen. The magical inner child may believe that she is literally expelling semen from her body by starving

it, and she may state this directly to the therapist. More often, it is the feelings that are being cleansed.

For the person who did not suffer childhood sexual abuse, the bad feelings might be sadness, loneliness, fear, grief, anger or shame arising from a failure to meet impossible family standards, from failure of parental bonding and nurturing, or from frank neglect. The survivor of childhood sexual abuse who has anorexia is likely to experience these feelings from neglect and family dysfunction, but in addition she, has feelings connected to the sexual violation and betrayal.

If the child or adolescent experienced any emotional or sexual arousal during the sexual abuse, she may often interpret this as absolute proof of the badness of the self. Then the self must be punished, cleansed of the badness through restricting. The body becomes the enemy, and the abused must suppress any hint of sexuality, both psychologically and physiologically at the endocrine level, to prove that she is not a depraved harlot.

PSYCHODYNAMICS OF BINGEING AND PURGING

Weight and Body Image Management

Weight and body image management are core components of all eating disorders, whether or not there is a history of childhood sexual abuse. The generic dynamics of body image management are present in the sexual abuse victim with bulimia. These are compounded by pressure from peers, parents, television, magazines, super models and other cultural sources of the drive to thinness. Generic cognitive errors are present, including:

I have no value if I am overweight;
I am not intrinsically worthy or lovable; this is the one area of my life I can control;
I have value only as a sex object; and
my boyfriend will leave me if I gain three ounces.

In the survivor of childhood sexual abuse, these generic motives and cognitive errors are ramped up by the sexual abuse. The lesson that the self has value only as a sex object has been taught and reinforced very literally by word and deed throughout childhood, and often by many perpetrators. Thus, in this example, the defenses are the same, but the emotions and cognitive errors behind them are more charged and more intense than in the person without a sexual abuse history. The bingeing and purging behavior required to counter this greater intensity is therefore greater, and the resistance to relinquishing the defenses is greater.

Purging the Body of Bad Feelings

Purging the body of bad feelings is another generic defensive function of bulimia. A behavioral analysis of the genesis and development of bulimia generally reveals a series of steps:

a) an event such as being abandoned or snubbed, failing to meet someone else's needs or expectations, or being left alone;
b) a dysphoric mood state;
c) an auto–hypnotic focus on the binge behavior including setting up the food and consuming it;
d) satiation and suppression of the bad feelings;
e) panic and depression about the calories consumed and activation of core cognitive errors about food and weight;
f) purging; re–suppression of the bad feelings, calmness, and a sense of control; and
g) then a refractory period until the cycle is repeated.

Magical child thinking is often evident: The patient will state that she throws up her bad feelings and is rid of them. I may then ask her to describe the color of the feelings and tell me whether they sink or float. The patient will not understand my question, so I will explain that if she throws up her feelings in the toilet, I am interested in their weight, buoyancy, and color from a medical perspective. This conversation leads to the person realizing that she has been almost as concrete and magical in her thinking as I was being in my questioning. She realizes that the feelings were, in fact, stuffed inside her, not literally expelled into the toilet.

In the survivor of childhood sexual abuse, the same magical thinking of the wounded child is controlling behavior in the present. However, the content of the feelings and the wounds is, in part, specific to the sexual abuse, including bad emotions and bad physiological sensations. It is not random or coincidental that eating disorder behaviors in the survivor of childhood sexual abuse focus on the mouth and anus. These orifices were the brunt of the sexual abuse. These are the "bad" parts of the body, which need to be cleansed, purged, punished and controlled.

Mood State Management

As described above, mood state management is a core function of all eating disorder behaviors including bulimia. Indeed, it is the core defensive function of all addictions and defenses. In the survivor of childhood sexual abuse, however, the bad feelings are linked to events and betrayals that are absent in the person who was not sexually abused. To some degree, the work of therapy focuses on nonsexual sources of bad feelings,

with generalization of gains to the feelings derived from the incest or other sexual abuse. However, this usually does not address the whole issue and generalization can move in the opposite direction, so that working directly on the sexual abuse can help resolve less severe conflicts and less severely defended–against feelings.

Filling Up an Inner Emptiness

The survivor of childhood sexual abuse often feels spiritually empty and often can describe the location of the empty hole in her abdomen or chest. In contrast anger is usually described as black, with some red (at times), about eight or ten inches in diameter and located in the mid–abdomen, sometimes "causing" pressure in the chest, jaw or head. Although the emptiness can be in the abdomen and/or chest, it never is experienced as radiating to the head or limbs. The emptiness may come from failure of the parents to bond, nurture and attach, even though they were "good providers," or it may come from frank neglect.

The survivor of childhood sexual abuse is empty for additional reasons. The perpetrator took something from her, which she may identify as her innocence, her spirit, her childhood, her inner light, her worth, or something named by another term. In session, I may ask her what store I should go to in order to buy some worth. She will not understand the question: I then explain that if her worth, or spirit, was taken from her, then it must be somewhere, so she should be able to go there and retrieve it,. or, alternatively, it may be stocked at stores. After all, if someone steals your hammer, yon can go to a hardware store to get a new one.

The discussion leads to the conclusion that the hole inside is a feeling, not a literal fact. Therefore, the situation is not hopeless. There is emptiness because of dissociation, not because the perpetrator literally took something away with him. The substances that can fill the emptiness are available inside, but (depending on one's preferred vocabulary) are suppressed, stuffed, pushed away, or dissociated. One of the ways to fill the emptiness is to stop dissociating the feelings through bingeing and purging, and to fill the emptiness with these feelings instead of with food. Filling a spiritual emptiness with food is, in any case, impossible, and clearly is magical child thinking.

The reason the person resists dismantling the dissociation and recovering the feelings is that they are very painful. The problem is defensive overkill: the good feelings are gone, too, leaving an empty hole. Fortunately, the feelings are not as intolerable as the person believes them to be, affect management skills can be learned, and the feelings phobia can be

desensitized in a staged, systematic fashion. When this is achieved, the need for the eating disorder dissolves.

Maintaining An Illusion of Control

Maintaining an illusion of control is a core component of all eating disorders, including anorexia nervosa and bulimia. The different psychodynamics and behaviors interact through a complex set of feedback loops, and do not occur in isolation. They have both intrapersonal and interpersonal functions and have a historical, cultural, and social context. A person may restrict, binge and purge in order to maintain an illusion of control, in which case different behaviors have the same defensive function. Or a person may purge in order to maintain her weight to control her boyfriend's behavior and prevent abandonment by him; in this scenario, different defensive functions form a chain leading to an end behavior. Alternatively, the same behavior may have multiple defensive functions; for example, a person may purge to cleanse the body, manage weight, and maintain an illusion of control.

All of these combinations of defenses and behaviors can occur in people with and without sexual trauma histories. Nothing is specific as to cause, function, or interaction with other causes and defenses. Nevertheless, there are certain themes that occur only in the survivor of sexual abuse. A woman may purge in order to control and suppress her feelings about the sexual violation. Now she is in control of what goes into and out of her mouth and anus, which undoes the reality of her childhood, in which she was a powerless victim of violation at both ends of her gastrointestinal tract. Instead of being the victim of insertion, she is in control of excretion.

Purging is highly self–reinforcing because it really does work objectively to rid the body of calories. If purging after a binge caused additional weight gain, people would not purge. They do so because it actually works. This is generally true of addictions: they are self–reinforcing because they work from a short–term perspective. People would not drink at parties if alcohol made them more socially anxious and self–conscious.

Skilled bulimics can vomit at will and often pride themselves on their degree of skill and control. Once a woman has confirmed her absolute control over purging, in a therapy session, I might ask, "Would you mind demonstrating your complete control by not purging once for three months?"

The purpose of the question is to expose the paradox: complete control of purging combined with inability to stop purging. The further paradox,

which applies to all addictions, is that it is possible to choose abstinence and achieve recovery, which can be possible only if, ultimately, all the behavior is under control. Like all addictions, the choice to binge is experienced as uncontrollable, however, and psychologically, this may be true once the binge is under way. The addict neglects to note that the binge was preceded by a long sequence of choices made consciously for known purposes—taking money out of the bank, storing it in her purse, driving to a store, selecting food for binges, and placing it in the fridge or pantry.

Undoing Fellatio and Intercourse

The preceding discussion should make the logic of this psychodynamic clear. In the body of the adult woman with an eating disorder there lives the mind of the magical child whose concrete thinking controls thought, perception, and behavior in the present and the belief that it is literally possible to vomit up the semen that was inserted into her body twenty years ago, or to purge it out with laxatives. The behavior is the same as in all individuals who binge and purge, but the defensive function is specific and the intensity of the emotion behind it is greater.

PSYCHODYNAMICS OF OBESITY

Making the Body Unattractive to Perpetrators

One can make an adult female body unattractive to perpetrators by starving it down to 76 pounds or by making it weigh 350 pounds. Although this is understandable, it does not in fact work because rapists generally do not select their targets based on their matching the images in women's magazines. In fact, a subset of sexual predators prefers and seeks out obese women, therefore, the strategy of obesity actually makes the person more attractive to this group of sex addicts.

In my clinical experience, as with the dynamics of other eating disorder behavior, this defense is not a theory of mine, rather it is an explanation given to me by many women when I ask them why they think they are so overweight. I suspect that women who lose then regain their weight after bariatric surgery have higher rates of childhood sexual abuse than women who do not regain weight.

If a woman cannot explain why she is so overweight, I may ask what she thinks would happen if she lost all her excess weight. Often, she will react to this question with fear and alarm and state that she would be too vulnerable and that men would start looking at her "that way" again, just like they did after she reached puberty.

Insulation Between the Self and the Outside World

Adipose tissue is highly protective in several ways. Besides "turning off" perpetrators, it insulates the person from cruel remarks, rejection and abandonment: the pains and arrows of outrageous fortune cannot get through the fat to touch the soul. The fat works like the defense mechanism of character armor. The suit of armor protects her; the cruel remarks cannot penetrate it, according to the magical child, who has a driver's license and a college degree. Losing weight is unthinkable because the person would then be defenseless and based on her past experience as a victim of childhood verbal, emotional, and sexual abuse, violation would be certain to occur and would strike to her core.

To Suppress Promiscuous Ego States

I learned about this motive for obesity in the 1980s from a woman with multiple personality disorder (now dissociative identity disorder, or DID). She explained that she deliberately kept the body 80 pounds overweight because when she weighed above that threshold, her prostitute alter personality was too mortified by the condition of her body to take executive control and act out sexually. The woman used prostitution as an undoing of the victim role from childhood. As an adult, the prostitute was in control of whether she had sex or not and if she did, she got paid for it, so life was good for one personality, though not for other alter personalities, who were retraumatized by work in the sex trade.

As always, I asked myself how this motive could apply to women with eating disorders but no dissociative disorder. The theme and the function of the obesity is the same in both instances. I realized that one purpose of obesity is to turn off the perpetrator, but another is to turn off the self. It may be that obesity actually dampens libido through hormonal feedback loops, but it certainly does so psychologically.

In a person with multiple personality disorder and in the mind of the magical child, the obesity shuts down the sexual harlot who caused the childhood sexual abuse by attracting and seducing the incest perpetrator. The same cognitive error drives the same behavior in a person with no dissociative disorder, except that the depraved sexuality is housed in the self, not in "another person." Creation of the "other person" provides an additional layer of defense against ownership of the guilt for causing the incest: The guilt is in turn a defense against the underlying powerlessness and helplessness of the child victim. It is better to be bad, at fault, and in control of the incest than it is to be a helpless victim. One could decide to be good, choose to stop the seduction, and render the perpetrator helpless

so that the abuse would stop. If the self is innocent, there is no hope of escape.

The bad child who caused the incest had a body mass index within the normal range. In order not to be that person, one must adjust the body to a weight in the obese range, 350 pounds.

To Fill Up Inner Emptiness

The morbidly obese person has bulimia without sufficient purging. This is true whether or not there are numerous small "binges" per day or a small number of official, big binges. The purpose of the behavior does not vary depending on the size and number of feedings per day. In this variation, the purpose of eating is to fill up the inner emptiness. Inversely, the person with normal weight bulimia is an over–eater who purges enough not to gain weight.

To Punish the Self

The bad little girl who "caused" the sexual abuse must be punished for several reasons: The punishment is cathartic and discharges some of the anger. Like self–mutilation, it suppresses the bad feelings and manages the intolerable mood state, but in a hostile, angry fashion. The hostility and anger might be dissociated and driving the behavior covertly, but they are always there. Cutting on your skin, starving yourself in the midst of plenty, forcing your body to die young from cardiovascular illness, and destroying your parotid glands, tooth enamel and esophagus by chronic vomiting, are all hostile, angry, abusive things to do to a human being. They would be criminal acts if done to another person, and would be classified as torture if done during interrogations or imprisonments.

Self–punishment also serves as a form of atonement. If enough self–flagellation is performed, the debt will be paid off, and God, self, mother, or someone, will forgive the child for being so bad. In the mind of the survivor of childhood sexual abuse, the bad little girl caused her abuser to rape her. If no sexual abuse took place, then the child may have been so "unworthy, unlovable and bad" that her parents ignored her, failed to nurture her, or preferred a sibling. Or the child may have been bad because she wounded her loving parents by failing to meet their impossible standards for earning conditional love. This is especially a problem when unconditional love is unavailable. There are many reasons why the child is bad, and deserves ongoing punishment; sexual abuse is only one of them.

One punishment is having a "fat, disgusting body" that no one could love. This body image distortion may be impervious to genuine counter–claims by the woman's husband that he still loves her, wants to stay

married, and wants to continue having sex with her. Not only does the evil child not deserve an attractive healthy body or a long life, she does not deserve the love or fidelity of a decent man, as proven by the way her father, two brothers, two uncles and paternal grandfather treated her.

There are countless permutations and combinations of these cognitive errors, defenses and dynamics. The above discussion provides enough examples that the overall logic of the system is clear. Additional examples would not provide additional clarity. In therapy, it is important to work with the content while focusing on the general themes, structure and processes. Healing takes place at the level of structure and process, but therapy cannot proceed without content.

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