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SEXUAL TRAUMA AND EATING DISORDERS:

CURRENT TREATMENTS AND DIRECTION FOR FURTHER STUDY

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requirements for the Master of Science Degree in

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CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Sexual Trauma and Eating Disorders:

Current treatments and direction for further study

This is to certify that the Capstone Project of

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Abstract

Eating disorders are a serious problem that take the lives of many people. Research has shown that for many people, eating disorders are rarely the only mental health issue. Instead, research has found in most cases, individuals struggle with multiple co-occurring mental health issues. Specifically, research has found a link between sexual trauma and eating disorders. Research supports the need to express the trauma in order to treat the eating disorder. However, no research currently exists that examines the most effective treatment to care for populations with a comorbid diagnoses of sexual trauma and eating disorders. The purpose of this research is to examine the current treatments available for treating sexual trauma as well as eating disorders presenting the need for further research on effective treatments for a comorbid diagnosis of sexual trauma and eating disorders.

Contents

Introduction

According to the Eating Disorder Coalition or EDC (2012), almost half of the American population knows someone who is suffering from an eating disorder. Currently, eating disorders affect over 25 million Americans and rank as the third most common chronic illness among adolescents (NEDA, 2012; EDC, 2012). The National Eating Disorder Association or NEDA states that at some time in life, 20 million women and 10 million men will suffer from a clinically significant eating disorder in the United States. Furthermore, the EDC reports that eating disorders have the highest mortality rate of all mental illnesses (EDC, 2012). Crisp, et al. (2006) found that the high risk for mortality is due to an increased rate of suicide occurring among people with eating disorders. Since eating disorders are so prevalent and because of the high mortality rate associated with them, studying effective treatment is important for providers to understand how best to help those suffering from eating disorders.

Review of Literature

Risk Factors for Developing an Eating Disorder

While noting risk factors that may increase the likelihood of developing eating disorders is important, research has shown that eating disorders do not discriminate. Anyone can develop an eating disorder. According to NEDA (2012), eating disorders affect people across all ethnicities, genders, sexual orientations, and socio-economic statuses. Research has focused on determining what potential risks are associated with the development of an eating disorder (EDC, 2012). The risk factors for eating disorders are numerous due to the diversity of issues surrounding those diagnosed with eating disorders. Below will examine some of the more common risk factors found in research leading to the development of eating disorders.

Risk factors for women.

Among Western culture, women are disproportionally at higher risk for developing body-image distortions and disordered eating habits (Root, 1991). According to Root, western society encourages the development of eating disorders in women through the equation of thinness with success. By placing a high value on beauty and physical size, society tells women that in order for them to be important, they must meet certain ideals. These ideals are presented in society through women's family, peers and the media.

Family influence. Families promote the ideal for thinness in women by how they talk to their children about food or body image. According to Bandura's social learning theory, children learn through observation (Siegelman & Rider, 2012). The more children witness parental figures being dissatisfied with their own bodies or engaging in restrictive or binge eating behaviors, the more likely they are to develop unhealthy ideas about eating and body image (NEDA, 2012).

Peer influence. Peers can also play a role in helping to promote unhealthy eating behaviors and negative body image in women. According to Bandura's theory of social learning, children observe how their friends behave or the comments they make about themselves (Siegelman & Rider, 2012). Then, children begin to copy these behaviors and ideas because it is what they have learned to be *normal* (NEDA, 2012). Bullying in schools by peers can also shape how children begin to perceive themselves often resulting in the development of poor self-esteem (NEDA, 2012). When children have low self-esteem, they are at higher risk for developing an eating disorder (EDC, 2012). The EDC cited that eating disorders are the third most common chronic illness among adolescents.

Media influence. Root (1991) further suggests that eating disorders serve as an important tool in obtaining the feminine ideals of Western society which equate beauty and thinness to worthiness, power, acceptance and success. This theme is often portrayed in the media through advertisements. Women in the media are often more accepted when they look like supermodels (Newsom, 2012). In the film *Miss Representation,* director Siebel Newsom showed how women with influential careers such as Hilary Clinton have been scrutinized for their appearance. Furthermore, the film goes on to show how influential women in the media are valued more for the way they look and dress than for what they actually do or say. By linking women's beauty with value, western culture promotes the drive for thinness increasing the risk for women to develop eating disorders.

Risk factors for men.

Although much research tends to focus on women, men make up a significant portion of individuals suffering with eating disorders. The National Eating Disorders Association for Males with Eating Disorders cited that of the 25 million Americans suffering from eating disorders,

seven million of those are males (Hussa, 2012). According to *Men Get Eating Disorders Too* or MGEDT (2014), 1 in every 10 people with an eating disorder is male. Research has also shown that many men who have eating disorders go undiagnosed because of social stigmas associated with men and eating disorders (EDC, 2012). Therefore, it is difficult to obtain an accurate statistic of just how many men struggle with eating disorders. MGEDT cited a list of different risks for developing an eating disorder specific to men which are described below.

Sports and careers that have body type demands. Some of the most common risk factors associated with men developing eating disorders come from participation in certain activities or careers. Athletes are under intense pressure to perform and be competitive which can sometimes lead to extreme dieting and/or over exercising (MGEDT, 2014). For athletes involved in wrestling or running, a major demand is placed on body size in order to stay competitive. MGEDT reports these sports as being higher risk activities for athletes developing eating disorders. Men who have careers in modeling are also faced with increased body type demands. According to MGEDT, male models are at high risk for developing anorexia because of the demands for body perfection within the modeling community

Sexual orientation. Another area of potential risk for males is men who are gay or bisexual. ECD (2012) conducted a study that found that 20% of males who suffered from eating disorders were gay. The research conducted in this area noted that men who are gay or bisexual are often judged on their physical appearance making them more likely to have stressors that link thinness and attractiveness with success (MGEDT, 2014). These stressors, in turn, can increase the likelihood of developing an eating disorder.

Media and peers. Men can also be influenced by the media and peers. Men's fitness magazines present certain ideals for what men should look like if they want to be truly masculine

(MGEDT, 2014). Furthermore, advertisements for cosmetic surgery can lead to body dissatisfaction and encourage disordered eating behaviors (MGEDT, 2014). Through the process of social learning, children begin to develop unattainable ideals of masculinity by viewing men in media advertisements (Sigelman & Rider, 2012; MGEDT, 2014). MGEDT noted that boys are often bullied due to their physical size and are at higher risk for developing an eating disorder.

Comorbid disorders as a risk factor.

Brewerton (2007) states that people are rarely diagnosed with *only* eating disorders. Through his review of literature on people with eating disorders, he found that there were consistent findings that associated comorbid psychiatric issues with eating disorder diagnoses. Brewerton concluded that, as a general rule, most people who have an eating disorder probably have a comorbid mental health issue. His findings especially noted the association between post-traumatic stress disorder (PTSD) and eating disorders with a lifetime prevalence rate of 37% comorbidity (p. 291). PTSD can include many forms of trauma both physical and emotional. Brewerton noted extensive research in this area with many studies finding a link between trauma and the development of eating disorders. Brewerton also found sexual trauma to be one of the most common types of trauma associated with the development of eating disorders.

Sexual Trauma and Eating Disorder Comorbidity

The link between sexual trauma and eating disorders.

Some of the most notable findings of trauma and eating disorder comorbidity include associations with sexual abuse and/or sexual assault (Brewerton, 2007). A 1988 study at an in-patient facility for women with eating disorders found that more than 75% of in-patient samples reported sexual assault experiences (Root, 1991). In 1995, Dansky, Brewerton, Kilpatrick and O'Neil conducted a national study of 3,006 women and found that the women with bulimia

nervosa had significantly higher reports of sexual abuse and/or assault as well as PTSD. Brewerton (2007) revealed that men who were sexually abused reported greater body dissatisfaction as compared to men who were not sexually abused. He further reported that of the men studied, the ones who exhibited extreme weight control behaviors also had higher occurrences of sexual abuse. Finally, Brewerton (2007) discussed a notable study, involving 81,247 participants, which convincingly linked date rape and violence in high school with disordered eating among both genders.

Brewerton's (2007) review of literature also showed a significant link between childhood sexual abuse (CSA) and the development of eating disorders. He found that the eating disorder can persist long after the sexual abuse has ended. Brewerton noted, of those studied, female children and adolescents were at a greater risk for developing eating disorders in association with their sexual trauma. Another study conducted by Wonderlich, Crosby, Mitchell, Thompson, Redlin, Demuth, and Haseltine (2006), supports these findings showing CSA as a clinically significant risk factor for the development of eating disorders. A third study produced by Kong and Bernstein (2009) further supported these findings linking CSA with eating disorder diagnoses.

It is clear from previous research studies that survivors of sexual trauma are at higher risk for the development of eating disorders regardless of gender, but why do eating disorders so often develop alongside sexual trauma? Root (1991) explains this connection stating that survivors of sexual trauma attempt to avoid intrusive memories and situations associated with the trauma. In order to do so, individuals develop coping mechanisms which often include food abuse. Root stated that by abusing food, individuals are able to temporarily avoid re-experiencing victimization by focusing their attention on food (e.g. restricting or overindulging).

Another reason eating disorders are common among survivors of sexual trauma is because they offer a sense of security to safeguard against future abuse or assault. By altering their physical size, individuals may feel less appealing and therefore less likely to be sexually abused or assaulted again (Root, 1991). A third reason presented by Root is that eating disorders can serve as a way sexually traumatized individuals can punish themselves because they, in many cases, feel responsible for the abuse or assault that occurred (Root, 1991). In this way, by engaging in disordered eating behaviors, those with a history of sexual trauma are able to feel that they are back in control of their bodies—a feeling that was violated during their traumatic experience.

Root discussed the association between eating disorders and sexual trauma in order to show that eating disorders for those who have experienced sexual trauma may not be the actual issue, but merely a maladaptive coping strategy to deal with PTSD. She noted that the comorbid PTSD makes eating disorders more difficult to treat when the provider is unaware of the history of trauma. If the trauma history goes unaddressed, individuals with comorbid sexual trauma and eating disorders may never truly recover from their eating disorder (Brewerton, 2007). In order to properly treat those with comorbid sexual trauma and eating disorder diagnoses, the provider must be aware of individuals' trauma history. Once sexual the trauma history has been identified, providers can go on to treat those with comorbid sexual trauma and eating disorders.

Treatment for comorbid sexual trauma and eating disorders.

A consensus among researchers is that trauma needs to be addressed first in order for individuals with comorbid sexual trauma and eating disorders to fully recover from their eating disorder (Kong & Bernstein, 2009; Mitchell et al., 2012; Torem & Curdue, 1988; Wonderlich et al., 2001). Brewerton (2007) supported this idea stating, “trauma and PTSD or its symptoms

must be expressly and satisfactorily addressed in order to facilitate *full* recovery from the eating disorder and all associated comorbidity" (p.285). Clearly the research in this area has led to an understanding that trauma must be assessed during treatment in order for subsequent eating disorder treatment to be effective.

Currently, there is no research that has been found to address comorbid sexual trauma and eating disorder diagnoses. Research has focused on treatment for sexual trauma specifically as well as eating disorders specifically. However, no study has been found that looks at the effectiveness of a specific treatment that focuses on treating sexual trauma and eating disorders combined. It is then left to the clinicians to judge what the best course of treatment is for people with these dual diagnoses. While, the above research supports the link between sexual trauma and eating disorders, more research needs to be conducted to further study the effectiveness of treatments for this specific population. The following will review the current research on effective treatments for people with sexual trauma and effective treatments for people with eating disorders.

Current Treatments for Sexual Trauma

Short Post-Traumatic Stress Disorder Rating Interview (SPRINT).

Brewerton (2007) cautioned that often trauma victims are not forthcoming about their trauma because of shame or fear. In order for providers to identify trauma history, the must conduct both a thorough interview and utilize self-report instruments (Brewerton, 2007). Brewerton suggested the use of the Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) in order to obtain a reliable and valid self-report from clients. Another caution that Brewerton suggests is that clients may not be ready to discuss their sexual trauma in the first few sessions. While trauma is important to assess for in the initial interview, clients may not feel

comfortable sharing this information until a degree of trust has been established with their provider. Good ability to establish rapport with clients is essential then in allowing providers to gather information regarding trauma. Furthermore, Brewerton stresses the need to reassess for sexual trauma history throughout the course of treatment so that once clients are ready, they are able to share their experiences. This process allows clients to feel in control of when and what they share. By utilizing self-reports tools such as the SPRINT, providers can gather trauma history throughout the counseling process.

There is no research that assesses the use of this tool with a dual diagnosis of eating disorders. However, clinicians can administer this instrument to clients who present with an eating disorder in order to assess for a history of trauma. More research is needed to determine if this instrument is effective in identifying trauma of people who present with eating disorders.

Cognitive Behavior Therapy with prolonged exposure EMDR.

According to Brewerton (2007), the most empirically supported treatment for PTSD is Cognitive Behavioral Therapy (CBT) with prolonged exposure, eye movement desensitization and reprocessing (EMDR). Ringel's (2014) study also suggested efficacy for utilizing EMDR in treating trauma as a way of addressing the nonverbal issues associated with trauma. Not only has EMDR been shown to be effective for treating trauma, EMDR has also been shown to be effective in addressing negative body image among those with eating disorders (Bloomgarden & Calogero, 2008). Although, this study shows CBT with prolonged exposure EMDR to be the most effective treatment for PTSD, little research has been conducted on the efficacy of this treatment approach with comorbid sexual trauma and eating disorder diagnoses.

Dialectical Behavior Therapy (DBT).

Another successful treatment approach for PTSD mentioned by Brewerton (2007) is Dialectical Behavior Therapy or DBT. DBT treatment allows PTSD clients to develop ways of addressing trauma without dissociating by learning how to process the physical and emotional feelings that occur with trauma (Brewerton, 2007). Once individuals learn to contain the trauma, they are able to begin to process the trauma in a safe and more effective way.

Art Therapy.

Another effective treatment approach for trauma is art therapy. There has been considerable research conducted in this area finding this method of therapy extremely effective among children (Pretorius & Pfeifer, 2010). Children who have experienced trauma at an early age do not have the proper vocabulary available to express themselves (Pretorius & Pfeifer, 2010). According to Pretorius and Pfeifer, "children tend to feel overwhelmed and intimidated by the verbal expression of their [traumatic] experience" (p. 64). Norton, Ferriegel and Norton (2011) also present this idea by suggesting that not only do children not have the vocabulary, their traumatic experiences prohibit the brain from verbally recalling the event. They further identify that childhood traumatic experiences "activate somatic disorders and other traumatic traits" (p.138) in children as a way of expression without words. In other words, because of the inability for verbal expression, children who have suffered a traumatic experience, often manifest their trauma through somatic and behavioral issues. Through the use of art, providers are able to assist children in finding healthy ways to express themselves.

Group art therapy has been shown to be effective especially among individuals who were sexually abused. (Pretorius & Pfeifer, 2010). Researchers found that group art therapy helps by improving affect, behavior, cognition and interpersonal relationships by allowing individuals to express their painful traumatic experience in a medium that goes beyond mere words (Pretorius

& Pfeifer, 2010; Lantz & Raiz, 2003). In this way, individuals suffering from PTSD can learn to overcome their experience and strive to live a healthier life free from the weight of their traumatic experiences.

Current Treatments for Eating Disorders

Integrated treatment approach.

The primary treatment used for eating disorders is an integrated approach focusing on the bio-psycho-social model (Clinton & Hawkins, 2011). According to Clinton and Hawkins, individuals with eating disorders respond best to treatments that incorporate Cognitive Behavior Therapy or CBT in conjunction with nutrition and medication management. Often, treatment approaches focus on providing individuals with different teams to manage mental health issues as well as physical wellness. Clinton & Hawkins emphasize the need for a collaborative approach in order to best care for those struggling with eating disorders and manage the mental as well as physical issues that result.

Dialectical Behavior Therapy (DBT).

This therapy described earlier, has also been found to be effective in the treatment of eating disorders. Although their sample was small, Lenz, Taylor, Fleming and Serman (2014) found statistically significant results showing that DBT may be an effective treatment option for individuals with eating disorder diagnoses. Further research addressing the use of DBT treatment with comorbid sexual trauma and eating disorders is needed in order to definitively conclude the effectiveness of this treatment among populations with sexual trauma and eating disorder diagnoses.

Blended DBT and CBT.

A study, conducted by Federici and Wisniewski (2013), treated clients for eating disorders with another pervasive comorbid diagnosis such as major depressive disorder and PTSD. They found that a blended DBT/CBT is a promising intervention for the treatment of eating disorders among clients with complex diagnoses. This study seems to be one of the first to address comorbidity in eating disorder treatment, but still lacks a focus on sexual trauma as a comorbid diagnosis. Further research on blended treatment of DBT and CBT would be needed to assess the effectiveness for individuals with comorbid sexual trauma and eating disorders.

Creative Therapies.

There are a number of different creative therapies that have been shown to be helpful in treating eating disorders such as movement/dance therapy and music therapy (NEDA, 2012). NEDA states that creative therapies have been shown to promote healing through the use of creativity and exploration of symbolism. Movement therapy focuses on the relationship between body and mind (NEDA, 2012). This therapy effects changes in feelings, cognition, physical functioning, and behavior. Dance/movement therapy is defined by the American Dance Therapy Association as the use of movement in the therapeutic process to integrate emotions, cognitions, and physical abilities of people (NEDA, 2012). Music therapy works much like art therapy by allowing people to express themselves through music whether that be writing or listening to songs. This is a therapeutic way to promote healing and can be very beneficial in conjunction with other forms of treatment (Hussa, 2012).

Discussion

There has been considerable amounts of research linking sexual trauma and eating disorders. As mentioned above, individuals who present with an eating disorder may actually have a history of sexual trauma that led to the development of their eating disorder. Simply treating the eating disorder in such a case would not lead to successful treatment because the core problem (i.e. trauma) has not been addressed. Furthermore, Brewerton (2007) found that the trauma must be expressed in order to fully recover from a co-occurring eating disorder. The previously discussed treatments are shown to be effective in treating trauma or eating disorders, but research needs to further compare the outcomes of utilizing these treatment approaches in populations with *comorbid* sexual trauma and eating disorder diagnoses.

Although the consensus of current literature leads to positive results from the above treatment approaches for sexual trauma and eating disorders individually, there are no research studies that compare these treatment approaches to see which is most effective in the treatment of populations with comorbid sexual trauma and eating disorders. In order to further the research on this topic, researchers need to begin looking at the different types of treatment that have been effective for sexual trauma and eating disorders individually so that studies can be done to test these current treatments on populations with comorbid sexual trauma and eating disorders.

Conclusion

Eating disorders are a complex mental illness. Many of those with eating disorders have other comorbid issues like sexual trauma. In millions of cases around the world, individuals are being controlled by their eating disorders and they are losing their battle (EDC, 2012). Twenty percent of those with serious eating disorders who go untreated will die (Hussa, 2012). However, the outcome does not always have to be a sad one. Sixty percent of people who have been properly treated, make full recoveries (EDC, 2012). The outcome for individuals with eating disorders varies for many reasons. Through further research, effective and proactive treatments can be identified to help with the unique needs of specific comorbid populations with eating disorders. Knowledge of how to best care for individuals struggling with this devastating disorder can help decrease the number of lives lost to eating disorders each year.

Author's Note

This topic is of special interest to me personally. I have known many friends and family members who have dealt with eating disorders. Having seen the destruction this disorder has on not only the persons suffering, but also on those around them, I want to raise awareness to this issue. I first became interested in this topic after having numerous conversations with individuals who were struggling or had struggled with eating disorders. A reoccurring theme became evident: the people who considered themselves recovered from their eating disorder had a history of sexual abuse. Furthermore, those who identified themselves as still struggling with their eating disorder, reported no history of sexual abuse. I began to develop a theory that those with a history of sexual abuse may be more likely to experience full recovery from their eating disorder because the eating disorder developed as a result of their trauma. If they were able to successfully deal with their trauma, they may be more likely to recover from their eating disorder that developed as a result of their trauma.

When I began my review of the literature, I was encouraged to find that research had found a link between sexual trauma and eating disorder diagnoses. As I continued, I found many different studies supporting the link between sexual abuse and the subsequent development of eating disorders. Next, I wanted to find what treatments were most effective in treating this population of people with comorbid sexual trauma and eating disorders. What I found was that there are no specific studies that focus on treatment for this specific population. Although this research does not help the whole population of those suffering from eating disorders, it is a start to begin addressing effective treatments for people with eating disorders. It is my hope that through continued research which focuses more specifically on the unique development of eating

disorders, more effective treatments will be found so we can put an end to the epidemic of deaths caused by eating disorders.

References

Bloomgarden, A., & Calogero, R. M. (2008). A randomized experimental test of the efficacy of EMDR treatment on negative body image in eating disorder inpatients. *Eating Disorders: The Journal of Treatment & Prevention, 16*(5), 418-427. doi:10.1080/10640260802370598.

Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: focus on PTSD. *Eating disorders: The journal of treatment and prevention, 15*(4), 285-304. doi:10.1080/10640260701454311.

Clinton, T., & Hawkins, R. (2011) *The popular encyclopedia of christian counseling.* Eugene, OR: Harvest House Publishers.

Crisp, A., Gowers, S., Joughin, N., McClelland, L., Rooney, B., Nielsen, S., . . . Clifton, A. (2006). Death, survival and recovery in anorexia nervosa: A thirty-five year study. *Euopean Eating Disorder Review, 14*(3), 168-175. doi: 10.10002/erv.704.

Dansky, B. S., Brewerton, T. D., Kilpatrick, D. G., & O'Neil, P. M. (1997). The national women's study: relationship of victimization and posttraumatic stress disorder to bulimia nervosa. *International Journal of Eating Disorders, 21*(3), 213-228.

Eating Disorders Coalition for Research, Policy & Action [EDC]. (2012). *Facts about eating disorders*. Retrieved September 29, 2013, from http://www.eatingdisorderscoalition.org/documents/EatingDisorderFacts.pdf.

Federici, A., & Wisniewski, L. (2013). An intensive DBT program for patients with multidiagnostic eating disorder presentations: A case series analysis. *International Journal of Eating Disorders, 46*(4), 322-331.

Hussa, R. (2012, March 12). *Myth busters about eating disorders*. Retrieved October 3, 2014, from http://www.normal-life.org/wp-content/uploads/2012/03/2012-MythBusters-for-students.pdf.

Kong, S., & Bernstein, K. (2009). Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders. *Journal of Clinical Nursing, 18*(13), 1897-1907. doi:10.1111/j.1365-2702.2008.02740.x.

Lenz, A. S., Taylor, R., Fleming, M., & Serman, N. (2014). Effectiveness of dialectical behavior therapy for treating eating disorders. *Journal of Counseling & Development, 92*(1), 26-35. doi:10.1002/j.1556-6676.2014.00127.x.

Men Get Eating Disorders Too [MGEDT] (2014). *The facts*. Retrieved November 3, 2014, from http://mengetedstoo.co.uk/information/the-facts.

Mitchell, K. S., Mazzeo, S. E., Schlesinger, M. R., Brewerton, T. D., & Smith, B. N. (2012). Comorbidity of partial and subthreshold PTSD among men and women with eating disorders in the national comorbidity survey-replication study. *International Journal of Eating Disorders, 45*(3), 307-315. doi:10.1002/eat.20965.

National Eating Disorder Association [NEDA]. (2012). *Educator toolkit*. Retrieved September 29, 2013, from http://www.nationaleatingdisorders.org/sites/default/files/Toolkits/EducatorToolkit.pdf.

Norton, B., Ferriegel, M., & Norton, C. (2011). Somatic expressions of trauma in experiential play therapy. *International Journal of Play Therapy, 20*(3), 138-152. doi:10.1037/a0024349.

Pretorius, G., & Pfeifer, N. (2010). Group art therapy with sexually abused girls. *South African Journal of Psychology, 40*(1), 63-73.

Ringel, S. (2014). An integrative model in trauma treatment: Utilizing eye movement desensitization and reprocessing and a relational approach with adult survivors of sexual abuse. *Psychoanalytic Psychology, 31*(1), 134-144. doi:10.1037/a0030044.

Root, M. P. (1991). Persistent, disordered eating as a gender-specific, post-traumatic stress response to sexual assault. *Psychotherapy: Theory, Research, Practice, Training, 28*(1), 96-102. doi:10.1037/0033-3204.28.1.96

Siebel Newsom, J. (2012). *Miss representation* [Motion picture]. Virgil Films.

Sigelman, C.K., & Rider, E.A. (2012). *Life-Span Human Development* (7th Edition). Belmont, CA: Wadsworth, Inc.

Wonderlich, S. A., Crosby, R. D., Mitchell, J. E., Thompson, K. M., Redlin, J., Demuth, G., . . . Haseltine, B. (2001). Eating disturbance and sexual trauma in childhood and adulthood. *International Journal of Eating Disorders, 30*(4), 401-412.