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# Eating disorders as a specific method of solving the sexual identity crisis

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***Summary***

*This article is dedicated to the subject of eating disorders in the context of sexual development of women in adolescence and early adulthood. Epidemiological and symptomatological data on eating disorders have been reviewed and results of empirical studies on sexuality of females with eating disorders as well as several theoretical concepts dedicated to these disorders have been analysed. The results of our own study including 73 females with eating disorders have also been presented. Methods used in the study: Life Check List, and Sentence Completion Test (SCT), a Self-rating Scale on Eating Disorders (FSE). The results suggest comorbidity of eating disorders and negative attitude towards both sexuality and males neglecting sexual behaviour.*

*Key words*: anorexia, eating disorders, identity crisis, sexuality, and development

*Eating and sexuality unite in unconsciousness*
Menniger [1]

## Introduction

Every year more and more adolescent women suffer from eating disorders: anorexia and bulimia nervosa. Most often, the first symptoms occur during adolescence and the critical moment is the crisis of sexual identity. The crisis consists in confrontation with changes that take place in the body and new social roles inherent to matured women. Eating disordered patients find it very difficult to accept the changes, something which is manifested in symptoms of the disorder [2, 3, 4]. Empirical data confirming this hypothesis will be assigned and theoretical concepts analysed. Furthermore results of personal research will be presented.

## Current incidence and prevalence of the eating disorders

DSM-IV recognises two independent entities: anorexia nervosa (307.1) and bulimia nervosa (307.51). Furthermore two subtypes of anorexia are introduced: 1) restrictive

and 2) bulimic (eating attacks with or without the episodes of purging) and two types of bulimia: 1) with purgation and 2) without purging.

Epidemiological data concerning eating disorders incidence indicate, that most often their onset takes place between the 13th and 25th year of life, and that they are most intense between 14th and 18th year of life, thus in the period of sexual identity crisis [6]. Eating disorders are 10 to 20 times more frequent in women than in men [7].

Prevalence data show that the disorders are present mainly in the societies dominated with Western culture, and their intensity has been gradually and regularly growing since the 1970's. The question comes to mind, what makes the culture different. The attempts to explain the problem focused on the conflict between the traditional model of femininity – often present in eating disordered patients' mothers - the model in which social binds, emotional engagement, devotion and care are essential features of woman identity development – and the new social model of assertive, emotionally and economically independent woman. This results in a crisis or even denial of femininity because it is inconsistent with the current social pattern [8] Eating disorders are manifestations of femininity negation. Moreover western culture attaches enormous attention to the outlook that determines one's value. Young women diet in order to obtain a perfect figure and dieting is often the first step to the eating disorder. Eating disorders are much more frequent in countries, where the sexual identification pattern is incoherent, and where intense emphasis is put on physical attractiveness. The data indirectly support the hypothesis regarding the relation between eating disorders and development of sexuality.

## Sexuality of patients suffering from eating disorders in empirical research

Empirical research on sexuality of women suffering from eating disorders has its half century history. Many researches indicate that the disorder is accompanied with the sexual sphere dysfunction, both concerning creations of intimate relations and sexual activity. Kay and Leigh [9] explored the Attitude towards sexuality in this group of women and found that majority of them is indifferent or even hostile to interest manifested by men. In 1969 Dally [10] found ex post that 40% of patients were embarrassed by and feared their sexuality and the woman's role even before they became ill. Also Palazzolli [11] indicated that sexual inhibition was based on patients' fears connected with maturation and both Crisp [12] and Sours [13] observed anxiety connected with sexuality of patients with eating disorders. In 1990 Hsu [14] reported that eating disorders were accompanied with sexual dysfunction. Several other researchers confirmed the observation. Raboch and Faltus [15] found that at least 80% of anorectic patients suffered from poor sexual life. Turnbull et al. [15] also confirmed statistically significant differences between the eating disorder and control group regarding the level of psychosexual development. The ill show significant tardiness, very strongly manifested especially in restrictive anorexia.

## Relations between eating disorders and sexuality in theoretical concepts

Therapists who work with eating disorder patients are aware of the variety of fears connected with sexuality and sexual relations in them. Despite the fact that the fears are

hidden under the external symptoms of the disorder and patients reluctantly share their sexual problems, it is obvious that they have unsatisfactory sexual lives. The observed problems find their reflection not only in the empirical studies mentioned before but also in various theoretical deliberations. K. J. Zerbe [17] presented a very interesting psychodynamic conception on sexuality of eating disorders in 1995. According to it, majority of patients experience a sense of guilt connected with their sexuality. Their superego is too restrictive. Furthermore they suffer from identity fears and are afraid to loose boundaries in intimate relation. They are afraid to disappear in an uncontrolled symbiosis. Zerbe criticises the hypotheses that the discussed dysfunction results from hormonal changes, changes evoked by the long period of malnutrition (low level of testosterone). In her opinion, endocrinological disturbances and malnutrition do not explain sexual dysfunction. Clinical practice shows, that majority of eating disorder patients with such a dysfunction, also suffer from other problems that influence the dysfunction. Zerbe was one of the first to notice the relation between eating and sexual spheres. Probably a conscious refusal to eat, attacks of gluttony or purging in the society where food is easily accessible, are symptoms of the relation between two basic vital activities – eating and making love. As a matter of fact, eating is often identified with being loved and loving and its refusal is identified with rejecting love or a lover [17].

Other relations between the sexual and feeding spheres were noticed as early as in 1973 by Wiktor Szyryński [2]. He reported that the fear of getting pregnant, represented by eating and gaining weight, intensified the symptoms of eating disorders. The fear was also present in their fantasies of "oral impregnation".

Suzanne Abraham and Derek Llewellyn-Jones, basing on personal research and clinical observations advanced a hypothesis on relation between the Attitude towards eating in eating disorders and sexual behaviour. In their opinion people who suffer from eating disorders present four types of sexual behaviour correlated with various types of eating disorders and certain personality traits. The following types were distinguished: 1) denying sexuality, 2) uncertain of it, 3) passive and 4) sexually active. Even though the authors did not mention directly, the convergence between DSM-IV diagnostic subgroups and the types mentioned above is clear.

Similar opinions were presented in the work *Anorexia, Bulimia and Obesity* by Jablow [18]. Sexual activity in anorexia nervosa is different from sexual activity in the group suffering from bulimia. Namely the second group is much more interested in such activity. Many authors [see 2, 3, 4] observe, that patients were afraid – and consequently – they evaded maturity, independence and undertaking social roles, especially those connected with sexuality.

Analysis and interpretation of functional meaning of eating disorder symptoms in clinical practice point at a strong relationship between the disorder and sexuality. Atrophy and irregularity of the menstrual cycle and indifference to it observed in anorexia and bulimia nervosa can be interpreted as a sign of a dislike to one's own sexuality and a means to postpone maturity. It is also consistent with the denial of sexual needs, so often declared by these patients. Loss of body weight in anorexic girls, resulting in disappearance of the feminine shape, can be understood as a negation of external female

features. This way they freeze psychosexual development. Behavioural and cognition symptoms, such as sense of lacking body attractiveness, extreme body devaluation and hostile perception of body as something strange, combined with low self-esteem and complete concentration on eating activities result in withdrawing from sexual relations, protecting the girls. Emotional changes such as apathy, irritation, impulsiveness, sense of guilt or anxiety lower their self-esteem and make them more distant in human relations. All of the mentioned above symptoms involve the disappearance or negation of sexual needs, anxiety, lacking interest in the other sex and sexuality, withdrawing from social roles and tasks connected with sexuality.

The present study puts emphasis on adaptive function of symptoms of eating disorders since effects of the symptoms make realisation of developmental tasks difficult. Therefore the function of eating disorders is adaptive and helps the ill to postpone the crisis and the tasks connected with it until the moment when they are capable to cope with them in a healthy and conscious way.

## Research hypotheses

Theoretical conceptions, results of empirical research and clinical observations quoted above are not univocal and suggest many questions. The aim of the personal empirical research was to answer some of them. Firstly – we explored if the eating disorder patients experience a more intense inner conflict regarding sexuality and the opposite sex (H.1.) If so, then if there is a relationship between the intensity of the conflict and intensity of symptoms. (H.2.). Secondly – if eating disorders symptoms actually allow postponement of the confrontation with adult women life hardship, then the following hypotheses should be true: Eating disorders symptoms should influence the time and manner in which the ill undertake sexual roles. It was assumed that eating disorder persons compared with healthy ones would undertake sexual activity later and continue it less regularly (H.3.) Another task was to determine if the intensity of the eating disorder symptoms were inversely proportional to the sexual activity of the ill (H.4.) Taking the social aspect of the female role into consideration, we advanced the hypothesis, that young women suffering from eating disorders would enter into marriage or informal relations more rarely and also have offspring more rarely than healthy individuals (H.5.).

## Methods

### The sample and course of the study

1. Sample of eating disorders (EDS)

The sample consisted of 73 consecutive patients aged between 19 and 32 (average age – 24) who reported to Provincial Neurosis Centre and Department of Psychotherapy of the University Hospital between 1996 and 2002 due to eating disorders. They all were diagnosed as eating disorders in accordance to the DSM-IV criteria. 9 patients were diagnosed with restrictive anorexia, 23 with bulimic anorexia, 9 with bulimia

without purging and 32 had bulimia of the purging type (DSM-IV). The patients filled out the tests on the day they reported to the therapy.

2. Control group (CG)

The group includes 31 women volunteers aged 21 to 30 years old (average age – 25) mostly students with no history of eating disorder.

### Methods applied

The following variables were investigated:

- Intensity of selected eating disorder symptoms were measured by R. Hettinger and B. Jager Self-rating Scale on Eating Disorders (1990). The following variables were taken into consideration: BMI index, intensity of fear on putting on weight, irregularity of menstrual cycle, sense of own attractiveness, regularity of having meals, frequency of belief that some parts of the body were too fat, importance of gaining desirable weight.
- Sexual behaviour and behaviours connected with undertaking sexual roles were determined with the use of: Life Check List from the Psychotherapy Department of CMUJ.
- Joseph M. Sacs and Levy Sidney Incomplete Sentences Test investigated attitude towards opposite sex and sexual life. In accordance to the aim of the study, two categories of the test were applied: Attitude towards men and Attitude towards sex. Patients' comments were analysed with respect to the intensity of inner conflict by three independent, competent judges (a psychologist and two psychotherapists experienced in analysing SCT- workers of the Department of Psychotherapy of the University Hospital). The subjects responded by circling a number (0 through 2) that was printed next to each item. Alternatives were as follow: 0 meant lack of conflict and 2 intense conflict.
- The following statistical methods were applied: test of significance of differences between two structure indexes to investigate differences between the groups and Spearman Rank Correlation Test to assess mutual correlation.

## Results

Results of the study confirmed the correlation between eating disorders and sexual inhibition. Analysis of SCT results indicates, that the ill much more often than healthy ones manifest a contradictory or ambivalent attitude towards sexuality internally, which confirms the hypothesis H.1. For example, only one out of ten of those ill (and a half of the healthy) manifested a peaceful attitude towards men; more results are presented in table 1.

Comparison between the incidence and intensity of eating disorder symptoms and

Table 1

**Intensity of a confrontational attitude towards men and sexual life (SCT assessed by 3 competent judges) in the group of eating disorder patients (EDS) and control group (CG)**

| | | 0 – no conflict | 1 – moderate conflict | 2 – intense conflict |
|---|---|---|---|---|
| Attitude towards men | EDS (N=73) | 8.24%** | 34.49% | 57.27%* |
| | CG (N=31) | 51.61%** | 25.81% | 22.58%* |
| Attitude towards sexual life | EDS (N=73) | 16.44%* | 49.31% | 34.25%* |
| | CG (N=31) | 45.17%* | 48.38% | 6.45%* |

Significant differences marked: * p<0.005; ** p<0.001

intensity of inner conflict regarding opposite sex and sexual sphere (SCT) partially confirms the hypothesis H.2. (Table 2). The essential observation is that more attention is paid to achieving certain weight of body, the more disturbed Attitude towards men and sex.

Analysis of the responses regarding the development of sexual sphere (Life Check

Table 2

**Coexistence of the intensity of eating disorders symptoms and the intensity of confrontational attitude towards men and sexual life (SCT) in the eating disordered women (N=73)**

| | Intensity of confrontational attitude towards men | Intensity of confrontational attitude towards sexual life |
|---|---|---|
| Frequency of belief that some parts of patients body are too fat | R = -0.261* | R = - 0.171 |
| Importance of achieving certain weight | R= - 0.271* | R= -0.316 * |

Significant differences marked *

List) showed that 38.36% of the ill hadn't yet experienced sexual intercourse (statistically significant – p<0.01) compared with the control group (12.9%). 65.75% of eating disordered patients and only 19.35% control group (p<0.01) did not have sexual life when examined. The results confirm hypothesis H.3. According to hypothesis H.4, the less regular the menstrual cycle of eating disordered women the later they start sexual intercourse, the fewer sexual partners they have and they report that their sexual life is unsuccessful more frequently (table 3). The more frequent they experience an impression that they loose control over eating during the attack, the earlier they started sexual intercourse and the more sexual partners they had. This reflects the way how loss of control on eating influences loosening of sexual drive, which once again confirms a strict relation between the two spheres.

It is interesting, that no correlation between the BMI rate and fear of gaining weight

Table 3

**Correlation between selected eating disorder symptoms and sexual behaviour**

| | Irregularity of menstrual cycles | Sense of own attractiveness | Regularity of having meals | Frequency of loosing control during the attacks of eating | BMI |
|---|---|---|---|---|---|
| First sexual intercourse | R= - 0.345 * | R= -0.101 | R = 0.170 | R= -0.209 | R = 0.104 |
| Number of sexual partners | R= - 0.236 * | R= -0.150 | R = 0.312 * | R= - 0.313 * | R= - 0.005 |
| Regularity of sexual intercourse | R= - 0.188 | R= -0.105 | R = 0.010 | R= - 0.249 * | R= - 0.119 |
| Satisfaction of sexual intercourse | R= - 0.346 * | R= -0.122 | R= - 0.038 | R= -0.129 | R = 0.011 |

Significance of differences marked *

with any other dimensions of sexual sphere was found. Probably the studied group was not homogeneous enough, especially BMI rate is different in anorexia and bulimia and it influences the intensity of symptoms differently.

As expected (H.5.) both groups differ with respect to the pace of undertaking social female roles. Significantly ($p<0.05$) fewer young women suffering from eating disorders (26.44%) than healthy ones (35.48%) had been married. No differences were observed regarding the number of children but the result may not be reliable because only 10% of the both groups had children. Clearly a group of older women should be compared in this respect.

## Conclusions

Results of the study confirm a relationship between eating disorders and sexuality dysfunction. It seems that eating disorder symptoms allow the patients to prolong undertaking the demanding female roles for a long time. Eating disorders may therefore be a means of solving sexual identity crisis. The mechanism is specific and fleeting; in this way girls may avoid and postpone confrontation with adult woman roles. If a maturing woman is not capable of undertaking the roles and the confrontation with them may inflict destruction; such solution may seem adaptive.

Summing up, eating disorder therapy should focus on preparing patients towards a successful confrontation with matured woman roles. It should reinforce their emotional and mental abilities and construct a more coherent image of femininity and unambiguous and balanced attitudes towards sexuality and the opposite sex.

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