Pastoral counselling of youth with eating disorders as a result of sexual abuse

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ABSTRACT

Living in a world where there is a cost attached to everything, it is without a shadow of a doubt true that exposure to traumatic events such as sexual abuse also comes at a cost. Those who have been victims of such abuse often find themselves battling a range of psychosocial and behavioural challenges that emerge because of emotional dysregulation following trauma and as an ongoing attempt to cope with painful emotional experiences.

This study explores the complex relationship that exists between exposure to sexual abuse and the subsequent development of eating disorders that often arise because of such trauma. Attention is given to how these experiences influence an individual's sense of mental well-being, identity, view of sexuality and spiritual life. This is achieved by drawing a fine balance between scientific knowledge and personal narrative allowing both empirical understanding and lived experience to inform the process of healing.

The study explores treatment methodologies for working with youth with eating disorders as a result of sexual abuse from a multidisciplinary background, as the complexity of the topic paves the way for multi-disciplinary collaboration. Based on these findings, the study suggests a list of pastoral guidelines and strategies which can be utilized when working with these individuals.

KEY WORDS

Eating disorder, youth, sexual abuse, pastoral counselling

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Pastoral counselling of youth with eating disorders as a result of sexual abuse

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LIST OF ABREVIATIONS

AN - Anorexia Nervosa

BED - Binge-eating disorders

BN - Bulimia Nervosa

BPD – Borderline Personality Disorder

CBT – Cognitive Behavioural Therapy

CPSC – Council for Pastoral and Spiritual Counsellors

CPT – Cognitive Processing Therapy

CSA – Child Sexual Abuse

DALYs – Disability Adjusted Life Years

DBT- Dialectical Behaviour Therapy

DSM-5 – Diagnostic and Statistical Manuel for Mental Disorders

ED - Eating disorder

EDNOS – Eating disorders not otherwise specified

EMDR – Eye movement desensitization and reprocessing

ET – Exposure therapy

FBT – Family-based therapy

FED – Feeding and eating disorder

GBV – Gender-based violence

GDP – Gross Domestic Product

HIV - Human Immunodeficiency Virus

HPCSA – Health Professions Council Of South Africa

HSRC – Human Sciences Research Council

ICAT – Integrative Cognitive-Affective Therapy

ICD-11 – International Classification of Diseases

IRMAS - Illinois Rape Myth Acceptance Scale

ITP – Interpersonal therapy

KJV - King James Version

MDD – Major Depressive Disorder

NGO – Non-Governmental Organisation

NYP - National Youth Policy

OCD – Obsessive Compulsive Disorder

OCPD – Obsessive Compulsive Personality Disorder

ON – Orthorexia Nervosa

PTSD – Post-Traumatic Stress Disorder

RMA – Rape Myth Acceptance

SDGs – Sustainable Development Goals

SGBV – Sexual and Gender-Based Violence

STDs – Sexually transmitted diseases

STI – Sexually transmitted infections

TF-CBT – Trauma Focused Cognitive Behavioural Therapy

UN - United Nations

UNDESA – United Nations Department of Economic and Social Affairs

WHO – World Health Organisation

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CHAPTER 1: INTRODUCTION

1.1.1 Title

Pastoral counselling for youth with eating disorders as a result of sexual abuse

1.1.2 Key Words

Eating disorders, youth, sexual abuse, pastoral counselling

1.2 Concept clarification/definition of terms

In this study, four key words or concepts resonate with the theme. The author therefore begins by clarifying these concepts to underscore the paradigm or context for the reader.

1.2.1 Eating disorders

This concept relates to a group of psychological disorders which are linked to issues associated with feeding or eating (Colman, 2003:235). This is supported by Walsh *et al.* (2020:17), who went on to define eating disorders (ED) as mental health issues that tend to inflict physical health risks and negatively impact day-to-day functioning in everyday life. Walsh *et al.* (2020:18) mentioned that "eating disorders are considered psychiatric illnesses and are therefore listed in the DSM-5." The term eating disorders is broad, and it is made up of issues ranging from[1] anorexia nervosa, bulimia nervosa, binge-eating disorder, pica and rumination disorders (Colman, 2003:235; Walsh *et al.,* 2020:19). A broader discussion of what characterises each of these eating disorders will be done in Chapter 3 of this study.

[1] Two other terms were introduced at the end of the 20th century to describe two types of eating disorders which are "orthorexia" and "diabulimia" (Walsh *et al.,* 2020:25). These are not recognized in eating disorder criteria laid out in the DSM-5 (Walsh *et al.,* 2020:19).

1.2.2 Youth

The term youth is often defined based on age. This is seen from the definition of youth provided by the United Nations (UN) which states that the term applies to individuals between the ages of fifteen to twenty-four years (UN, 2022). However, the UN went on to mention that this is a general definition which tends to differ from one country to another (UN, 2022). The South African definition of youth differs slightly from that of the UN. According to the National Youth Policy (NYP) of South Africa, the concept relates to individuals between the ages of fourteen and thirty-five years (Department of Women, Youth and Persons with Disabilities, 2021). The definition that is most acceptable and fits well with the scope of this study is the one provided by the NYP.

From a sociological perspective, youth is characterized as "the period in which adult identities are shaped and through this society's institutions and cultural beliefs are either reproduced or remade" (Woodman & Leccardi, 2015:56). A more common definition describes youth as a time when an individual is [2]young and is transitioning between childhood and maturity (Merriam-Webster Inc., 2022).

Due to the biblical nature of this study, it is important to discuss the scriptural perspective of the word youth. According to the King James Version (KJV) online dictionary, the term youth refers to:

> The part of life that succeeds to childhood. In a general sense, youth denote the whole early part of life, from infancy to manhood; but it is not unusual to divide the stages of life into infancy, childhood, youth, and manhood (KJV dictionary, 2022).

Furthermore, according to BibleGateway (2022) the concept is characterised as "a time of vigour and strength (Ecclesiastes 11:9-10; Isaiah 40:30; Proverbs 20:29)". Throughout Scripture there are references to the pressures (Psalm 88:15; 2 Timothy 2:22) and expectations (Ephesians 6:1-2; Exodus 20:12; 1 Peter 5:5-9; Proverbs 1:8-9) facing youth today. The Bible goes on to "warn about the temptations facing young people" (Colossians 3:5-12) and encourages young people to live in righteousness and holiness which is pleasing to God.

[2] Within the context of this study the term *youth* is used interchangeably with the word *young*. This interchangeable usage of the word is also seen in the Biblical text (Ecclesiastes 11:9-10; 1 Timothy 4:12).

1.2.3 Sexual abuse

The concept generally refers to all sorts of criminal behaviour that violates and exploits individuals sexually (VandenBos, 2015:972). Sexual abuse comprises any inappropriate sexual act including rape, molestation and harassment (Palumbo, 2018). The World Health Organization (2012:2) has broadened this definition and stated that sexual abuse comprises:

> Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

According to Kinnear (2007:2) it was mentioned that [3]child sexual abuse (CSA) involves the following:

> Involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest or other sexually exploitative activities.

In the context of this study the term *sexual abuse* is used to refer to all sexual behaviours which occur through coercion and are intended to exploit individuals (WHO, 2004:1). Furthermore, the concept also refers to all sexual behaviours which occur without any consent (Kinnear, 2007:2; Merriam-Webster Inc, 2022; WHO, 2012:2).

1.2.4 Pastoral care and counselling

Pastoral counselling is a branch of practical theology (Van Straten, 2019:27) concerned with individuals' emotional and spiritual well-being. Scholars have argued that the essence of pastoral care and counselling is rooted in the realm of spirituality

[3] The author uses words such as "sexual abuse", "child sexual abuse" and "sexual violence" interchangeably throughout this study.

(Louw, 2012:15; Magezi, 2016:5; Van Straten, 2019:27). This statement is supported by Karner (2013:2) who mentioned that pastoral care and counselling involve pointing individuals to the face of Christ. This is usually done when pastoral care-givers proclaim or share the message of Christ with counselees. However, it does not mean that pastoral care and counselling are equal to *kerugma,* although sharing the gospel is an integral point of departure within this field. It can be said that spiritual disciplines such as Scripture reading and prayer are foundational elements within the scope and practice of pastoral counselling (Redding, 2012:6).

The Scriptures in this context are used to reproof, rebuke, urge and encourage (Karner, 2013:2). This statement made by Karner agrees with 2 Timothy 3:16 which states that "All Scripture is God-breathed and is useful for teaching, rebuking, correcting and training in righteousness." Louw (2012:15) mentions that in pastoral counselling emphasis is not only placed on the reading of scripture, but hermeneutics also play an integral part of the counselling process. It was stated that pastoral care is rooted in other spiritual disciplines such as worship, healing, hospitality, care, counselling and faith formation (Redding, 2012:4-19).

One of the goals of counselling involves shining the redemptive and liberative light of Christ on earth amid challenging life circumstances or existential threats that people are faced with. This can, for instance be done through the portrayal of "God images" (Louw, 2012:15) which include being empathetic, compassionate, comforting, loving *etc.* to individuals. Scholars have pointed out that pastoral care and counselling is concerned with *cura animarum* which means "the care of souls" (Louw, 2012:15; Magezi, 2016:1; Redding, 2012:2). According to Malureanu (2014:25) it is mentioned that the Greek word *therapon* refers to one who helps, serves and heals. Therefore, it can be argued that in the field of pastoral counselling Jesus is considered as the ultimate Healer and Restorer of those who are hurting. It is only through Christ that true transformation can be experienced.

Furthermore, it is vital to mention that pastoral care and counselling are often rooted within a multi-disciplinary perspective. A multi-disciplinary or holistic perspective is one that integrates spirituality with other scientific disciplines such as psychology, nutrition, sociology *etc.* Malureanu (2014:27) defined pastoral counselling as "a unique form of counselling which uses spiritual and psychological resources for healing the

whole person: mind, body and soul". It is in this context that the words *pastoral care* and *counselling* will be referred to in this study.

1.3 Introduction

Sexual abuse is a very prominent issue in society today and without a doubt it is true that the effects of it among individuals are detrimental (Banwari, 2011:117; Jewkes *et al.,* 2001:422; Phasha, 2022:2). Due to the high prevalence of sexual abuse cases in the country, it is asserted that this is an issue which does not discriminate based on sexuality, socio-economic status, ethnic or educational background (Van Duin *et al.,* 2018:1). News headlines are constantly flooded with stories of individuals who have experienced sexual violence, and this is cause for serious concern. The author of this study developed an interest in this topic because we live in a society where sexual abuse is a reality that resonates with so many people. Equally so, social issues like addictions often occur because of trauma. Both sexual abuse and behavioural addictions such as eating disorders tend to inflict pain on people both directly and indirectly. As someone who has previously volunteered as an online mentor for a Durban-based NGO called *Focus on the family* and currently volunteers at *Project Exodus*, the author became aware of the existing links between trauma and behavioural disorders. Therefore, to gain a deeper understanding of this topic and to further expand on her master's dissertation titled, *A pastoral study on gender-based violence and femicide in South Africa*, the author saw the need to investigate pastoral counselling perspectives on eating disorders among the young with a history of sexual abuse.

Although ample research exists on both topics within a variety of fields such as psychology, medicine, neuroscience, sociology and epidemiology (Bonomi *et al.,* 2013; Castellini *et al.,* 2018; Guillaume *et al,* 2016; Jina & Thomas, 2013; Rikani *et al.,* 2013), the author did find that there are limited pastoral counselling studies in South Africa which focus on eating disorders. It is for this reason that the author of this study decided to conduct a study focussed on integrating both sexual abuse and eating disorders as issues which are not isolated from each other. This will allow the author to explore pastoral counselling guidelines for youth struggling with eating disorders after sexual abuse. Despite this study being conducted from a theological paradigm,

perspectives from multi-disciplinary fields will also be investigated due to the complexity of the topic (Palumbo, 2018).

It is maintained that sexual abuse tends to threaten the identity and self-concept of individuals (Andalibi *et al.,* 2018:19). Those who have experienced childhood sexual abuse are often at risk of developing body image issues which can also result in feelings of inadequacy (Price, 2017:23). In a country like South Africa where childhood sexual abuse is common, it is essential to understand the link between trauma and the possible development of eating disorders as well as other psychological issues such as depression and anxiety.

The research topic is relevant because in South Africa sexual abuse is an escalating socio-economic problem which affects people in varying degrees. It is not uncommon for those affected to seek out various coping mechanisms like eating disorders to try and numb the pain caused by the abuse. Taking this into consideration, the author hopes to establish an innovative, sustainable and holistic treatment strategy directed towards sufferers of eating disorders who have a history of childhood sexual abuse. This will help to contribute to a new body of knowledge within the field of pastoral counselling.

1.4 Preliminary literature review

An extensive literature review was conducted. This was done through making use of various academic resources such as journal articles, books and eBooks. Most of these resources were found through popular academic search engines such as google scholar, EBSCOHOST, SABINET and PROQUEST. Due to the nature and complexity of this study, the sources used come from various multidisciplinary fields.

1.4.1 An overview of sexual abuse in South Africa

Traumatic life experiences such as childhood sexual abuse continue to remain a reality for most people in South Africa and globally (Meinck *et al*., 2016:910). Sexual abuse is defined as:

> Any unwanted physical invasion of an individual's body that is sexual in nature. This abuse ranges from touching and kissing to forced oral sex, forced sexual penetration or rape, attempted rape, and being forced to perform prostitution and bestial acts as well as other forms

> of sexual assault such as criminal sexual exposure, voyeurism, or coercion (Kaldine, 2012:288).

It is important to mention that this definition can sometimes differ from one country to the next. According to Dartnall and Jewkes (2013:4) there are often differences in the legal definitions of sexual abuse across different parts of the world. Statistics have shown that sexual abuse affects approximately one in four girls and one in six boys globally (Foster & Hagedorn, 2014:538). Kaldine (2012:291) pointed out that children between the ages of 15-17 are the most vulnerable to possible experiences of sexual abuse. However, this statistic is only based on cases reported between 2009 and 2010, and the statistic could have shortcomings due to the under-reporting of sexual-related crimes in the country.

Research has shown that most young people will encounter some form of sexual violence before the age of eighteen (Foster & Hagedorn, 2014:538; Matthews & Benvenuti, 2014:27; Richter *et al.,* 2014:382). This statement is supported by Kaldine (2012:291) who claimed that approximately forty-five percent of women between the ages of 14-24 have reported that their first sexual experiences involved coercion. In a study conducted in two South African provinces (Mpumalanga and the Western Cape), it was found that "14.8% of children reported lifetime sexual harassment and 12.8% reported sexual harassment in the past year" (Meinck *et al.,* 2016:912). These statistics provided by Meinck *et al.* (2016:912) do not show the full extent of sexual abuse and may contain discrepancies due to the under-reporting of sexual abuse cases in the country (Fleming & Kruger, 2013:107; Mitchell *et al.,* 2017:317; Nareadi, 2013:625; Singh *et al.,* 2015:98). A common issue in sexual abuse research is that these studies tend to focus solely on women and little attention is given to men who are victims of abuse. This study will strive to fill the gap by addressing sexual abuse as a gender-neutral issue. Doing this is important to the author because she is aware that sexual abuse can affect anyone irrespective of sexual orientation.

In South Africa most young people are forced to grow up in vulnerable and unsteady environments where exposure to potential sexual abuse is common (Scorgie *et al*., 2017:53). It is essential to take note that sexual abuse not only occurs in the home environment, but it can happen in a wide array of settings such as schools; playgrounds; parks; restaurants; police stations; churches; post offices *etc.* (Meinck *et al.,* 2016:913). Furthermore, it can be said that most sexual abuse cases are

perpetrated by respectable members of society who are well-known to their victims (Hackett *et al.,* 2013:232; Mohler-Kuo *et al.,* 2014:305). However, the potential of perpetrators being unknown to victims should not be ignored.

Research has shown that exposure to sexual abuse often puts victims at risk of developing mental health issues (Meinck *et al*., 2016:910). These mental health issues can range from depression, anxiety, post-traumatic stress disorder (PTSD) and other mental health conditions (Matthews *et al*., 2013:640). At the other end of the spectrum are those who resort to behavioural disorders in order to cope with the abuse. In this study eating disorders have been identified as behavioural disorders or process addictions which are likely to occur because of past exposure to sexual abuse.

1.4.2 An overview of eating disorders

Eating disorder research in South Africa dates to the 1970s (Szabo, 2019:1; Delport & Szabo, 2008:272). However, during this time-frame researchers viewed eating disorders as an issue which only affected white females (Delport & Szabo, 2008:272; Szabo, 2019:1). After the first black patient had been hospitalised with an eating disorder-related illness in 1993, researchers resorted to investigating this problem within the black community in 1995 (Szabo & Allwood, 2004:41). Taking into consideration this brief history, it should be mentioned that eating disorders, just like sexual abuse, do not discriminate based on ethnic; religious; socio-economic or educational backgrounds (Hesse-Biber *et al.,* 2006:209; Huryk *et al.,* 2021:1). This statement is supported by Wassenaar *et al.* (2000:225) who found that eating disorders in South Africa are common among the diverse ethnic groups. However, some studies continue to dispute that eating disorders are more prone to occur amongst those coming from the middle or upper socio-economic classes (Jordaan, 2012:436).

Eating disorders are commonly considered to be a female problem, which results in most scholars investigating the issue from a feminine perspective (Hesse-Biber *et al.,* 2006; Hoek, 2016; Sharan & Sundar, 2015). This perspective is often used due to most diagnosed eating disorder cases being among women as opposed to their male counterparts. Jordaan (2012:439) stated that men are commonly driven to building more body mass as opposed to achieving excessive weight loss which is frequently

seen amongst women. To fill this gap, a comparative literature review which focuses on the impact of eating disorders among both men and women will be conducted.

The three main eating disorders which most research studies tend to focus on are *anorexia nervosa* (AN), *bulimia nervosa* (BN) and *binge-eating disorders* (BED) (Alexander-Mott & Lumsden, 2015:xv). The DSM-5 has a broad category of feeding and eating disorders, thus only focussing on these three eating disorders will result in a limited understanding of the pathology or complexity of other related feeding and eating disorders such as pica, rumination disorder, avoidant/restrictive food intake disorder and eating disorders not otherwise specified (*EDNOS)*. If one were to research eating disorders it would be useful to study them as a whole and not in part. In the context of this study, making use of such an approach will help the author gain an understanding of how these eating disorders are influenced by a traumatic event like sexual abuse.

Based on a study which was investigated at an ED unit at the Tygerberg Hospital in Cape Town, it was found that the prevalence of eating disorders constitutes approximately 40.1% for BN, 33.3% *EDNOS* and 26.5% *anorexia* (Williams *et al.,* 2020:1). Additionally, the study found a correlation between eating disorders and psychological issues such as major depressive disorder (MDD). Williams *et al.* (2020:4) also maintained that those struggling with BN usually have a substance dependence on items like laxatives (52.2%), tobacco (40.9%) and appetite suppressants (24.3%). These substances are habitually used in conjunction with a specific ED as an attempt to help individuals lose weight. In South Africa the motivation for eating disordered behaviour is often rooted in the drive for thinness and perfectionism among individuals (Jordaan, 2012:411; Wassenaar *et al.,* 2000:231). In comparison, BED frequently results in significant weight gain, which poses a risk of obesity (O'Reilly *et al.,* 2014:259).

It remains a reality that eating disorders are a significant health risk to those suffering from them (Hambleton *et al.,* 2022:2). Research has shown that eating disorders have a very high mortality rate (Krug *et al.,* 2025:1) in comparison to other psychological and psychiatric disorders (Hambleton *et al.,* 2022:1). This statement is supported by Jordaan (2012:413) and Szabo (2019:127), who stated that AN has the highest

mortality rate of all the existing psychological disorders. This suggests that eating disorders essentially have a negative impact on the life expectancy and well-being of individuals. The aetiology of eating disorders is often rooted in biological, psychological and socio-cultural factors (Jordaan, 2012:429, 431, 436).

Unfortunately, some individuals resort to eating-disorder behaviours as an attempt to look unattractive, so that they will no longer be subjected to the trauma of sexual abuse (Ross, 2009:214; Talago, 2024). The following section investigates the link between sexual abuse and eating disorders.

1.4.3 The link between sexual abuse and eating disorders

Numerous research studies within interdisciplinary fields have focused specifically on investigating the link between sexual abuse and eating disorders. Research studies on sexual abuse and eating disorders show evidence that there is an existing link between these two issues (Sanci *et al.,* 2008:261; Jordaan, 2012:436; Matthews *et al.,* 2013:640). This correlation occurs because of individuals using the eating disorder as a coping mechanism after past experiences of sexual abuse (Yoon *et al.,* 2021:2). This is not to say that everyone who is sexually abused will struggle with an eating disorder. However, it is a potential risk factor that we should consider. Research has shown that approximately thirty percent of people with a history of childhood sexual abuse have developed some form of eating disorder which can range from “anorexia nervosa, bulimia nervosa and binge eating disorders” (Cowden, 2020; Smolak & Murnen, 2002:144). Furthermore, research shows that bulimia and EDNOS are common struggles among those with a history of past sexual abuse (Palumbo, 2018). These individuals usually display symptoms ranging from “restrictive eating, excessive use of laxatives, obsessive calorie counting, binging, purging and over-exercising” (Palumbo, 2018).

According to Palumbo (2018), it is argued that both sexual abuse and eating disorders are complex issues that can affect anyone irrespective of his or her background. It is therefore not uncommon for those struggling with these issues to suffer in silence due to the stigma associated with these problems (Palumbo, 2018). Likewise, most individuals fall prey to eating disorder-related behaviours because they desire to

regain control after having encountered traumatic sexual abuse that most likely made them feel powerless (Palumbo, 2018).

1.4.4 Biblical perspectives on sexual abuse and eating disorders

Sexual abuse is an issue that existed throughout the ages. Evidence of this is seen in the Biblical text which does not remain silent on the topic (Turell & Thomas, 2008:140). In fact, there are a few Bible references which show examples of sexual abuse such as Genesis 16, Genesis 34, Genesis 38, 2 Samuel 11:2-4 and 2 Samuel 13. Although these scriptural passages address sexual abuse, none of them discusses how an issue like this correlates with eating disorders. The is mainly since the Biblical text does not mention eating disorders. The only biblical reference related to over-eating is found in the book of Proverbs where scripture discusses gluttony.

Because eating disorders are a modern clinical concept, the Bible does not speak to them directly. For this reason, this study does not attempt to draw explicit links between biblical texts and eating disorders. However, it is widely recognised that both eating disorders and sexual abuse bring significant pain, guilt, and shame into the lives of those who struggle with them (Oluyori, 2014:47). In light of this, the biblical texts engaged in this study are those that speak to hope, comfort, inner healing, and peace among individuals.

1.5 Problem statement

In South Africa eating disorders are commonly treated through hospitalisations and rehabilitation programmes (Delport & Szabo, 2008:272; Szabo, 2019:121; Williams et al., 2020:2; South African Society of Psychiatrics, 2025). Consequently, rehabilitation services are not always easily affordable or accessible for everyone due to the high expenses associated with these programmes. In rehabilitation, patients would normally have access to a multi-disciplinary team of professionals ranging from doctors, nutritionists and counsellors who walk the journey to recovery with them. Some well-known treatment methods used by psychologists when working with those struggling with eating disorders are bio-psychosocial interviews, cognitive behavioural therapy (CBT) as well as acceptance and commitment therapy (ACT). Making use of

these treatment methods is essential because eating disorders are regarded as one of the most fatal mental health issues which affect individuals physically, mentally and emotionally (Palumbo, 2018). This physical, mental and emotional effect is also common among individuals who have experienced past sexual abuse (Fergusson *et al.,* 2013:664).

Despite the existing treatment methods, the author strives to explore and design a holistic strategy aimed at treating eating disorders among those with a history of sexual abuse. A pastoral counselling strategy focussed on helping individuals heal in body, mind and soul will be developed. The problem of this study is to explore the link between sexual abuse and eating disorders to design a pastoral strategy aimed at supporting those who struggle to find inner healing. This is, of course, essential in helping youth heal from the impact of both sexual abuse and eating disorders.

1.6 Research question and further questions

1.6.1 Research question

What does a pastoral counselling strategy designed for youth struggling with eating disorders as a result of sexual abuse look like?

1.6.2 Further questions that arise from the research question:

1.6.2.1 What can be learned from a descriptive-empirical perspective regarding current treatment for youth with eating disorders as a result of sexual abuse?

1.6.2.2 What interpretative aspects can be learned from multi-disciplinary fields, such as the fields of Nutrition and Psychology, regarding the development of eating disorders as a result of sexual abuse?

1.6.2.3 What normative perspectives are important for the pastoral counselling of youth with eating disorders as a result of sexual abuse?

1.6.2.4 What pragmatic guidelines are important in developing a pastoral counselling strategy for youth with eating disorders as a result of sexual abuse?

1.7 Research aim and objectives

1.7.1 Aim

This study aims to design a pastoral counselling strategy for youth struggling with eating disorders as a result of sexual abuse.

1.7.2 Objectives

To answer the main research questions and aim of the study the following objectives have been developed:

1.7.2.1 To investigate descriptive-empirical perspectives regarding the available professional help for youth with eating disorders as a result of sexual abuse.

1.7.2.2 To explore interpretive aspects from multidisciplinary fields such as psychology and nutrition regarding the development of eating disorders after sexual abuse.

1.7.2.3 To explore normative aspects which are important for the pastoral counselling for youth with eating disorders as a result of sexual abuse.

1.7.2.4 To develop pragmatic guidelines which are important in the development of a pastoral counselling strategy for youth with eating disorders as a result of sexual abuse.

1.8 Central theoretical argument

The central theoretical argument of this study maintains that there is an existing link between sexual abuse and the possible development of eating disorders amongst South African youth. In the context of this study, it will be possible to develop a pastoral counselling strategy aimed at exploring holistic treatment methods for youth struggling with eating disorders as a result of sexual abuse.

1.9 Epistemology of the study

The epistemology of this study is derived from a practical theological paradigm. According to Heyns and Pieterse (1990:11), it has been mentioned that the field of

Practical Theology is broad and contains multiple sub-fields. One of these sub-fields is Pastoral Counselling which will be the central point of departure in this study. According to a statement made by Brunsdon (2014:2), it has been asserted that there are multiple definitions of practical theology. Louw (2014:48) defines practical theology as a field which "focuses on the interpretation of the praxis of God and its implication for ministry within different social and cultural contexts". Another definition of practical theology described by Louw (2014:50-51) maintains the following:

> Practical theology is the science of the theological, critical and hermeneutical reflection on the intention and meaning of human actions as expressed in the practice of ministry and the art of faithful daily living. It is related to life skills within the realm of spirituality. In this regard practical theology is connected to the praxis and will of God; it deals inter alia with the human quest for meaning within the encounter between God and human beings. Praxis (the intentional and meaning dimension of actions and being functions) is expressed in the actions of ministry, care and communication.

Heyns and Pieterse (1990:11) further discuss the view that the goal of practical theology usually involves portraying communicative action to the issues faced by the church and society through spreading the message of faith. God is essentially the sole foundation in practical theology. This is reiterated by Brunsdon (2014:2) who argued that "practical theology happens whenever and wherever there is a reflection on practice, from the perspective of the experience of the presence of God".

As a result, it can be contended that prayer and Scripture are important pillars in practical theological interpretation. Both prayer and Scripture are life-giving principles which not only point us to Christ, but they also play a fundamental role in the healing and wholeness of individuals. This statement is supported by Breed (2013:1) who said that "the Word of God is the revelation of the truth for life".

It is also important to mention that although faith is fundamental to the field of practical theology, this field also functions through incorporating holistic disciplines within its work. It is for this reason that the author will be making use of both Scriptural perspectives and theories from other sciences such as Psychology, Sociology, Social Work *etc.* (Breed, 2013:1). In the context of this study, eating disorders and sexual

abuse are viewed as complex life issues which need to be addressed within a holistic perspective. The practical theological model of Osmer (2008) allows individuals to use a holistic approach in both theory and practice. This is echoed by Streets (2014:1), who argued that there are four foundational questions in practical theology which are:

> How do we understand the concrete situation in which we must act? What should be our praxis in this concrete situation? How do we critically defend the norms of our praxis in the concrete situation in which we practice theology? What means, strategies and rhetoric should we use in this concrete situation?

Streets (2014:10) mentioned that without considering a multi-faceted and holistic approach in Practical Theology, our understanding of life issues would be limited. Furthermore, it has been maintained that:

> Our discerning the nature of God and the witness of the church in our time (context) and situation are embedded in these methods and theoretical orientations to our doing researching and theological reflection upon the various meanings of faith and practices of ministry (Streets, 2014:10).

1.10 Research methodology

The author uses Osmer's practical theological model as the foundational point of departure to answer the research questions, aims and objectives. This model is well-suited to the context of this study because it not only involves a hermeneutical approach (Pieterse, 2017:3), but it also allows for an interdisciplinary approach to be utilised (Smith, 2010:101). The model takes into consideration four questions which are:

- What is going on?
- Why is it going on?
- What ought to be going on?
- How might we respond (Osmer, 2008:4).

These questions are each embedded within a specific practical theological task which is reflected in the various chapters. A summary of what each task entails in the context of this study is discussed below.

- Descriptive-empirical task: What is going on?

The descriptive-empirical task involves gathering information (Osmer, 2008:4) that is useful in guiding us to understand the nature and dynamics of situations which people encounter. A core element within the descriptive-empirical task is priestly listening (Osmer, 2008:35). Osmer (2008:35) maintained that priestly listening "reflects the nature of the congregation as a fellowship in which people listen to one another as a form of mutual support, care and edification". To portray priestly listening and a spirituality of presence one needs to pay attention to the current situations and needs of communities and individuals (Osmer, 2008:34). For this reason, one can argue that priestly listening and a spirituality of presence are interrelated.

An extensive literature study will be carried out to contextualise the current situations surrounding the issue of sexual abuse (Chapter 2) and eating disorders (Chapter 3) in the context of South Africa. The information will be gathered using books, academic journals and articles.

As part of the descriptive-empirical task, the author conducted empirical research of a qualitative nature (Chapter 4). According to Nieuwenhuis (2021:56), qualitative research is described as "an exciting interdisciplinary landscape comprising diverse perspectives and practices for generating knowledge". In this study the author engaged with pastoral counsellors and mental health professionals on the current trends they have observed when working with youth who battle with eating disorders due to a history of sexual abuse. These professionals comprise a diverse group of individuals, including psychologists, addiction counsellors, social workers and pastoral counsellors across various parts of South Africa. The study will take the form of semi-structured interviews. According to Osmer (2008:54), one of the key research methods to collecting data in qualitative research is through interviews. These interviews have been designed to help the author gain knowledge and perspective on eating disorder treatment amongst those who have a history of sexual abuse. Doing this helps the

researcher identify gaps in treatment and through designing an independent strategy to explore ways to fill some of these gaps.

- Interpretive task: Why is it going on?

The interpretive task involves interpreting situations in a holistic manner. This usually involves integrating scientific theories emerging from interdisciplinary fields (Osmer, 2008:83) such as Psychology, Sociology, Nutrition Sciences and Medical Sciences to gain a better understanding as to why certain patterns and dynamics occur (Osmer, 2008:4). The interpretive task is of importance because it provides the author with the opportunity to assess and understand current situations from different angles. An interpretive approach is essentially important when evaluating possible treatment methodologies which are suitable for those battling with eating disorders as a result of sexual abuse. The role of an interdisciplinary team plays an integral part in the treatment of individuals. This is supported by Osmer (2008:83) who asserts that such an approach is important because it allows for many perspectives to be evaluated to understand complex multidimensional phenomena.

Osmer (2008:79) went on to discuss that a core element within this task is sagely wisdom. This notion of sagely wisdom includes making wise judgements (Osmer, 2008:80). This serves as a useful guide to discern which theories are applicable to a certain situation (Osmer, 2008:81). Furthermore, Osmer (2008:84) mentions the concept introduced by Aristotle known as *phronesis* which is concerned about "discerning the right course of action in particular circumstances, through understanding the circumstances rightly, the moral ends of action, and the effective means to achieve these ends".

In Chapter 5, literature from various interdisciplinary fields is used. This is helpful in terms of exploring the various theories to apply when trying to understand eating disorders and sexual abuse from multiple perspectives. The author attempts to understand why eating disorders commonly occur among those with a history of sexual abuse. Furthermore, a discussion of the current and most effective treatment methods used by professionals across multi-disciplinary fields will be included. This enabled the author to identify gaps in existing treatment methods and build a strategy that attempts to fill some of these gaps while also integrating knowledge from existing theories.

- Normative task: What ought to be going on?

The normative task of Osmer's methodology utilises theological concepts to interpret episodes, situations and contexts (Osmer, 2008:131). Notably the normative task is embedded in prophetic discernment. An essential tool within this task is the Word of God. In the field of practical theology, the Bible is viewed as authoritative (Erickson, 2013:369). This belief is embedded in 2 Timothy 3:16 which states that "All scripture is God-breathed and is useful for teaching, rebuking, correcting and training in righteousness".

It is for this reason that the author will always view the Scriptures as authoritative and inspired by the Holy Spirit. The use of Scripture played an integral role throughout this research project due to the theological nature of the study. In Chapter 6 the author explores Biblical views on inner healing for youth battling with eating disorders after past exposure to sexual abuse. Although the Bible does not use words such as "addictions" or "eating disorders", it does warn people against making idols for themselves and putting the things of this world above God (Exodus 20:3-6; Jonah 2:8; Leviticus 26:1; Isaiah 40:5-7; 1 Corinthians 10:7; 1 John 5:21). Furthermore, the Bible also contains multiple stories of sexual abuse and rape which some will be reflected on in the study. In chapter six an exegetical analysis will be conducted. The focus of the hermeneutical interpretation is on interpreting inner healing and peace which can be applied to those with eating disorders after sexual abuse. Pericopes such as Psalm 34, Genesis 1:26-27 and 1 Corinthians 6:19-20 were examined.

According to Osmer (2008:131), it is mentioned that the normative task also takes into consideration "the use of ethical norms to reflect on and guide practice". The author discusses and reflects on the ethical issues posed by addictive behaviours and sexual abuse in the lives of those who have struggled with these problems.

- Pragmatic task: How might we respond?

This is the final task of Osmer's methodology, which is focussed on developing a positive response to the nature of issues or circumstances faced by individuals. It can be said that the pragmatic task encourages the church, counsellors, researchers *et cetera* to find an adequate cause of action to the episodes, situations and contexts which individuals are often faced with. Osmer mentioned that the pragmatic task at its core is rooted in servant leadership, which is concerned with serving others. In the context of this study and essentially in the field of pastoral counselling, servant

leadership points to serving those who are broken and hurting in our respective communities.

To fulfil this role, the author worked towards developing pastoral counselling guidelines to be applied by pastoral counsellors and other mental health professionals who work with individuals battling with eating disorders after sexual abuse (Chapter 7). Alongside this, a pastoral counselling strategy has been proposed as a framework to be explored when working with youth who struggle with eating disorders after sexual abuse. This framework is one that considers the role of the Holy Spirit as central in guiding individuals to find healing in their spirit, soul and bodily dimensions.

Due to the interdisciplinary nature of this study, the strategy was built in accordance with transformational models of cross-disciplinary dialogue between theology and other fields in the arts and sciences (Osmer, 2008:167). Osmer argued that

> … moving from one field to another is not a matter of simple translation however it is a matter of transforming what is learned from another field by placing it in a different disciplinary context.

Although knowledge from other fields such as Psychology and Nutrition was integrated, the pastoral strategy has been rooted in Scriptural truths and in Jesus Christ, who is the ultimate healer and restorer of those who are broken.

1.11 Ethical considerations

The following ethical considerations or implications were considered when conducting empirical research in this study.

1.11.1 Population

The population of individuals who are eligible to participate in this study included a diverse group of professionals from interdisciplinary fields. These professionals had to be currently based in South Africa, this was useful in helping the author gain perspectives on how eating disorders among youth with a history of sexual abuse were treated within various fields such as Clinical and Counselling Psychology, Neuropsychology, Social Work, Addiction Counselling and Pastoral Counselling.

1.11.2 Population size

The author worked with four participants through semi-structured interviews. The author attempts to speak with two individuals from professions she had identified. Doing this helped her understand the different perspectives and approaches used in practice when working with those battling with eating disorders after a traumatic experience like sexual abuse. The reason for this was to diversify the results because mental health professionals usually differ in their approaches when working with individuals. This has also been emphasised by Rossouw (2020:33) who stated that professionals from different institutions tend to make use of a wide variety of counselling techniques.

1.11.3 Sampling

The sampling technique used in the study is called purposive sampling. According to Maree and Pietersen (2021:220) purposive sampling is a method used when “the sampling is done with a specific purpose in mind”. Within the context of this study the purpose of the sample was to find professionals who had experience of working with young people battling with eating disorders after past exposure to sexual abuse. The author interviewed professionals within the fields of pastoral counselling, clinical psychology, counselling psychology, addiction counselling and social work who have experience in this area. Potential participants of this study were personally contacted by the author.

1.11.3.1 Inclusion criteria

Professionals who have experience in addiction and trauma counselling were included in the study. Having adequate knowledge of eating disorders and sexual abuse was an important requirement for each participant. It was beneficial to engage with participants who has work experience in their respective fields. The participants were required to be fluent in English as it was the primary language used by the author. Furthermore, the participants would have to be registered with a relevant professional board which aligns with their field. For example, it was a requirement for someone who is a psychologist to be registered with the Health Professions Council of South Africa

(HPCSA). To ensure inclusivity and diversity the participants came from different ethnic groups across different parts of the country.

1.11.3.2 Exclusion criteria

The study will exclude everyone who is currently working as an intern or who is a student. Furthermore, anyone who was not working as a professional in any counselling related field was excluded from the study. Those without necessary registrations within various professional bodies were also excluded. The purpose is to work with registered professionals who had experience in eating disorder treatment.

1.11.4 Participant recruitment

The author used the purposive sampling for the recruitment of participants and had a list of potential candidates for the study. The recruitment began as soon as approval to continue with the study was given by the Ethics Committee of the North-West University (Rossouw, 2020:35). Participants who worked within different scopes of practice were recruited to take part in the study to diversify the nature of the results. This helped the author gain perspective on the experiences and approaches of participants who worked with those battling with eating disorders after having encountered sexual abuse.

The author ensured that the relevant letters such as invitations detailing the nature of the study and informed consent forms were sent out to all relevant participants.

1.11.5 Probable experiences of the participants

Participants were required to set aside at least 60 to 90 minutes of their time for the semi-structured interviews. The interviews were scheduled based on the availability of the participants. Based on the individual results the participants gave, the author might have needed to conduct follow-up interviews to gain in-depth clarification on the topic. The author also ensured that she mitigated bias by connecting the answers given by participants with information found in academic sources across multiple disciplines, such as the fields of Nutrition, Psychology, Pastoral Counselling, *et cetera.*

Each participant was rewarded with an incentive. The incentive was the full amount of the participants' consultation fees.

1.11.6 Estimated risk level

The estimated risk level for this study was minimal. The reason for this distinction is that the author did not speak to people struggling with eating disorders and sexual abuse. The reason for this was to prevent causing any harm or secondary trauma among those struggling with these issues. Instead, the author only interviewed professionals who worked with these young people on a daily basis and were well-versed in eating disorder treatment.

1.11.7 Risks and precautions

Risks

The following aspects are some potential risk factors which one can come across when conducting such a study:

- The participants in some cases might not have a formal or active registration with a professional board that is in line with their profession.
- There could be a breach in trust and confidentiality.

Precautions

The following precautions should be taken by a researcher when doing the empirical study:

- The researcher should ensure that every participant has a registration with a relevant professional board. This could require the participants to give consent to share their practice numbers and the name of the board they are registered with.
- All the information between the participants and the researcher will always be kept confidential. It is important to establish a participant-researcher relationship that is based on trust and accountability.

1.11.8 Risk/benefit ratio analysis

Taking part in this study posed a minimal risk to the participants. Participants were not required to share any client information as they were rather only required to share their experiences and treatment models/plans when working with youth who struggle in the areas of eating disorders and sexual abuse.

The participants received a financial incentive for taking part in the study. The results of the study were shared with participants after the completion and final approval of the study. Due to one of the goals of this study being the design of a pastoral counselling strategy which can be applied when treating youth who struggle with eating disorders after sexual abuse, it is the hope of the author that sharing this strategy will be beneficial to participants. She hopes that participants will be able to explore the strategy or even amend it a little for it to be aligned with their scope of practice.

1.11.9 Expertise, skills and legal competencies

The researcher has the necessary skills to conduct this study as she holds a Master of Theology degree in Pastoral Studies from the North-West University. Furthermore, as a registered student affiliate of CPSC, the researcher upholds the values of integrity, empathy and confidentiality.

The researcher has also been a participant in a qualitative study which took the form of semi-structured interviews in previous years.

1.11.10 Facilities

The facility where the empirical research took place was the participants' consulting rooms or on online platforms such as Zoom, Microsoft Teams, or Google Meet, depending on the participants’ geographical area and preferred meeting platform.

1.11.11 Legal authorisation

Due to confidentiality clauses that exist in the therapeutic relationship, the participants cannot mention any names of patients or release private patient information. Instead, they only shared their therapeutic approaches and knowledge on eating disorders with those who had a history of sexual abuse. The researcher commenced with the empirical study with approval from the various research committees of the North-West University.

1.11.12 Goodwill permission/consent

All study participants had to give informed consent before engaging in the study. The researcher could not continue with the study without the necessary consent given from participants. Each participant was required to sign a consent form to be eligible to take part in the study.

1.11.13 Informed consent

All participants received an email from the researcher which gave them details on the study. These details were focussed on explaining the nature of the study to participants. Additionally, the research question, aims and objectives of the study were also shared with participants. Each participant was reminded of the confidentiality clause mandatory for everyone, including the researcher. Furthermore, participation was voluntary and not forced on anyone. Therefore, as a result, participants were free to withdraw from the study at any moment should they feel any kind of discomfort or change of heart when participating in the study. Withdrawal from the study would not hold any negative consequences for the participants.

1.11.14 Distribution of study results to participants

All participants who participated in this research study would benefit from getting the full thesis sent to them via email after completion and acceptance by the research committee.

1.11.15 Privacy and confidentiality

To maintain privacy and confidentiality within the study, the names of all participants were kept anonymous. Instead, participants were labelled in a numeric format, e.g. participant 1, 2, 3, etc. The data collected was only accessible to the researcher and all participant information is kept in a password protected file. The researcher has found a sustainable and safe way to back up all collected data.

1.11.16 Monitoring of the study

The progress of this study was monitored by both the promoter involved and the researcher. A research journal and an Excel spreadsheet were used as basic tools to monitor each stage of the study ranging from data collection, literature studies to the writing up of the thesis. Furthermore, a substantial amount of time was devoted to each stage of the research writing process.

1.11.17 Trustworthiness, validity and reliability

The study takes the form of a qualitative approach with selected participants and to maintain trustworthiness four key aspects were considered during the data-collection process. These key aspects included ensuring that there were credibility, transferability, dependability and confirmability throughout the data-collection process (Nieuwenhuis, 2021:144-145).

To maintain trustworthiness, validity and reliability it is of upmost importance that the researchers adhere to the following procedures:

- Work with professionals who are well-versed and have a wide understanding of the topic.
- Ask open-ended questions which can be followed up at a later stage in case the researcher needs more clarity on certain aspects which had been discussed.
- Present the findings as they are and not falsify any of the data.

1.11.18 Role of the researcher

The researcher's role is to ensure that ethical considerations are upheld throughout the entire research process. She had to ensure that substantial progress was made in order for the thesis to be completed within the set time determined by the NWU. Furthermore, the researcher had to maintain professionalism, accountability and integrity throughout every stage of the research process.

1.12 Chapter outline

Chapter 1: Introduction

This is the opening chapter of the study which presents the methods, research questions, aims and objectives which are fundamental to the thesis.

Chapter 2: Descriptive-empirical study on sexual abuse in South Africa

In this chapter a literature study was conducted where the nature and context of sexual abuse in South Africa were discussed.

Chapter 3: Descriptive-empirical study on eating disorders in South Africa.

An extensive literature study on eating disorders was conducted to discuss the nature and context of this within the perspective of South Africa.

Chapter 4: Descriptive-empirical study on the link between sexual abuse and eating disorders.

A qualitative study was utilised to explore perspectives from mental health professionals on how to respond and effectively work with youth battling with eating disorders after exposure to sexual abuse.

Chapter 5: Interpretive task – Multidisciplinary perspectives of eating disorders occurring as a result of sexual abuse.

Multi-disciplinary perspectives from the sciences were used to explore how sexual abuse impacts youth and to answer the question why survivors of abuse are prone to resorting to eating disorders after trauma.

Chapter 6: Normative analysis of eating disorders and sexual abuse.

In Chapter six of this study the author conducted a hermeneutical interpretation focusing on leading youth to inner healing and peace. The author made use of the following pericopes: Psalm 34, Genesis 1:26-27 and 1 Corinthians 6:19-20.

Chapter 7: Pragmatic interpretation of eating disorders amongst sexually abused individuals.

In this chapter, the aim was to develop a pastoral strategy which could later be tested in practice for its effectiveness when working directly with those who had developed eating disorders after encountering sexual trauma. This was followed by a discussion of pastoral guidelines which should be followed when facilitating the pastoral process when working with youth struggling with eating disorders after exposure to sexual abuse.

Chapter 8: Conclusions and recommendations.

The final chapter of the study summarises the findings of the study.

1.13 Contribution of the study

This study strives to contribute to a new body of knowledge by proposing pastoral counselling guidelines and a pastoral counselling strategy for individuals struggling with eating disorders and who have a history of sexual abuse. The author hoped that this strategy could be used and explored by various mental health professionals within their respective fields as part of a holistic treatment plan to helping sexual abuse survivors who also battle with addictive behaviours after encountering the abuse.

1.14 Schematic Framework

Research title: Pastoral counselling for youth with eating disorders as a result of sexual abuse.		
Research question	Aim and objectives	Research method
Research question: How does a pastoral counselling strategy designed for youth struggling with eating disorders as a result of sexual abuse look like?	Aim: This study aims to design a pastoral counselling strategy for youth struggling with eating disorders as a result of sexual abuse.	Research method: The practical theological model as discussed by Osmer (2008:4) will be used as the foundational point of departure for the study. Empirical research through the usage of semi-structured interviews with mental health professionals will also be made use of in chapter 4 of this study.
Further question 1: What can be learned from a descriptive-empirical perspective regarding available professional help for youth struggling with eating disorders as a result of sexual abuse?	Objective 1: To investigate descriptive-empirical perspectives regarding the available professional help for youth struggling with eating disorders as a result of sexual abuse.	Descriptive empirical task As part of the descriptive-empirical task the author will be conducting empirical research of a qualitative nature (Chapter 2). An extensive literature study will be carried out in order to contextualise the current situations surrounding the issue of sexual abuse (Chapter 3) and eating disorders (Chapter 4) in the context of South Africa. The information will be gathered through the use of books, academic journals and articles.

Further question 2: What interpretive aspects can be learned from multi-disciplinary fields, such as the field of nutrition and psychology regarding the development and treatment of eating disorders as a result of sexual abuse?	Objective 2: To explore interpretive aspects from multidisciplinary fields such as psychology and nutrition regarding the development and treatment of eating disorders after past sexual abuse.	Interpretive task The author will attempt to understand the reasons behind why eating disorders often occur amongst those who have a past history of sexual abuse. Furthermore, the author will be discussing the current and most effective treatment methods used by professionals across multidisciplinary fields.
Further question 3: What normative perspectives are important for the pastoral counselling of youth struggling with eating disorders as a result of sexual abuse in helping them find inner healing and peace?	Objective 3: To explore normative aspects which are important for the pastoral counselling of youth struggling with eating disorders as a result of sexual abuse.	Normative Task In chapter six of this study the author will conduct a hermeneutical interpretation that focuses on leading youth to inner healing and peace. The researcher will make use of the following pericopes: Psalm 34, Genesis 1:26-27; 1 Corinthians 6:19-20.
Further question 4: What pragmatic guidelines are important in developing a pastoral strategy to assist youth struggling with eating disorders as a result of sexual abuse to find inner healing and peace?	Objective 4: This objective aimed at developing pragmatic guidelines which are important in the development of a pastoral strategy for youth with eating disorders as a result of sexual abuse.	Pragmatic task Within the context of the pragmatic task, the author developed pastoral counselling guidelines which can be applied by pastoral counsellors and other mental health professionals who work with individuals battling with eating disorders after sexual abuse (Chapter 7). The author

		will also take into consideration the current existing treatment methods across various interdisciplinary fields to build a pastoral strategy that can be used to as a departure point when helping those battling with eating disorders after past sexual abuse within a pastoral counselling perspective.

CHAPTER 2: DESCRIPTIVE STUDY ON SEXUAL ABUSE IN SOUTH AFRICA

2.1 Introduction

In this chapter, the focus is on discussing Osmer's first task of practical theology by providing a descriptive analysis of sexual abuse within the South African context. The first task of Osmer's practical theological model seeks to answer the question "What is going on?" (Osmer, 2008:4). In this chapter the author took a broad approach to understanding sexual abuse within the context of South Africa and conducted a discussion with a specific focus on the following areas:

Firstly, the discussion begins with contextualising sexual abuse through exploring the various definitions and laws which exist on sexual abuse in the country. This is followed by a discussion on debunking rape myths in South Africa, done through defining rape myths, analysing and debunking these myths and looking at the role social media plays in the perpetuation of rape myths. The author of this study continues this discussion by defining the problem with rape myths.

Thirdly, in this chapter the issue of South Africa being named as the rape capital of the world is discussed, followed by a discussion of the human rights violations suffered by those who experience sexual abuse. Furthermore, the study also deals with sexual abuse as a public health issue. As part of this discussion, the author took into consideration the interrelation among sexual abuse, HIV/AIDS and unwanted pregnancies. The economic impact of sexual abuse in the country is discussed, followed by a discussion of our understanding of the interconnectedness between sexual abuse and sustainable development goals.

In order to gain an understanding of the extent of sexual abuse within a South African context, the author conducts a statistical analysis on current trends of sexual abuse. This is followed by a discussion of the impact of sexual abuse on individuals, specifically examining its effects on their physical, psychological, and spiritual well-being. Lastly, the author discusses the role of sexual abuse in the church.

2.2 Exploring the complexity of sexual abuse

As mentioned in the previous chapter, sexual abuse is a broad concept (van Zyl-Bonk *et al.,* 2024:243). This is due to the multiple factors that make up or influence sexual abuse. These are inclusive of the different types of sexual abuse, different laws and different definitions of what constitutes to sexual abuse which exist across the world (Latzman *et al.,* 2017:2; Hunt *et al.,* 2024:2569). In this section the various definitions of sexual abuse are explored.

2.2.1 Exploring definitions of sexual abuse.

According to Artz *et al.* (2016:14) it is conceptualized that there is a wide array of sexual offences which exist. Artz *et al.* (2016:14) defined sexual abuse as acts relating to "rape, sexual offences, gender-based violence (GBV), sexual and gender-based violence (SGBV), intimate and non-intimate partner violence, defilement, sexual assault, and so on". The following definition provides a fundamental starting point to understanding the complexity of sexual abuse. From this definition it is evident that sexual abuse can be embedded in so many different acts, although the various offences mentioned by Artz *et al. (2016:14)* each carries depth and various meanings. It is important to mention that these behaviours have more commonalities than differences. This reasoning stems from witnessing through previous research how interconnected these offences are. For example, the United Nations High Commissioner for Refugees (UNHCR, 2023) defines GBV as "a serious violation of human rights and a life-threatening health and protection issue" which places individuals at risk of "physical, sexual and psychological violence, such as rape, sexual abuse, trafficking and forced prostitution." Researchers are cognisant of the fact that abuse of all kinds affects individuals on physical, psychological, and emotional levels (Muyambo, 2018:12; Liountris, 2020:2). In worst case scenarios, sexual abuse can be life-threatening to individuals as perpetrators may resort to dangerous and violent behaviours such as choking victims (Kate *et al.,* 2021:953). Abrahams *et al.* (2017:1) mentioned strangulation as a common cause of death among children and adult females who lose their lives as a direct cause of sexual homicide. In SA, a lot of victims of sexual abuse have had their lives taken away from them by those who perpetrated the violence. This is a common narrative in the context of South Africa, where

headlines about people who suffered sexual abuse and went on to be murdered flood the news far too often. An example of such a story is that of Uyinene Mrwetyana, who was raped and murdered at a Post Office in Claremont, Cape Town (Midgley, 2019). At other times the life-threatening effects occur as individuals resort to committing suicide or making suicide attempts due to their inability to cope with the effects of sexual abuse (Alabi, 2022:1). Others end up succumbing to the injuries they have sustained as a direct result of the abuse (Seedat *et al.,* 2009:1011).

Furthermore, sexual abuse is a violation of human rights (Hall & Hall, 2011:2; Watson, 2015:1). It takes away individuals' freedom of choice and autonomy, forcing them to lose control over their own bodies. To support this view Louw and Louw (2020:280) discussed “sexual bullying” and argued that bullies typically try to gain control over their victims. They continued by stating that often bullies attack others without reason and view their victims as weak counterparts. This is the type of skewed ideology that sexual abusers have adopted regarding their victims.

Louw and Louw (2020:408) continued to define sexual abuse as:

> Any illegal sexual act committed against a child. It includes rape, fondling of the genitals or breasts, sodomy, exhibitionism, exposing the child to indecent acts and using a child in the production of pornography.

This definition fills a gap that most sexual abuse definitions fail to achieve by discussing the exposure of a child to pornography as a form of sexual abuse. This is a critical gap to fill especially in a world where pornography is normalized and is viewed as an appropriate form of entertainment (Biota *et al,* 2022:1). Recently children have been getting exposed to pornography at very young ages (Harris, 2016:23) due to the increase of digitalization and easy access to the internet (Fradd, 2013:24). This only makes one wonder how the easy access to pornography plays a role in the perpetuation of sexual abuse in South Africa?

Additionally, Kaldine (2012:288) has defined the concept “sexual abuse of children” as “any act or acts resulting in the exploitation of a child, whether with or without his or her consent, for the purpose of sexual or erotic gratification”. Although this definition does not differ much from those mentioned above, it carries weight because it takes into consideration the issue of consent. Consent is something which should not be ignored in any sexual relationship. The problem with sexual abuse is that it is an act

done out of a sense of entitlement (Kwenaite & van Heerden, 2011:142; Jewkes *et al.,* 2010:23; Warrener & Tasso, 2017:377) and lack of respect towards the victim. In the case of CSA, it is impossible for children to grant any form of consent. Research has shown that children are incapable of giving any form of consent due to their lack of maturity, age and an inability to comprehend sexual behaviour (Kaldine, 2012:288; Langberg, 2015:276; Langberg, 2020:69). Other factors which affect one's ability to consent include the presence of a mental illness, intellectual disabilities, over-consumption of alcohol and intoxication from substances (Langberg, 2015:277). Furthermore, it was taken into consideration that consent cannot be obtained from someone who is unconscious or asleep (Centre for Applied Legal Study & Tshwaranang Legal Advocacy Centre, 2017:4; Stal, 2023:4). Liountris (2020:3) said that "true consent cannot be given under certain circumstances, such as if the accused used force, threats of harm, abuse of power, or fraudulent claims". These definitions make it evident that individuals must be sufficiently mature to make informed choices regarding sexuality. However, despite age and maturity level, consent is a fundamental factor in matters pertaining to sexuality. The author argues that sexual abuse is a self-centred action which is solely about serving the selfish ambition of the perpetrator. Odinye (2018:73) also concluded that selfish desire is one of the motivations for sexual abuse. It is an attack on individuals which threatens their freedom of security and their ability to be vocal. The inability to give consent not only silences individuals but also reinforces the harmful message that they do not matter.

Furthermore, Kaldine (2012:288) went on to provide a broader definition of sexual abuse and defined it as follows:

> Any unwanted physical invasion of an individual's body that is sexual in nature. This abuse ranges from touching and kissing to forced oral sex, forced sexual penetration or rape, attempted rape and being forced to perform prostitution and bestial acts as well as other forms of sexual assault such as criminal sexual exposure, voyeurism, or coercion.

In this definition coercion is described as a form of sexual assault. The author argues that coercion should not be viewed as a form of sexual assault, but it should be viewed as an element which plays a key role in the perpetuation of sexual assault. Individuals are usually put in situations where they experience threats of harm (Buchhandler-Raphael, 2011:196) being inflicted upon them if they do not co-operate with

perpetrators. This brings the author to the point that all sexual abuse consists of this element of forcefulness and coercion. This argument stems from the fact that sexual abuse is something which never happens willingly or naturally. Buchhandler-Raphael (2011:196) supported this by specifically mentioning that rape serves as an act of sexual coercion. This was further elaborated and supported by Tan-Chi Mendoza (2015:83) in her memoir *"When a good God allows rape."* In her definition of sexual abuse, she made the following statement: "The force used by the aggressor can either be physical or non-physical." Another factor that stood out in this definition is that Tan-Chi Mendoza went to the lengths of defining sexual abuse as something which affects both men and women. She describes sexual abuse as "any sort of sexual activity between two or more people in which one of the people is involved against his or her will" (Tan-Chi Mendoza, 2015:83). Although this definition is technically correct, it is vital to mention that it is possible to have multiple victims in one scenario. A good example of this within the perspective of South Africa was the case in Krugersdorp where a group of women were gang- raped while filming a music video in July 2022 (Joyi, 2022)

According to the definition provided by Allender (2008:47), sexual abuse involves "any contact (visual, verbal or psychological) between a child/adolescent and an adult when the child/adolescent is being used for the sexual stimulation of the perpetrator or any other person". Langberg (2020:69) made use of a similar definition by distinguishing that sexual abuse is composed of verbal, visual or physical activities that are engaged in without any consent. A factor standing out in these definitions is the psychological aspect which Allender mentioned. Allender (2008:51) stated that psychological abuse often comprises activities such as "intrusive interest in menstruation, clothing, pubic development, repeated use of enemas, intrusive interest in child's sexual activity, use of child as a spouse surrogate (confidant, intimate companion, protector, counsellor)".

In this definition Allender gives the perspective that sexual abuse serves as a violation of the victims' boundaries in all areas of life. It is an act which is rooted in manipulation and deceit where communication "erodes the appropriate role boundaries between a child and an adult" (Allender, 2008:50). It is equally important to mention that although sexual abuse usually involves a child or adolescent and an adult, the possibility of child-on-child sexual abuse exists (Harris, 2016:19). With the rise in pornography addiction, it is an unfortunate reality that there is also a rise in child-on-child sexual

abuse (Watson, 2015:17). Child-on-child sexual abuse can easily be confused with curiosity or experimentation among children (Harris, 2016:22).

The definitions discussed in this section of the study show that sexual abuse can be a difficult concept to define. Although similarities exist in most of these definitions, there are definite differences and gaps which other authors have stated in their understanding of what sexual abuse entails. One can argue that these definitions do not provide the full view of sexual abuse because so many different behaviours constitute this type of abuse. According to Kaldine (2012:292) it is argued that professional definitions of sexual abuse tend to differ from those used among different communities and cultures. Kaldine (2012:292) goes on to explain that complications in the definition of sexual abuse occur because of who provides a particular definition, the type of acts that are mentioned as part of the definition and among others the laws which are aligned with this type of abuse.

2.2.2 Exploring South African laws on sexual abuse

There are usually existing differences in the definition of sexual abuse (Mathews & Collin-Vezina, 2019:132), and this is often recognized across varying laws on sexual abuse in different countries (Akbaba, 2020:641). This is due to countries implementing different laws on sexual abuse and having different perspectives on the age of consent. In this section of the study the discussion centres on understanding definitions of sexual abuse in alignment with the existing laws in South Africa. According to Artz *et al.* (2016:14, 16), South Africa has developed various laws which strive to broadly define the nature of sexual abuse. The sole purpose of these laws is to work towards implementing prevention of crimes related to sexual abuse (Artz *et al.,* 2016:15). It is maintained that these laws comprise the “Domestic Violence Act (116 of 1998), the Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007) and the children’s Act (38 of 2005)” among many others (Artz *et al.,* 2016:14: Watson, 2015:2). A brief discussion of each of the laws follows.

2.2.2.1 Domestic Violence Act 116 of 1998

Due to the broadened definition of youth in this study, it is of importance to discuss the Domestic Violence Act (DVA). According to the United Nations (2024) domestic violence (DV) is a form of abuse which is often perpetrated in an intimate relationship

where the aim is to gain control or power over another individual. The Domestic Violence Act is therefore defined as:

> Physical abuse, sexual abuse, emotional, verbal and psychological abuse, economic abuse, intimidation, harassment, stalking, damage to property, entry into the complainant's residence without consent, where the parties do not share the same residence; or any other controlling or abusive behaviour towards a complainant, where such conduct harms or may cause harm to the safety, health or wellbeing of the complainant (Kaldine, 2012:286; Mathews & Abrahams, 2001:7; Sibisi, 2017:30-31).

This definition highlights the diversity and universal nature of the different acts which can be considered as DV. Although sexual abuse forms part of this definition the limitation rests in the fact that this type of abuse is not defined comprehensively within the DVA. Based on the Domestic Violence Amendment Act 14 of 2021m sexual abuse is defined as "any conduct that abuses, humiliates, degrades or otherwise violates the sexual integrity of the complainant". Furthermore, sexual harassment was defined as:

> (a) Any unwelcome sexual attention from a respondent who knows or ought reasonably to know that such attention is unwelcome; (b) unwelcome explicit or implicit behaviour, suggestions, gestures, remarks made, communications sent or delivered, or electronic communications disclosed, to the complainant – (i) of a sexual nature; or (ii) regarding the complainant's or related person's sexual orientation, gender or gender expression, by a respondent, that has the effect of offending, intimidating or humiliating the complainant; (c) implied or expressed promise of reward made to the complainant if they comply with a sexually orientated request; or (implied or expressed threat of reprisal made to, or actual reprisal against, the complainant for refusal to comply with a sexually orientated request.

Looking at these definitions, it is evident that sexual abuse and sexual harassment are interrelated. Living in a technologically advanced world, one finds that there are multiple techniques which predators can use to abuse others and take advantage of them sexually. Over the past few years, a lot of young people have fallen into the trap of sexting (Huddleston, 2016:71), usually due to coercion, and their images then get

leaked on social media and pornographic websites. It can be said that revenge porn should be viewed as a form of sexual abuse which affects large numbers of young people world-wide (Huddleston, 2016:71-72). It was mentioned that this notion of non-consensual image sharing is viewed as image-based sexual abuse (Maddocks, 2018:349; Zauner, 2021:484). Relying on the DVA alone could result in serious gap in understanding and or criminalizing various forms of sexual abuse. Equally so this law is important in the sense that it mentions many behaviours which can be found in sexual abuse scenarios such as physical, emotional, verbal and psychological abuse. Sexual abuse does not function in isolation. Victims usually experience intimidation, harassment and threats from perpetrators. Although elements such as these are not entirely easy to incriminate because evidentiary support is not easily recognizable.

This law is of importance because it takes into consideration the fact that violence has a negative impact on the health and wellbeing of victims. South Africa is one of the countries which has the highest rates of HIV/AIDS in the world (Pantelic *et al.,* 2017:1; Satoh & Boyer, 2019:467; Mofokeng, 2020:29). Therefore, it remains a sad reality that sexual abuse poses an increased risk of HIV infection among victims (Watson, 2015:1; Mofokeng, 2020:54). As a result, Liountris (2020:4) has argued that within the medical community the law tends to put an increased emphasis on HIV reduction as opposed to other health-care aspects and the initial forensic examination. The country is also faced with an increasing rate of teenage pregnancies, with children as young as ten becoming mothers (Baron, 2022:252). It can be argued that a lot of these socio-economic issues are rooted in the fact that South Africa is a violent country which bears the unfortunate title of “rape capital of the world” (Artz *et al.,* 2016:14).

Furthermore, this law acknowledges that violent behaviours pose a threat to the safety of individuals. As a result, one of the core goals of the DVA is to provide victims with “maximum protection” from violent situations (Mathews & Abrahams, 2001:2,7; Fredericks & Sanger, 2014). While this is the aim of this law, it seems like a goal that requires more work for it to be effective. Looking at the state of violence in the country it should be mentioned that maximum protection cannot be reached yet. The basis of this argument stems from the fact that sexual violence is often perpetrated in spaces which are deemed safe such as an individual’s home environment, schools, university residences and health-care facilities (Watson, 2015:3; Langberg, 2020:69-70; Mamabolo *et al.*, 2022:130). Watson (2015:3) and Langberg (2020:241) continued by

stating that perpetrators of sexual offences are often known to their victims. The DVA places emphasis on issuing protection orders as part of tackling violence in the country. Mathews and Abrahams (2001:3) pointed out that there are limitations to obtaining a protection order because it cannot change women's experiences of violence. For many people obtaining a protection order is not possible because they live in the same house as their abusers and have nowhere to go.

2.2.2.2 Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007)

In 2007 the Sexual Offences and Related Matters Act was implemented (Artz *et al.,* 2016:13, 16; Kaldine, 2012:288). This law was put into place to replace some of the common law provisions on sexual offences under the Sexual Offences Act 23 of 1957 (Centre for Applied Legal Studies and Tshwaranang Legal Advocacy Centre, 2017:2). The current law specifically supports the purpose of this study as it acknowledges sexual abuse as a gender-neutral issue which can be perpetrated and experienced by people of all genders (Sonke Gender Justice, 2023; Kaldine, 2012:288; Liountris, 2020:3). A common misconception is that only women are subject to experiencing sexual offences and that perpetrators are males. This statement is supported by the International Commission of Jurists (2015:10) who mentions that often rape is defined from a feminine perspective over the idea that "men cannot be raped". This law fits into the context of this study because it debunks misconceptions such as these and recognizes that so many barriers still need to be broken in research focused on sexual abuse. The author is reminded of a story where a young girl she knows was bullied by her peers and was sexually assaulted by a group of boys and girls simultaneously. This goes on to show that abuse knows no gender and perpetrators could be anyone. Kaldine (2012:288) explained this notion well by stating that "a woman, a man or a child can be raped by a male or a female". Another important factor is that this law strives to address sexual offences amongst children and those battling mentally taking into consideration that such individuals are unable to consent to sexual activity. The Sexual Offences Act (SOA) is important because it defines the legal age of consent within the South African context. Artz *et al.* (2016:17) discussed the view that a child refers to an individual below 18 years of age and as a result statutory rape can occur to children younger than sixteen. In South Africa, the legal age of consent to sexual

activities is sixteen and as a result any sexual activity that occurs among those children younger than sixteen is constituted as rape (Centre for Applied Legal Studies, 2014:11). Children younger than twelve are considered legally incapable of giving consent (Artz *et al.,* 2016:17; Centre for Applied Legal Studies, 2014:11).

Furthermore, this law is inclusive of all sexual crimes and distinguishes between penetrative and non-penetrative sexual offences (Artz *et al.,* 2016:17). It is common for researchers to divide sexual offences within a group of categories; however, this does not undermine the impact that these offences have on people. The most common categorization is that sexual offences are made up of contact (penetrative) and non-contact (non-penetrative) behaviours (Kaldine, 2012:288; Allender, 2008:50-51; Artz *et al.,* 2016:16). The following table provides a summary of what each one of these types of sexual abuse constitutes according to these various studies. However, it is important to mention that the table does not mention every sexual act which exists - it serves as a mere example of how these acts are categorized.

Table 2.1: Examples of penetrative and non-penetrative sexual abuse

Penetrative sexual abuse	Non-penetrative sexual abuse
Genital fondling or penetration, masturbation, oral sex and or coercing individuals to sexually stimulate the perpetrator.	Exhibitionism, voyeurism, sexual harassment, exposing a victim to pornography.

Source: Artz *et al. (*2016:16)

Furthermore, Liountris (2020:3) mentioned that this specific law acknowledges that sexual abuse can constitute behaviours which include inserting objects into the genitals of victims. Although the Sexual Offences and Related Matters Amendment Act provides a comprehensive view of various sexually related crimes, it is important to mention that some offences are harder to prove and prosecute due to their nature. Researchers have stated that this law is designed to provide support to the victim through each stage of the reporting, investigation, and trial processes (Artz *et al.,* 2016:13). With the increasing rates of sexual violence in the country (Mofokeng, 2022:101), the government has implemented sexual offences courts in the hopes to intensify support to victims (Mofokeng, 2020:59). Although this initiative strives to

place attention on victim-support, not all sexual abuse survivors have this opportunity to access them. This is because of the assistance (or lack thereof) that they receive from first responders, who are often the police. The criminal justice system continues to fail them by not providing adequate support to victims, creating further challenges for them. These challenges have played a critical role in the under-reporting of sexual offences in the country (Gordon & Collins, 2013:93; Watson, 2015:6,9; Orchowiski *et al.,* 2020:1-2). Victims often feel that the criminal justice system works against them and is otherwise supportive to perpetrators because those who are victimized are often humiliated by law enforcement officers.

2.2.2.3 Children's Act (No 28 of 2005)

The law always has the best interests of children at heart. This is supported by Hendricks (2014:551) who argued that "the South African Constitution explicitly addresses the rights of children and affords them specific protection". Children are often regarded as vulnerable, and they account for approximately thirty-eight percent of the population rate (Hendricks, 2014:550). This notion of the vulnerability of children stems from the reality that children are not capable of giving consent to matters pertaining to sexuality (Artz *et al.,* 2016:17). According to Artz *et al.* (2016:16) it is stated that the child protection manual defines child sexual abuse as: "Any act or acts, which result in the exploitation of a child or young person, whether with their consent or not, for the purposes of sexual or erotic gratification." This definition shows the reality of what sexual abuse truly is. It is behaviour that is rooted in pleasuring oneself at the expense of another individual.

According to Langberg (2015:275) it is evident that child sexual abuse violates every aspect of a child's life. It is an unfortunate reality that the average age for sexual abuse is "six for girls and ten for boys" (Langberg, 2015:116). This painful truth forces us to acknowledge that children need to be protected. The Children's Act is designed to support and protect children from sexual violence (Artz *et al.,* 2016:17; Hendricks, 2014:551). This specific law if founded on the premise that all authority figures are legally compelled to report all suspected cases of sexual abuse against children (Hendricks, 2014:550). It is required by law that all cases of child sexual abuse cases be reported to the Department of Social Development and should be included in the

Child Protection Register (Artz *et al.,* 2016:16). However, this is not always easy to do because the signs of sexual abuse are sometimes not easy to distinguish. Another difficulty lies in the fact that children do not always disclose their experiences of sexual abuse. Hendricks (2014:550) has stated that the mandatory reporting of child sexual abuse is often received with great difficulty because professionals will often try to protect the integrity of the child. From the perspective of this study, it is argued that authority figures could have reservations when it comes to reporting child sexual abuse because it is not always known how families would respond to abuse being reported without their immediate consent. Some families might resort to accusing health-care professionals or other authority figures of interfering and this could result in strained relationships. A response such as this could arise due to the high level of secrecy which constitutes sexual abuse (Artz *et al.,* 2016:16). Most families hold firmly to the belief that sexual abuse is a family issue and decisions on what actions to take should be a family affair.

2.2.2.4 Criminal Law Forensic Procedures Amendment Act

The aim of the Criminal Law Forensic Procedures Amendment Act is to establish a DNA database which will be utilized to solve and prosecute sexual crimes in the country (Knoetze & Crouse, 2016:40). According to Watson (2015:11) this database contains DNA profiles of arrestees, convicted criminals and of individuals who play an integral part in the investigation. Although the intentions of this law could play a key role in solving crimes, the author argues that there are gaps to this law which need to be addressed. Firstly, the database does not contain the entire population's DNA and not all crimes can be linked to convicted criminals and arrestees. Relying on this database will result in difficulties in solving cases where the perpetrator's DNA is not available on the system. This argument stems from acknowledging that sexual crimes are not always perpetrated by hard-core criminals or strangers in a dark alley (Spies, 2016:390). Instead, many of these crimes tend to be perpetrated by known and trusted people in society (Hendricks, 2014:550; Spies, 2016:390; Watson, 2015:16). Perpetrators of sexual abuse could range from family members, teachers, church leaders, coaches, professors, employers, *etcetera* (Langberg, 2020:69-70) who have no track record of arrests. Furthermore, not all sexual crimes can be solved by the existence of DNA evidence because if their samples do not match with those on the

database, some perpetrators might never be found. Crimes such as sexual harassment might not contain the slightest bit of evidence because of the nature of how the crime was perpetrated. Watson (2015:11) continued by stating that in cases where perpetrators are unknown, approximately three out of one hundred are found and this negatively influences the outcome of most rape cases. Additionally, the usage of a Crime Scene Index (Watson, 2015:11) is not always sufficient because at times a sexual assault will be reported at a later stage and perpetrators could attempt to tamper with evidence.

In cases where sexual abuse was reported later than the 72-hour period, it causes limitations on crimes being solved (Watson, 2015:11). At times evidence becomes corrupted due to victims opting to take a shower prior to reporting the abuse to the police. Another problem which can arise is that DNA evidence can get contaminated because of incorrect methods being used when collecting evidence (Watson, 2015:14). Watson has continued to point out that South Africa has a challenge with police failing to process rape kits and they get lost at times (Watson, 2015:11). Some parts of the country have experienced shortages in rape kits and this negatively influences rape cases (Malema, 2020:23). A common challenge in cases involving children is that DNA evidence is not always found due to semen lasting on average 24 hours (Watson, 2015:16). In some instances, perpetrators resort to using a condom as an attempt to avoid leaving behind any evidence which could be incriminating.

2.2.3 Analysing the effectiveness of South African laws on sexual abuse.

South Africa's constitution prides itself in being one of the best and progressive constitutions in the world (Metz, 2011:550). This is a constitution which is founded on the ethos of democracy where all individuals are meant to be protected from all harm. One of the intentions of the law is to ensure that all people are equal before the law. Within the context of South Africa this notion of equality is not always well reflected. The reason for this argument stems from the belief that the law strives to protect perpetrators over victims. According to Spies (2016:389) it has been established that the judiciary seems to base convictions based on rape as myths and stereotypes. This is a flawed approach for making convictions and one that needs to be addressed with urgency, because not all victims of sexual violence will present with visible injuries or

actual DNA evidence. It is important to state that physical injuries are not the determinant of whether sexual abuse has occurred, but it always causes emotional harm to victims (Spies, 2016:399). Making decisions in alignment with rape myths is discriminatory to victims of sexual violence (Spies, 2016:403). The purpose of the law is to stand with victims of violence and not to find excuses for perpetrators (Spies, 2016:394). Feminist researchers view the law as a patriarchal agenda which further elevates the existing inequalities in the country (Spies, 2016:392). This notion of accepting violent behaviour based on male masculinity is not only practised by the judiciary, but police officers rely on the same belief systems (Spies, 2016:399). Most victims of sexual abuse do not report to the police because they fear condemnation (Spies, 2016:397), bullying tactics, apathy, secondary trauma and lack of respect from police officers (Mathews & Abrahams, 2001:27). Mathews and Abrahams (2001:7) have argued that the criminal justice system portrays an unsympathetic and hostile approach towards victims of sexual abuse due to reluctance to intervene as a direct result of irrational attitudes on rape.

A common problem in South Africa which negatively influences the effectiveness of the law is corruption (Mathews & Abrahams, 2001:26; Jewkes & Abrahams, 2002:1232). At times police officers take bribes to throw dockets away (Jewkes & Abrahams, 2002:1232). This then results to cases not being followed up and issues such as this have led to victims losing faith in the justice system. According to Artz *et al.* (2016:69) it is maintained that South Africa's criminal justice system is not effective. Research studies have demonstrated that the law has failed victims of sexual abuse and it has done little to assist those who find themselves in abusive situations (Artz *et al.,* 2016:13). The shortcomings in the law are supported by the alarming rates of sexual abuse prevalent in the country (Artz *et al.,* 2016:13). However, this is not to say that everything pertaining to the law is negative. The author of this study holds the firm belief that the law, when applied with dignity and fairness, has the potential to bring about positive, impactful and transformational change in solving sexual abuse cases. A non-biased approach to the law could change individual perspectives on the effectiveness of the law in South Africa. The following section looks at some of the myths which society hold regarding rape and will focus on debunking these misconceptions.

2.3 Debunking rape myths in South Africa

Sexual abuse is a taboo subject in society regardless of the high incidence rates in the country. It is an unfortunate reality that sexual abuse is one of those topics that tend to be embedded with a wide array of myths to try and justify its incidence. As a result, it is no surprise that rape myths continue to be common within South Africa. In this section of the study the focus will be on defining the concept “rape myths” as well as analysing and debunking current myths.

2.3.1 Defining rape myths.

Rape myths are viewed as false misconceptions and ideologies that hold a rape victim at fault for their experiences (Watson, 2015:3). Despite the false beliefs that are embedded in these myths, they continue to be widely held in society (Spies, 2016:390). When discussing rape myths, researchers often focus on males as the sole perpetrators and females on the receiving end of the abuse. Within the context of this study, it can be stated that such an approach is inconsistent, considering that sexual abuse can be experienced by anyone regardless of gender. This argument is supported by Daigneault *et al.* (2009:639) who maintain that there is an increased risk for sexual victimization for both men and women. It is for this reason that debunking rape myths is crucial. The author holds firm to the belief that sexual abuse is not a female issue, it is a human issue because no-one is immune to the effects that sexual abuse has on individuals and on society at large.

Research has pointed out that rape myths are complex in nature (Liountris, 2020:1). This complexity could be tied to these myths being accepted irrespective of their root in reinforcing the perpetration of violent behaviour towards women (Spies, 2016:390). The concept can also be defined as a form of justification of male sexual aggression towards their female counterparts. This is supported by a statement made by Spies (2016:391) which acknowledges rape myths as “a form of patriarchal control that legitimizes women’s subordination in the criminal justice system”. The author argues that this viewpoint is accurate because as stated above the essence of rape myths seems to have a patriarchal agenda where women are faulted for their experiences and excuses are made for male perpetrators (Spies, 2016:394). However, this is a narrow-minded approach because both victims and perpetrators can come from any gender.

2.3.2 Analysing and debunking current rape myths.

Research states that rape myths are deeply ingrained in our society (Spies, 2016:391, 404). They shape the perspectives and views of individuals on what a true rape is expected to look like. The problem with these myths is that they are flawed beliefs of what rape truly looks like. An important factor that should be noted is that every rape is different, the experiences of individuals differ and these myths are built to limit the notion that rape will be experienced differently by individuals. As a society, our duty is not to put the experiences of people in a box, but to embrace the uniqueness of individual experiences. In this section, rape myths will be analysed from the perspective of both society and victims.

2.3.2.1 Common societal rape myths

Rape myths are often looked at from the perspective of what constitutes a “real rape”. The concept of “real rape” was established by Susan Estrich, who hypothesized that an action qualifies as rape only when it involves penile-vaginal penetration and results in victims being incredibly upset by the ordeal (Orchowski et al., 2020:8). Such an approach is limited because as mentioned before sexual abuse is a broad and complex concept which is not linear and it is one that looks different for all individuals. This real rape paradigm is based on the belief that a behaviour qualifies as rape only if it has been perpetrated “by a stranger in the alleyway” and involves an excessive amount of violence which a woman is unable to protect herself from (Spies, 2016:390; Liountris, 2020:9). Such a perspective is limited because, as mentioned multiple times in this study, it is common for perpetrators to be known to their victims. Liountris (2020:9) supported this statement and stated that the notion of what constitutes a “real rape” is a narrow-minded perspective which is often influenced by culture. According to a study by Artz *et al.* (2016:11) it is estimated that 11.3 percent of the young people who were surveyed in their study reported to have been abused by known individuals throughout their lives. Approximately eighty percent of perpetrators are known to their victims (Bromley, 2007:10; Louw & Louw, 2020:409). According to Naidoo (2013:210) approximately 21% of perpetrators are relatives and 33% are teachers. These numbers are staggering and are a cause for concern. It is equally true that what these

statistics teach us is that it is imperative for society to start moving away from stereotypical beliefs of who perpetrators can be. It has been previously mentioned that abusers can be anyone, and they can come from different backgrounds. Furthermore, not all rape cases will include physical violence or evidence of violence, but the act of rape itself should be viewed as violent regardless of whether victims present with injuries or not. Perpetrators of sexual abuse will not always use excessive violence, because there are situations where victims are sexually abused from an intoxicated or drug-induced state. In cases such as these, victims are often unaware of the injustice being perpetrated against them. In cases of child-on-child sexual abuse, the behaviour might be made to look as innocent and can be depicted as “a game” and as a result, violence then does not become so prevalent. In cases where a perpetrator sexually abuses a victim at gunpoint, it can be easy for victims to easily give in over fears of being hurt by their abusers. While the “real rape” approach explicitly argues that a situation is only categorized as rape when excessive violence was used “to overcome the woman’s resistance” (Spies, 2016:390), other studies have argued that it is not rape if a victim did not fight back (Liountris, 2020:11; Watson, 2015:3). However, victims will not always have the capacity to fight their perpetrators because people have different responses to traumatic events. While some might have the ability to fight others, might resort to freezing, which is an aspect that is often overlooked in society (Orchowski *et al.,* 2020:8).

Liountris (2020:9) further mentioned that rape myths are often grouped into seven different domains. The following figure is a representation of the seven rape myths firmly held by society.

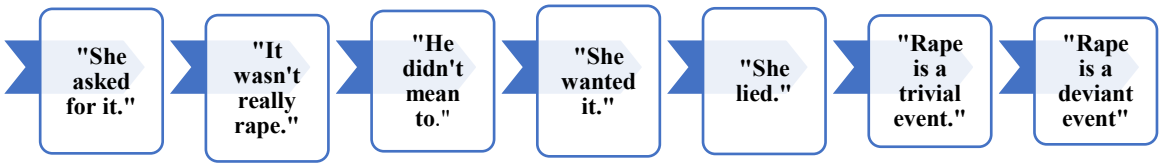

Figure 2.1: The seven domains of rape

Source: Liountris, 2020:9-10; Stubbs-Richardson, 2018:92

The Figure above is not only representative of the common myths associated with rape, but it also represents the view that rape myths are well-known for blaming victims and making excuses for the perpetrators of sexual abuse. These myths paint a

misguided image of victims because no-one ever asks to be sexually abused. Stating that someone asked for it is to presume that consent was given, yet this is inaccurate as sexual abuse does not involve consent. Myths such as “he didn’t mean to” or “boys will be boys” are incredibly concerning because they send a flawed message that the sexual desires of men are superior to those of women (Langberg, 2020:30). In the perspective of this study, it is believed that gender should not be used to justify behaviour and it should never be grounds for taking advantage of others. Myths such as these are doorways to gender inequality and unequal power relations. Furthermore, a myth such as “boys will be boys” supports the false ideology that males are incapable of becoming victims of sexual abuse (Liountris, 2020:3).

In 2008 a twenty-five-year-old woman was raped by a group of taxi drivers at a Johannesburg taxi rank because she was wearing a miniskirt (Kwenaite & van Heerden, 2011:142). Another case is that of a woman who was sexually assaulted by four men for wearing trousers in Umlazi where women were banned from wearing trousers (Kwenaite & van Heerden, 2011:142). To argue that someone asked to be raped because of the clothing they wore is atrocious. The clothing a victim wears should never be a deciding factor of whether someone should be sexually abused. The author argues that clothing is not consent; intoxication is not consent and those who find themselves in unlikely positions should instead be protected.

Viewpoints like these from the perspective of the author can be regarded as a form of gaslighting of victims. The reason for this line of argumentation is because blame-shifting is at the root of most rape myths and they make victims seem problematic, while perpetrators are painted as figures of perfection (Oparinde & Matsha, 2021:6). To argue that something “wasn’t really rape” seems to undermine the experiences and pain of another individual. Furthermore, it is the belief of the author that society does not have the authority to decide whether an experience counts as rape or not. The moment a sexual encounter seems inappropriate or makes an individual uncomfortable it can be regarded as abuse. It is appalling that one of the commonly held myths are based on victims lying about their experiences. However, within the context of this study, it is noted that the period it takes a victim to disclose abuse is not the final determinant of the legitimacy of their disclosure. It cannot be assumed that someone lied because they took time to disclose or report the abuse. Research has shown that only a small fraction of reported rapes is false allegations accounting to 2.1

to 10.3 percent of all reported cases (Orchowiski *et al.,* 2020:16). To make assumptions that a victim lied about sexual abuse is discriminatory and stereotypical. A study conducted by Liountris (2020:13) found that rape myths such as “she asked for it”; “he didn’t mean to”; “it wasn’t rape” and “she lied” form part of the Illinois Rape Myth Acceptance Scale (IRMAS) and these are the myths society seemed to be the most accepting of. This is an unfortunate circumstance because it builds a society that supports a rape culture and for as long as people hold on to these ideologies it will be difficult to reduce rape in South Africa.

The rape myth acceptance (RMA) theory is another indicator of the problematic rape epidemic and acceptance rates in society (Liountris, 2020:11). Lerner’s just world belief (JWB) theory proposes the following:

> The world is just and fair, and that good and bad things happen to people who deserve it. It implies that individuals have many choices in any given situation, and therefore if something negative happens to an individual, the fault lies with them because of their bad choices or behaviour.

The author of this study disagrees with this theory. Firstly, the world we live in is not just and fair, because we live in a world where justice and fairness are not always present. If fairness were a factor in this world, then challenges such as victim-blaming would not be present. Perpetrators of sexual crimes would be brought to book without the judiciary or society at large making excuses for them at the expense of the victims. The truth is that this world is a broken world, and this is confirmed in John 16:33 where Jesus told the believers that there will be trouble in this world, but He encouraged them to take heart as He had overcome the world. Secondly, while as individuals our hope is to experience only good things, we are all prone to experiencing bad and difficult things in this lifetime. No one is deserving of injustice and difficult experiences. This hypothesis undermines the true nature and impact of sexual abuse on victims. Sexual abuse is not always the direct result of bad choices, and it is imperative to state that making a bad choice does not give anyone the right to take advantage of others. For example, to fault a rape victim for rape because they were drunk is to support a culture of entitlement and to overlook the very essence of grace. Furthermore, taking advantage of someone based on their vulnerability proves the point that perpetrators of sexual abuse prey on vulnerability. It is interesting that rape myths always fault the

victim, but they never find fault with the perpetrator. The following section will examine rape myths from the perspective of victims.

2.3.2.2 Rape myths from the perspective of victims

Victims of sexual abuse often hold on to myths and misconceptions about their abuse. While a lot of these myths occur as a direct result of the flawed beliefs held by society, many of them are influenced by shame (Bromley, 2007:33-34; Bowley, 2012:83). The voice of shame is one that tells victims that they are at fault for what happened to them (Bromley, 2007:25,33). It can therefore be established that victim-blaming is a two-way struggle which can be imposed by society or by oneself.

Some of the common myths that victims believe about sexual abuse according to Bromley (2007:27-33) are as follows:

> "I could have stopped it."
>
> "I wanted it; I'm responsible for my family's happiness."
>
> "I'm afraid nobody will believe me; I'm afraid something worse will happen."
>
> "I'm afraid something bad will happen to my abuser."
>
> "I was still so ashamed, and I though everyone would think it was my fault and wouldn't like me anymore."

These myths tend to have a debilitating effect on victims. However, it is important to mention that sexual abuse occurs outside the victims' control and there is nothing that could have been done to stop the abuse from happening. As mentioned above, no-one ever asks to be abused or even desires to be abused and as a result the victims should not be faulted for their experiences. Equally so, victims are not to be deemed responsible for their families' happiness at the expense of their own personal well-being. Bowley (2012:83) further identified more myths which comprised the following beliefs from victims of sexual abuse:

> "I didn't say no loudly or firmly enough."
>
> "I didn't resist or fight hard enough."
>
> "I didn't scream."
>
> "I didn't get up and run out of the room as soon as he walked in."
>
> "I never told my mom. If I had, maybe she would have made it stop."

Although most of these lies are based on societal expectations of desirable reactions, it is likely that the abuse would still have occurred no matter how loudly a victim screamed or how hard they fought and tried to resist. At times it is impossible to run away from a situation or to reach out for help quickly enough. To debunk these myths, victims of sexual abuse need to be pointed to the truth that is found in Jesus Christ because where there is truth there is freedom. This statement is supported by 2 Corinthians 3:17 which says that “Where the Spirit of the Lord is there is freedom”. John 8:32 is supportive of this as it states that “Then you will know the truth, and the truth will set you free”. By intentionally walking in the truth of Christ and rejecting the lies of the enemy those who have experienced sexual abuse can begin to find wholeness in Christ, understanding full-well that sexual abuse does not define the course of their lives.

2.3.3 The role of social media in encouraging rape myths

Social media plays a pivotal role in society today (Stubbs-Richardson *et al.,* 2018:90). It is a space which allows individuals the freedom to freely express their views and to become influencers within the digital world (Tsugawa & Ohsaki, 2015:151). As a result, the language used on social media indirectly influences behaviour, perspectives and attitudes relating to everyday life experiences. This statement is supported by Oparinde and Matsha (2021:2):

> Language has the potential to unite, but also to divide. Language possesses the power to influence through the ways it shapes and is shaped by society. Language is central to human understanding.

The author of this study agrees with this statement by Oparinde and Matsha. The reason for this is based on evidence from other research studies which have shown the power held by the words spoken on social media. An example of this is a post made by the South African Government on Twitter which said:

> Violence and abuse against women have no place in our society. Govt[4] is calling on women to speak out and not allow themselves to be victims by keeping quiet. Women who speak out can act, effect change and help others” (Oparinde & Matsha, 2021:6).

[4] Govt. refers to Government.

Although the original intention of this post was intended to stand in solidarity with victims of sexual abuse, the wording of this post poses problems as it leans more towards victim blaming and shaming those who choose silence over speaking out. This post blatantly undermines the reasons behind victims choosing to remain quiet about the injustice they have experienced. While this post focused solely on women as victims, the author of this study would like to reiterate that silence about sexual abuse is evident across all genders. This statement is supported by Orchowiski *et al.* (2020:2) who mentioned that only a few men speak out about their experiences of sexual abuse. It can be said that males are more likely to remain silent about abuse because of false societal beliefs that "men are incapable of being raped" (Liountris, 2020:3). For all victims of sexual abuse, silence on the issue is usually related to the stigma that is attached to it and the low prosecution rates of sexual crimes (Oparinde & Matsha, 2021:6). The author holds firm to the belief that for rape myths to be debunked it is essential to eradicate all forms of stereotypical language and myths in governmental institutions, in the courtroom and in society at large.

Stubbs-Richardson *et al.* (2018:90) indicated that social media posts that resorted to victim blaming were more likely to gain more audience support as opposed to those which supported victims of sexual crimes. This is mostly because of the rape culture which is prevalent on social media. In their study *'Tweeting rape culture: Examining portrayals of victim blaming in discussions of sexual assault cases on Twitter'* Stubbs-Richardson *et al*. (2018:102) went on to explore whether victim-blaming or victim supporting tweets carry a more influential societal impact. The following results were found:

Table 2.2: Victim-blaming and victim-supporting tweets between 3 April 2013 to 10 May 2013

	Victim blaming	Victim supporting	Total
Date			
3 April 2013	121(67.6%)	58(32.4%)	179(100%)
10 April 2013	73(41.5%)	103(58.5%)	176(100%)

25 April 2013	115(62.8%)	68(37.2%)	183(100%)
10 May 2013	35(53.8%)	30(46.2%)	65(100%)
Total	**344(100%)**	**259(100%)**	**603(100%)**

Stubbs-Richardson *et al.,* (2018:102).

Based on the table above, it is clear that victim blaming tweets are regarded as more influential as opposed to victim-supporting tweets. Furthermore, it has been noted that twitter accounts which engage in victim blaming are prone to gaining more followers who in turn retweet posts from these accounts (Stubbs-Richardson *et al.,* 2018:102-103). This is a cause for concern, because it is indicative of the fact that rape myths are universally accepted in society today and social media plays a key role in spreading negative messages which shame those who have experienced sexual abuse. According to Tsugawa and Ohsaki (2015:151) it has been found that negative messages on social media are prone to spread more quickly than those which have positive connotations. However, when social media users resort to changing their narratives and spreading more positive messages, it could ignite transformative change in society. For rape myths to be debunked, it will be essential for RMA to be reduced as this has a harmful effect to victims of sexual abuse and the larger society (Stubbs-Richardson *et al.,* 2018:105). Stubbs-Richardson *et al*. (2018:105) further state that additional work is required to amplify efforts aimed at reducing the acceptance of rape myths in society. The next session focuses on discussing the problems posed by rape myths.

2.3.4 The problem with rape myths

Rape myths are viewed as a problematic part of society (Liountris, 2020:8; Stubbs-Richardson *et al.,* 2018:99). The author of this study agrees with this viewpoint because research has shown that rape myths tend to be very gendered in their approach (Watson, 2015:3). As a result, this gendered approach fails to recognize men as potential victims of sexual abuse and women as potential perpetrators. One of the key problems of rape myths is that they intensify the notion of victim-blaming and shaming. This is an issue because victim-blaming serves as a form of bullying to

those who have experienced abuse and it often has detrimental effects on affected individuals (Stubbs-Richardson *et al.,* 2018:93). An example of this as shown by Stubbs-Richardson *et al.* (2018:100) involves the story of a young girl who committed suicide when her rape resulted in online victimization. It can be argued that the culture of victimizing individuals in media or social media outlets reflects the toxicity of our world and this plays a critical role in increasing rape culture. According to Langberg (2020:29), it is said that we live in a society that thrives on blaming individuals despite their woundedness. This is a way of living that needs to be rectified. Winning the fight against sexual abuse will not be possible for as long as victims are blamed for their experiences. The fight should never be against those who are persecuted, but it should be against those who are persecutors of innocent people. It is the victims of sexual abuse who require support and it is essential to break the toxic cycle of protecting the perpetrators of these senseless crimes against humanity. Resorting to victim-blaming teaches individuals that they are responsible for their experiences (Stubbs-Richardson *et al.,* 2018:99) and this is a flawed lesson, because sexual abuse is never the fault of a victim.

Furthermore, Watson (2015:3) continues to mention that “rape myths stem from deeply embedded views about the role of women and women’s sexuality in relation to that of men in a society”. Based on this statement from Watson, it remains a fact that patriarchal beliefs remain central to all rape myths (Spies, 2016:391). This link to patriarchy is especially not surprising when evaluating sexual abuse within the context of South Africa (Mathews & Abrahams, 2001:7; Moffett, 2006:132). The basis of this argument stems from acknowledging that SA has a very strongly patriarchal society where sexist views on sexuality continue to be rampant (Mamabolo *et al.,* 2022:131). This is no surprise since in most African cultures, women are taught to be submissive to their male counterparts (Mathews & Abrahams, 2001:7; Mofokeng, 2022:66). The author of this study argues that teachings on submission can often be misguided and misinterpreted, because the sexuality of women should be respected as much as that of males. Cultural perspectives on submission only intensify the nature and extent of rape myths in South Africa.

2.4 South Africa as the rape capital of the world

As previously mentioned, South Africa is known as the rape capital of the world (Artz & Smythe, 2007:13; Gordon & Collins, 2013:93; Jewkes & Abrahams, 2002:1231; Jewkes *et al.,* 2010:23; Mamabolo *et al.,* 2022:121; Woodbridge & Joubert, 2018:106). Research attests to the staggering rates of sexual abuse which SA continues to grapple with (Naidoo, 2013:210). Naidoo (2013:210) estimated that an individual gets raped every 35 seconds, while another researcher has estimated that rape occurs every 17 seconds in SA (Woodbridge & Joubert, 2018:107). According to Woodbridge and Joubert (2018:107) it is suggested that SA experiences approximately 900 000 rape-related cases annually. Although this number is preposterously high, it is a known fact that it does not reflect the complete picture of rape in the country due to cases which go unreported (Jewkes et al., 2010:23). According to Naidoo (2013:210), it is shown that one in twenty rape cases are reported to the police. This statistic by Naidoo reflects a serious gap which exists in terms of having a full understanding of the actual number of rapes which are encountered by individuals daily. It can therefore be argued that the known statistics only reflect the tip of the iceberg (Mathews & Abrahams, 2001:6, 7; Jewkes & Abrahams, 2002:1231).

However, despite the known statistics on sexual abuse, naming South Africa as the rape capital raises questions based on the reliability and validity of this title. This is supported by researchers such as Artz *et al.* (2016:14) and Jewkes *et al.* (2010:23) who have mentioned that within the South African context it is difficult to validate this title because the possibility of global statistics being inaccurate is high. The author agrees with this statement because the shame and stigma surrounding sexual abuse is universal and it fuels the high rates of under-reporting within the global community, thus making the “true rates of rape perpetration” unknown (Jewkes *et al*., 2010:23). Social media interactions have reflected this notion of under-reporting through women who first shared their stories on these platforms. An example of this is that of threads such as #BeenRapedNeverReported (Stubbs-Richardson, 2018:94), #WhyIDidntReport and #MeToo which went viral on Twitter where women not only shared their stories, but they also shared their reasons for not reporting (Hosterman, 2018:69; Reinhard, 2019:1046; Garrio et al., 2020:2-3; Xue *et al.,* 2023; Ferzan, 2021:1; Monaco, 2020:9). Furthermore, the inconsistency of naming South Africa the rape capital of the world lies in the fact that countries such as India (Patil &

Purkayastha, 2017:15) and the Democratic Republic of Congo (Bolseth, 2013:9; Lewis, 2021:55) have been given the same status. It is suggested that the idea behind naming certain countries as “rape capitals” could simply be a way to reflect the bad reputation held in those countries regarding high rates of sexual abuse (Bolseth, 2013:46).

2.5 Sexual abuse as a human rights violation

When discussing sexual abuse, human rights is a topic which cannot be ignored. It is vital to first give an overview of what human rights are. Human rights are defined as ethical and moral norms which citizens are meant to live by and enjoy (Greer, 2018:300; Metz, 2011:541). Odinye (2018:65) gave a further definition which states that fundamental human rights are inalienable, and all people are entitled to these simply because they are human. Odinye (2018:65) went on to discuss that these rights are put in place as part of an attempt to restrain acts of violence, marginalization and impunity. These rights are designed to enhance the well-being of individuals and to foster a society where all people live in peace and harmony with one another (Metz, 2011:541). In the context of South Africa, the Bill of Rights which forms part of Chapter 2 of the Constitution is the formal document in which the rights of all citizens are defined (Constitutional Court of South Africa, 2017). These rights are extended to all individuals irrespective of gender, sexuality, religion or socio-economic background and they are meant to be upheld by all people (Parliament of the Republic of South Africa, 2023). This statement shows that every citizen is meant to be treated equally. Furthermore, these rights ought to be respected, protected, promoted, and always fulfilled by both the state and members of society (Centre for Applied Legal Studies, 2014:10). Although these viewpoints on human rights are well-defined, the fact of the matter as seen by the content of this chapter is that individuals do not uphold these rights. People tend to violate these rights through engaging in behaviours which deprive others of their fundamental human rights. The following quote by Odinye (2018:65) supports this statement:

> Human rights violations can occur when individuals in a given cultural milieu abuse or deny others their basic human rights which might be social, political, personal, cultural and civil in nature.

It is for this reason that within the context of this study sexual abuse is acknowledged as a violation of fundamental human rights (Odinye, 2018:63; Misra, 2019:3). Human rights violations are not only degrading, but they are dishonouring to others (Metz, 2011:542,545). They undermine the notion of freedom which is a central element in which human rights are founded. This notion of freedom is supported by Vorster (2017:11) who maintains that human rights are rooted in freedom, justice and peace. However, freedom, justice and peace are not always something which victims of sexual abuse enjoy. In the next section, focus will be placed on exploring the way freedom is violated because of sexual abuse.

2.5.1 Exploring the violation of freedom because of sexual abuse.

As mentioned above, that human rights violations undermine the notion of freedom, in this section the author will discuss sexual abuse as a violation of freedom (Misra, 2019:3). Before going further and discussing how this freedom is violated, it is important to first ask the question "What is freedom?" In her Master of Theology dissertation titled *"A pastoral study on gender-based violence and femicide in South Africa",* Mofokeng (2022:24) describes freedom as living in a world where one can express themselves without being limited to fear. Yet in South Africa living in freedom and harmony as a country seems to be a distant dream as crime runs rampant in most parts of the country which inflicts a sense of fear in the lives of individuals (Mofokeng, 2022:24). As a result, sexual abuse can be described as a violation of freedom and the human rights of people. At this point a question which can be asked is "Which rights or freedom is being violated by sexual abuse?" This can be a very broad question to ask as sexual abuse as a concept is not only broad, but it can occur in multiple spaces. For example, for those individuals who fall prey to sexual abuse at schools, university settings or work it means that it violates their rights to study and work in safe environments. To respond to this question based on the bill of rights it can be said that there are multiple human rights which are threatened by sexual abuse. These violations will be discussed below.

2.5.1.1 Freedom of movement

Article 13 of the declaration of human rights stipulates that all people “have the right to freedom of movement and residence” (Vorster, 2004:10). This is supported by the South African Bill of rights which also goes further to state that the right to freedom of movement also means that individuals are entitled to “remain and reside anywhere in the Republic” (The Constitution of the Republic of South Africa, 1996:8). This gives evidentiary support that the right to movement is a right that is held both locally and globally. The author of this study believes that the essence of the right to movement is focused on giving citizens the right to move within the state without fear of harm. However, with the high risk of violence in the country, this right is violated daily. This results in people experiencing increased fear regarding their safety (Singh & Zondi, 2020:14). The question at hand at this point is how freedom of movement is violated? To answer this question, it would be beneficial to begin with the author’s perspective on how she personally feels unsafe to walk alone in the streets due to unhealthy forms of behaviour that she has encountered on the streets which made her feel objectified as a woman. Some of the stories which support the notion of safety being constantly violated within the context of South Africa are:

- The story of the young girl who was raped in a toilet at a restaurant (Geldenhuys, 2020:58).
- Over the years there have been countless reports of children who have fallen prey to sexual violation within the confines of school premises that have flooded the media (Kaldine, 2012:286; Prinsloo, 2006:305; Centre for Applied Legal Studies, 2014:3). Bhana (2018:217) agrees that school sexual abuse continues to be problematic in South Africa. On this note the author is reminded of a more personal story of a young girl who experienced sexual assault daily in the school transport by a group of school children. A story like this is mentioned in the book *Beggar’s daughter,* where the author shared a story of sexual abuse which took place in the school bus (Harris, 2016:20). Another similar story the author of this study can think of is one which occurred to her in a taxi when another scholar sexually assaulted her during the taxi ride.
- There are a lot of stories of students who have become victims of sexual violence within the confines of their campuses and university residences where perpetrators often range from students to lecturers (Kaldine, 2012:286).

- Another common incidence of sexual abuse involves cases which occur in church settings where pastors are often implicated as the sole perpetrators. An example of this was discussed by Buchhandler-Raphael (2011:218), who mentioned a story of a pastor who resorted to manipulation, coercion, deception and fraud to lure young boys into sexual abuse situations. South Africa has a lot of stories of pastors who take advantage of young men and women. Practices such as these are mostly common among the more unconventional churches which exist across the country. However, this is not to say that it does not happen in any other church settings.

While the points above are grounds to support an argument that the places in society which are supposed to be safe are no longer safe, a contradictory fact to this is that safety is no longer restricted to movement. People are also not necessarily safe even in their own homes. A lot of young people are faced with the sad reality of living in the same houses as their perpetrators. For others, homes get broken into, which places them at the risk of getting raped. Kaldine (2012:286) supports this by mentioning that people experience violation in a wide array of spaces including their homes, neighbourhoods, public spaces and on the streets. Bromley (2007:9) has added to this by saying that sexual abuse tends to take place in places where we least expect it. The author agrees with this, as she remembers a time where a visit to the doctor resulted in unpleasant groping and it was very uncomfortable for her.

2.5.1.2 Freedom of speech

The Constitution states that all individuals have the right to freedom of expression *(The Constitution of the Republic of South Africa*, 1996:7). This notion of freedom of expression is reiterated by the *Universal Declaration of Human Rights* (Odinye, 2018:65) and it states that:

> Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers (Vorster, 2004:11).

Howard (2019:94) went on to discuss that freedom of speech is an important value. Looking at this specific human right, the author of this study stands by the belief that even when it comes to issues pertaining to sexuality, individuals have the right to make decisions over their own sexuality. What is meant by this is that all people are allowed to freely express when they feel uncomfortable by a certain sexual situation. However, the flawed belief that comes with sexual abuse is that individuals do not necessarily have a say over their own bodies. We live in a society which assumes that women for example do not have a say over their own sexuality. Gordon and Collins (2013:99) reiterate this well by stating the following:

> In South Africa women are told: "you better make yourself seem safe in order to be safe – stay at home, participate in the cult of femininity, give in to unwanted sexual advances, surrender many choices, make yourself as small, quiet and invisible as possible.

Sexual abuse often leaves victims feeling small and powerless, regardless of their gender. Many victims, both male and female, continue to carry the weight of shame on their shoulders because of past sexual abuse. Shame silences them and makes individuals feel like they have lost their voices. Gordon and Collins (2013:101) have described this silence as a root of the notion that sexuality is often viewed as a "private and personal matter that should not be articulated in public, and that the female sexual experience is shameful, even when it is not chosen". Furthermore, it has been found that silence plays a pivotal role in delaying the healing process by causing victims to continue experiencing feelings of hurt, shame and guilt (Bromley, 2007:37). The author of this study believes that this notion of silence can also be further influenced by cultural expectations. There are moments when young people who are victimised by people who are close to the family are encouraged to keep quiet about the abuse. In many of these instances, children are expected to forgive perpetrators and not report the abuse to the authorities. Another commonality is that those who were made to marry at young ages do not have a voice to consent to sexual experiences and as a result it puts young girls at an increased risk of sexual violence (Irani & Roudsari, 2018:1586). It has been found that in the case of child marriages, children are forced to drop out of school and take on responsibilities, such as becoming wives and mothers at very tender ages (Raj, 2010:931; Irani & Roudsari, 2018:1586). In the case of child marriages, it is essential to take note that patriarchy and abuse of power cannot

be overlooked in these situations. Children are obliged to be obedient and give in to the demands of those they have been given to in marriage. The notion of child marriages can also be linked to statutory rape as children do not always have the choice to consent to the idea of marriage in the first place, and secondly to matters of sexuality.

2.5.1.3 Bodily autonomy and integrity

The Bill of Rights stipulates that all individuals have the right to "bodily and psychological integrity" (*Constitution of the Republic of South Africa*, 1996:6). According to Sanger (2010:6), this right has various meanings embedded within it such as:

- All individuals deserve to have their bodies respected.
- No one has control or power over the body of another person.
- All people are supposed to feel safe and protected from all forms of harm.

Although these rights are well intended, the limitation that comes with them is that as citizens we sometimes fail to acknowledge the responsibility that comes with these rights. Sexual abuse completely contradicts the message brought about by the Bill of rights in the sense that it is rooted in lack of respect for others; it is rooted in perpetrators having flawed beliefs that they can control other people's bodies and it not only inflicts harm on people, but it also takes away the notion of safety from people as discussed earlier in this thesis.

Buchhandler-Raphael (2011:293) specifically made use of the word *autonomy* which the *Merriam-Webster Online Dictionary* defines as "self-directing" freedom and especially moral independence. Researchers tend to view autonomy in relation to sexual abuse from the perspective of consent (Pugh, 2020;1; Varkey, 2021:17) and this is making me wonder whether viewing autonomy through this lens is sufficient? The reason for this argument stems from taking note that consent is not the all-encompassing response to avoiding sexual abuse from occurring. While consent can be useful in establishing a sense of understanding between two people, it is not always something that is asked for when it comes to matters related to abuse. In a marital relationship, this becomes even trickier because many are prone to believe that sexual relations should come freely in marriage which raises a concern for the author. This

concern is regarding situations of child marriages where young girls are expected to engage in sexual relations with older individuals and they find themselves in situations where they must do as they are told because they are overpowered. Child marriages still occur within the context of South Africa, and this is mostly because of cultural practices (Ngema *et al.,* 2024:61). Children are not always in a space of understanding certain concepts such as consent, but even more, they should never be put in uncomfortable situations such as these. If consent alone was enough, and respect adhered to, then the numbers of sexual abuse instances in the country would be much lower. Alban (2020:119) further elaborated on the meaning of autonomy and defined it as:

> The individual's legal and practical capacity to make and act upon her own choices. mc implies that the individual has her own sense of self, enjoys moral and ethical equality with others and has the rights to participate in moral and ethical decisions regarding not only her own private life but also the life of the community and country. Autonomy also means that women have the legal, moral and personal capacity to make decisions as to where their interests lie, what social roles they value, which of the various identity they choose to emphasize, and which beliefs they hold or principles they emphasize.

This definition was also expanded to viewing autonomy as a form of "self-direction" and places a specific focus on individuals having the capacity to act in accordance with their own motives and values. While this definition is broad, the only limitation it has is that it views autonomy from a female perspective, which is not adequate. All people, regardless of gender or socio-economic status, have the right to autonomy. A violation of autonomy also serves as a violation of integrity. The basis for this argument stems from the belief that sexual abuse violates the integrity of others as it often goes against their own morals, values and even cultural or religious values of sexuality. It is because of this that those who encounter sexual abuse often describe feeling dirty, not only because a violation has been committed against them, but also because they feel that all their moral ground has been defiled by the abuse.

2.6. Sexual abuse as a public health issue

As discussed, many times in this thesis, sexual abuse is complex and as a result, it affects many aspects of people's lives. We cannot discuss the issue of sexual abuse without taking into consideration the dire effect which it has on the health and well-being of individuals. As a result, it is fitting to describe sexual abuse as a public health issue (Mathews & Collin-Vezina, 2016:304). The reason for this distinction is because sexual abuse poses a huge risk for mental health issues, HIV and pregnancy (Mathews & Collin-Vezina, 2016:305). In this section the discussion is specifically directed at discussing the role of sexual abuse in contracting HIV/AIDS and pregnancy among South African youth. Discussions of mental health and eating disorders are included at a later stage in this thesis.

2.6.1 Sexual abuse and HIV/AIDS

South Africa currently struggles with HIV/AIDS as one of the biggest epidemics in the country (*Human Sciences Research Council*, 2023). The numbers of people infected with HIV are staggering. It is a known fact that South Africa has high rates of people infected with HIV/AIDS (Peltzer & Pengpid, 2008:1463). The Human Sciences Research Council (HSRC, 2023) conducted the sixth *South African National HIV Prevalence, Incidence and Behaviour Survey* which presented the reality that there has been a slight decrease in HIV infections in South Africa between 2017 where 7.9 million people were HIV positive, and 2022 where 7.8 million people were infected with HIV. The HSRC further aired the view that HIV prevalence in SA was significantly higher in females as opposed to their male counterparts. The following findings have been recorded by the HSRC:

> The most pronounced differences in HIV prevalence by sex were seen among younger populations which calls for focused interventions. Compared to males of the same age groups, HIV prevalence was approximately two-fold in females aged 15–19 years (5.6% vs. 3% respectively), and 20–24 years (8% vs. 4% respectively), and three-fold higher in females aged 25–29 (20% vs. 6% respectively).

Mabaso *et al.* (2021:1-2) noted that between the years 2008, 2012 and 2017 there has been a significant growth in HIV infection recorded among adolescents between the ages of 10-19, with females constituting a higher likelihood for infections. Taking into

consideration that this study has established that sexual abuse, although it is a gender-neutral issue, is most likely to be perpetrated against females at higher rates than males, it could be one of the defining factors for high infections amongst women. This study does not wish to deviate from other possible underlying causes of HIV which are not sexual abuse related.

However, it should be mentioned that research has shown that there is a definite link between sexual abuse and HIV/AIDS infection in the country (Andersson, 2004:1; Chitando & Chirongoma, 2013:7; Mofokeng, 2022:9) According to Allinder and Fleishman (2019), approximately sixty percent of South African women across various communities in KwaZulu Natal (KZN) have been infected with HIV (Mofokeng, 2022:29). Along with this statistic, it has been mentioned that approximately 4500 individuals find out they have HIV on a weekly basis and a third of young people ranging between the ages of 15-24 fall within this number. This is a serious cause for concern and one which raises questions as to what is going wrong or what needs to be done to change this.

While it might be easy to suggest that an end to sexual abuse should be the first step to drastically reducing HIV/AIDS in the country, it is known that this is not going to happen anytime soon, although it is hope that the author cherishes that one day we will find ourselves living in a violence-free country. The author of this study argues that creating awareness around sexual abuse and the processes that can be introduced after possible abusive situations is essential, especially among the youth. Young people need to be educated on things such as reaching out for medical assistance after a sexual abuse experience and receiving *Post Exposure Prophylaxis* (PEP). Under-reporting could, however, come as a barrier to young people reaching out for help after sexually traumatic experiences and this will then prevent them from gaining access to treatments to avoid possible HIV exposure and unwanted pregnancies (which is discussed in the next section).

2.6.2 Sexual abuse and unwanted pregnancies

Teenage pregnancy is a massive problem that South Africa currently grapples with. In fact, the country is known to have one of the highest teenage pregnancy rates in the world, which is a major cause for concern (Bhana *et al.,* 2010:872; Thobejane, 2015:273). Girls as young as ten years of age are getting pregnant in South Africa

(Barron e*t al.*, 2022:252) and it is an unfortunate reality that these pregnancies have a host of negative implications for these young people. Unwanted pregnancies often carry the risk of mental health issues, abortions, abandoned children and poses a risk to children being neglected by parents. The negative implications of this are that cases of abandonment and neglect can result to a ripple effect of continued abuse among children. According to Chabalala (2021), approximately 70% of teenage pregnancies which have occurred in South Africa during the time of the COVID-19 pandemic were unplanned and unwanted. Chabalala went on to mention an earlier report by *News24* which stated that one in three girls aged between 10 and 19 years in South Africa fell pregnant and did not return to school. Barron e*t al.* (2022:252) responded to this by stating that teenage pregnancies among those in the age group of 10 to 14 years old showed an increase of 48.7 percent between the years 2017 to 2021, but disturbingly this statistic was only based on a sample size of 2726. Baron *et al.* (2022:252) went on to further mention that among those aged 15 to 19 "the number of births increased by 17.9" percent with a sample size of 114329. Furthermore, it was noted that many of these pregnancies were prevalent in the rural parts of South Africa as opposed to the more urban areas such as Gauteng and the Western Cape (Baron *et al.,* 2022:252). This is a serious cause for concern (Mkhwanazi, 2010:347), one which makes the author question what the root causes for these pregnancies are.

Teenage pregnancy is a complex issue as the causation of it is embedded in a wide array of issues ranging from issues such as poverty and gender inequality (Jonas *et al.,* 2016:2). According to Jonas *et al.* (2016:1,3) it has been argued that substance abuse is one of the behaviours which play a role in the high risk of teenage pregnancies. This is a factor that the author agrees with, because substances are mind-altering and not only do they put young people at risk of potentially engaging in sexually risky behaviour, but they can also put young people at risk of finding themselves in vulnerable situations such as sexual abuse. This takes us back to acknowledging that the high rates of gender-based violence which are prevalent in the country are possible contributing factors to some of these pregnancies. This statement is supported by Baron *et al.* (2022:252) who mentioned that these pregnancies reflect on the dire socio-economic circumstances which are inclusive of the "sexual and gender-based violence' which are prevalent in the country. Therefore, within the context of this study, it can be argued that sexual abuse plays a critical role in many

teenage pregnancies reported in the country, especially those involving children as young as ten years of age. Having discussed the legal aspects of how sexual abuse is viewed in the country, it goes without saying that when a ten year-old comes home and she finds herself in a position where she is pregnant, a strong case of statutory rape can be made, taking into consideration that the legal age for sexual consent in South Africa is 16 (Kangaude & Skelton, 2018; Ahinkorah, *et al.,* 2021:4).

Another possible contributing factor to teenage pregnancies and sexual abuse in South Africa is *ukuthwala*, a practice common in rural South Africa, which usually involves children younger than eighteen years getting married to older men (Machaka, 2019:iii, 1). This practice mostly commonly involves arranged marriages which are usually orchestrated by family members (Mofokeng, 2022:27). Kheswa and Hoho (2014:2808) stated that in many of the cases where forced marriages are involved, young people often find themselves in positions where they are vulnerable to abuse of a sexual, emotional and psychological nature. Although what is mentioned in this section is very disturbing, the implications of sexual abuse can also be economical. The following section of this study deals with the economic impact of sexual abuse within the context of South Africa.

2.7 The economic impact of sexual abuse in South Africa

Sexual abuse is not only an issue which has a negative impact on the lives of those who encounter it, but it poses a serious economic threat to the country (Artz *et al.,* 2016:10). The reason for this is because existing resources to try and tackle sexual abuse cost the country huge amounts of money. According to Mathews and Makola (2016:3) the cost of sexual violence is estimated at a value of approximately R28.6 billion. Artz *et al.* (2016:13) reiterated this in the *Optimus Study* where they mentioned a statistic from a 2014 KPMG study which showed that the country spends between R28.4 billion to R42.4 billion on costs related to sexual violence. Fang *et al*. (2017:1) reviewed the economic impact of sexual abuse in relation to the Disability-adjusted life years (DALYs) lost. Firstly, it is important to give a definition of what the concept DALYs refers to. According to Badirzadeh *et al.,* (2017:515) the concept DALYs "is a measure of overall disease burden which is expressed as the number of years lost due to ill-health, disability, or early death". Fang *et al.,* (2017:1) estimated that the

economic cost of DALYs lost because of violence against children costs the country, on average, approximately R173 billion in 2015 which was equivalent to 13.5 billion US dollars at the time and equivalent to 4.3 percent of South Africa's *Gross Domestic Product* (GDP). In relation to sexual abuse, the economic cost of DALYs lost amounted to R28.6 billion (Fang *et al.,* 2016:10). It was further mentioned that an estimated R1.6 billion was spent on child-care in the 2015/2016 financial year (Fang *et al.,* 2017:1). The following table provides a summary of the economic costs of sexual abuse in terms of the estimated amounts spent on childcare provincially:

Table 2.3: Estimated economic cost of childcare and protection nationally in South Africa (Fang *et al.,* 2016:20)

Provinces	**Eastern Cape**	**Free State**	**Western Cape**	**North-West**	**Gauteng**	**KZN**	**Northern Cape**	**Mpumalanga**	**Limpopo**
Estimated costs expended on child-care and protection (2015/2016) in South African Rands	216512	78284	175376	55023	507563	324436	36687	54092	133190

From this table it is evident that the estimated cost of childcare and protection nationally is extremely high. The national cost amounts to an average of R1581163. This leads the author to assume that costs are probably drastically higher in our current day and age. What the author of this study finds interesting in these trends is that as it was discussed earlier in this chapter, the rural parts of South Africa are known to have higher rates of sexual abuse, yet it seems that in some of these areas there were fewer costs expended on childcare and their protection. This then leads the author to questioning whether this occurred because of under-reporting in these areas? Another realization the author of this study occurred when looking at these costs is that the economic burden could get much higher if under-reporting were not a problem -

equally so if corruption and the possible mismanagement of funds did not occur, more individuals would most likely be able to receive adequate care even in areas which can be looked at as under-resourced. The gap in this is that it does not provide the full picture of economic costs, because we do not necessarily know how much of this finance ends up being used to help people and it does not paint a full picture because this study has not yet mentioned the economic cost of sexual abuse in other sectors, such as the health care sector, for example.

If sexual abuse can be tackled, not only will the economic costs be reduced, but it would play an integral role in fostering a healthy society. The UN proposed several goals to try and help establish healthily functioning societies and as a result, the following section deals with sexual abuse as it relates to the sustainable development goals (SDGs).

2.8 Sexual abuse and the UN Sustainable Development Goals

The United Nations Department of Economic and Social Affairs (UN DESA, 2024) has put in place a list of 17 sustainable development goals (SDGs) which most countries globally have set their focus on to achieve by 2030. Mathews and Collin-Vezina (2016:305) described the United Nations (UN) sustainable development goals as “an agenda for global human development efforts from 2015-2030”. The South African government took it upon themselves to play an active role in trying to achieve these goals (Mofokeng, 2022:30). While doing this is a great initiative from South Africa, the author is sitting with questions of whether the country will be able to achieve these goals by the year 2030. Maybe a more realistic approach would be one of making progress in each of the areas the sustainable development goals are trying to address and over time as the fruits of this might be fulfilled. With South Africa being one of the most unequal countries in the world (Makgetla, 2020:4; Francis & Webster, 2019:788) the author argues that more work needs to be done to achieve the sustainable development goals. Systems and strategies need to be put in place to ensure that progress is achieved but first let us look at how the sustainable development goals can serve as a useful tool to combat sexual abuse in the country.

The first goal looks at ending all forms of poverty everywhere (UN, 2023). Poverty serves as one of the fundamental causes of sexual abuse in the country (Banwari,

2011:117; Matta *et al.,* 2014:370). Poverty can come as a cause of those who have been previously sexual abused finding themselves in positions where they cannot cope with tasks related to education which ultimately results in unemployment or because of young people dropping out of school because of teenage pregnancies. Alongside this, research has shown that sexual abuse can result in a loss of productivity (Letourneau *et al.,* 2018:416; Henkhaus, 2022:1967) as people often find themselves in a position where they cannot play an active role in contributing to the economy. This then makes it difficult to fully attain goal 8 which focuses on promoting decent work and economic growth. Research has shown that in rural areas where poverty is usually rife, sexual abuse and gender based violence tends to thrive in places like that (Bob *et al.,* 2019:340). The author argues that this could be because of the high level of substance abuse that is usually present in poverty-stricken areas. We cannot ignore the role that substance usage and addiction play in the perpetration of sexual abuse. Poverty plays a role in leading young people to engage in risky behaviours such as prostitution or engaging in relationships with older men and these behaviours also carry a high risk of rapes and sexual assaults. At the other end of the spectrum there is an issue such as period poverty which typically involves young people not having access to menstrual products. This usually results in young girls staying away from school for the duration of their menstrual cycles which makes a lot of them vulnerable and susceptible to sexual abuse and interruptions to their education.

Goal three of the SDGs focuses on the health and well-being of all people (UN, 2023). To be able to make this goal attainable it is essential to make young people aware of the measures they can take in terms of accessing health-care services should they find themselves in the unfortunate position of encountering a crime like sexual abuse. Along with informing young people about these things, health-care professionals should strive to handle cases relating to sexual abuse with both integrity and care without turning people away without receiving the help they need. While the author is cognizant of the fact that a lot of health-care professionals working in the public sector are usually very burnt out and over-worked, measures should be put in place to ensure that professionalism is instilled at all times otherwise we will have a generation of young people who fear reaching out for help over fears of the type of treatment received in a lot of these public health facilities. This then has a potential ripple effect

of further unwanted pregnancies, an upsurge in STIs and STDs and untreated mental health related issues. Some of these things can potentially be treated and avoided if individuals were to reach out for help and receive the adequate help required within the first 72 hours after a rape.

Gender equality is another goal that the sustainable development goals is looking to achieve (UN, 2023). However, the United Nations has come to the realization that the world is not close to achieving this goal. Instead, it has been stated that it will take approximately 300 years to end child marriages (Cappa *et al.,* 2023). The current estimation is that 1 in 5 young women below the age of 18 are still subjected to child marriages globally (*United Nations Office of The High Commissioner*, 2025) while women continue to lack the autonomy to make their own decisions regarding their sexual and reproductive health (Tayal *et al.,* 2024:2). Not only is this a serious cause for concern, but the notion of gender equality is also one where the author argues that empowerment should not be limited to girls and women, but it is something which should be extended to the boy child as well. Boys need to be informed about sexual abuse and how to react should they be subjected to it, but equally so empowered as not to grow up to be perpetrators of such abuse moving forward. Gender equality should extend to all people, male and female, young and old and should not entirely be focused on females alone. According to Mathews and Collin-Vezina (2016:305) the SDGs have the target “to end abuse and exploitation of children”, to eliminate all forms of violence against women and girls, including sexual exploitation.” While all these are great goals to have, the author of this study holds on to the firm belief that males should never be left out of this topic as there are a lot of men who are silently struggling with the aftermath of sexual abuse.

A question which the author carries with her is: How can the UN Sustainable Development Goals achieve more not only globally, but in the context of our nation South Africa? With this question the author also intends to propose the argument that with addiction and addictive disorders being one of the biggest socio-economic issues we face in the country, it is essential to ensure that we tackle addiction of all kinds as a stepping stone to winning the battle against other socio-economic issues in our country and this is inclusive of winning the battle against sexual abuse and gender-based violence as whole. This ideology stems from the author’s awareness on how aspects such as substance abuse or problematic pornography use can serve as

contributors to the massive sexual abuse problem that continues to exist in the country. This is not to say that such an approach will eliminate socio-economic problems, but it can play a pivotal role in fostering effective change when it comes to reducing social issues such as sexual abuse.

2.9 The extent of sexual abuse in South Africa

As mentioned, multiple times in this chapter, sexual abuse remains one of the greatest concerns in the country today as it continues to be widespread. According to Artz *et al.* (2016:31) it is estimated that approximately 784 967 young people between the ages of 15 and 17 have been subjected to some form of sexual abuse. This is serious cause for concern because estimates continue to suggest that each classroom has approximately twelve children who have been sexually abused and the school bus has approximately twenty children who have experienced some form of sexual abuse (Artz *et al.,* 2016:31). Due to the nature of this study attempting to evaluate sexual abuse from a gender-neutral perspective, the tables below shows results of sexual abuse reporting among both girls and boys in South Africa taking into consideration a school based self-administered questionnaire (SAQ) and a household SAQ.

Table 2.4: School-based SAQ: Comparison of sexual abuse reports among males and females in urban and rural areas (Artz et al., 2016:31)

School-based SAQ

Gender	Sexual abuse reporting in urban areas	Sexual abuse reporting in rural areas
Males	38.8%	31.7%
Females	36.4%	27.2%

Household-based SAQ

Gender	Sexual abuse reporting in urban areas	Sexual abuse reporting in rural areas
Males	24.8%	25.7%
Females	27.2%	28.4%

The findings from the school based SAQ show that males are more likely to report sexual abuse in comparison to their female counterparts. This finding is fundamental because most research studies have indicated that females often experience sexual abuse at higher rates than men and from knowing this, it could be assumed that the reporting rates of females should be higher than males in both the school based and household self-assessment questionnaires. However, there is a significant difference between these SAQs in the sense that in the household, SAQ females are seemingly recorded as the ones who are more likely to report sexual abuse in comparison to males, although the differences are not that high. Another interesting factor in relation to these statistics is that reporting levels in the household SAQ have dropped in comparison the school based SAQ except for the reporting levels of females in rural areas which have increased by an average of 1.2 percent. Looking at these statistics has given the author of this study hope that there are males willing to speak out about their sexual abuse experiences and this is exactly what is needed in society to help change the narrative of sexual abuse being solely a female issue.

As already discussed earlier in this study, sexual abuse is a complex issue, and it involves a wide array of behaviours. As a result, it looks different for everybody. The following set of data is representative of the extent of sexual abuse currently. The data aims to look at the extent of sexual abuse in the county over the past four years.

Table 2.6: Current trends in sexual abuse in South Africa from October 2020 to December 2023 (SAPS, 2023/2024:8).

Types of sexual abuse	2020	2021	2022	2023
Rape	12218	11315	12419	12211
Sexual assault	2390	2069	2154	2114
Attempted sexual offences	625	524	763	773
Contact sexual offences	362	280	209	186
Total	**15595**	**14188**	**15545**	**15284**

Based on the data provided below, it emerges that rape is the most common sexual crime which individuals are most likely to report and contact sexual crimes are the least reported crimes. The data shows that 2020 had the highest number of cases reported, while 2021 had the lowest number of cases. Looking at the cases at provincial level it was found that the Northern Cape constantly had the lowest number of cases reported (SAPS, 2023/2024:145) over a four-year period while Gauteng had the highest number of reported cases over the same time frame (SAPS, 2023/2024:135). Although this data is useful in helping us identify the extent of sexual abuse in the country, it is not representative of the full extent of these crimes as it is only dependent on crimes which got reported to the police. The limitation of this data is also that it does not show differences between gender and the actual ages of the victims. As a result, it is unknown how many young people in these statistics reported sexual abuse of any kind to the police within this time period.

2.10 The impact of sexual abuse on victims

“I feel unworthy”

“I feel dirty”

“I feel ashamed”

“I feel alone”

“I feel unwanted”

“I feel scared”

“I feel numb”

Sexual abuse has adverse and negative consequences for all those who fall victim to it. According to Louw and Louw (2020:409), it is mentioned that “the impact of sexual abuse varies according to several factors” and they went on to argue that these factors are determined by the nature, frequency and duration of the instances of abuse as well as the relationship the victim has with the abuser. The statements above serve as a reflection of the perceptions, beliefs, pain and confusion sexual abuse can cause victims. This study has in many respects touched on the potential ill effects which can be brought about by sexual abuse in terms of health and the risk of pregnancies, but has not touched on the psychological, spiritual and neurological effects which sexual abuse has on victims. The author holds a firm belief that because human beings consist of spirit, soul and bodily dimensions, it is important to address the impact of sexual abuse by focusing on all of these elements. 1 Thessalonians 5:23 reads as follows “May God himself, the God of peace sanctify you through and through. May your whole spirit, soul and body be kept blameless at the coming of our Lord Jesus Christ.” Bromley (2007:85) supports the notion that sexual abuse serves as an assault on the body, soul and spirit dimensions of the victims who encounter it. Understanding sexual abuse and treating sexual abuse requires looking at the matter from a holistic viewpoint. The following sections aim at exploring the impact of sexual abuse upon individuals from a holistic perspective.

2.10.1 Effects of sexual abuse on the body

As mentioned earlier in this study, sexual abuse poses the risk of contracting STDs such as HIV/AIDS as well as teenage pregnancy. Although these are adverse side effects, it is essential to mention that both HIV and teenage pregnancy pose the risk of causing physical complications among young individuals. According to Christofides *et al.* (2014:1) pregnancies among young people are associated with short and long-term consequences which include but are not limited to, anaemia, urinary tract infection and pregnancy induced hypertension.

Inclusive of all these possible physical ailments Christofides *et al.* (2014:1) also mentioned depression as a psychological effect of pregnancy as well as social factors such as substance dependence, an increased risk of hypersexuality and negative consequences to educational achievement.

According to Artz *et al.* (2016:12) sexual abuse carries the risk of injury among individuals. Many of these injuries go untreated and this could be linked to the high prevalence of under-reporting. The following table presents of the likelihood of injuries amongst those who have experienced sexual abuse.

Table 2.7: Percentage of individuals who experienced injuries and sought out medical assistance after sexual abuse (Artz et al., 2016:64)

Type of sexual abuse	**Proportion of those who were injured after sexual abuse**	**Proportion of those who sought out medical assistance after injuries**
Sexual abuse by a known adult.	29.9%	33.3%
Sexual abuse by an unknown adult	13.0%	72.7%
Sexual abuse by a child or teen	10.3%	33.3%

Forced sexual intercourse (actual or attempted)	15.0%	52.6%
Exposure to sexual material	3.6%	33.3%
Sexual harassment	-	-
Sexual experience with an adult	3.1%	22.2%

Looking at the trends above it can be concluded that although individuals are more susceptible to experiencing sexual abuse by a known adult, those who have a higher likelihood of seeking out medical treatment after experiencing injuries are individuals who were abused by adults not directly known to them. It was also interesting to note that there is a similarity between the percentage of individuals willing to seek out medical assistance after injuries caused by sexual abuse with a known adult, sexual abuse with a child or teenager and exposure to sexual materials. The following section will explore the psychological impact of sexual abuse.

2.10.2 The psychological impact of sexual abuse on victims

It is no surprise that sexual abuse often causes victims a wide array of mental health consequences (Artz et al., 2016:63). Cashmore and Shackel (2013:7) have expressed the view that there is a complexity which exists between the interrelation of sexual abuse and physical health problems which can manifest as behavioural, emotional, social and cognitive factors. This is something the author of this study agrees with, because the way sexual abuse affects victims mentally is not a one size fits all. For one person the mental health effects might not be as severe or long-standing as much as it could affect another person. Some of the most common psychological effects of sexual abuse include the development of depression. Research has indicated that early exposure to sexual abuse poses a threat of depression later in life (Mandelli *et al.,* 2015:666). The worst-case scenario of depression would involve the risk of suicidal tendencies where individuals think that taking their own lives is the only way out from their pain (Bromley, 2007:78). According to Artz *et al.* (2016:12) it is estimated that youth who have been sexually abused are twice as likely to develop depression or

anxiety and three times as likely to experience symptoms related to PTSD as opposed to younger people who have not faced sexual abuse. Louw and Louw (2020:409) further explained that many of the symptoms experienced by those who have been sexually abused resemble severe stress.

Alongside this Louw and Louw (2020:409) went to mention that common reactions people experience because of sexual abuse are:

> …fear; anxiety; anger; fatigue; depression; passivity; difficulties in concentrating and withdrawal from usual activities… In later childhood and adolescence; low self-esteem; self-blame; guilt feelings; eating disorders and antisocial behaviours such as drug abuse, delinquency and promiscuous sexual activities are reported frequently.

The fact that Louw and Louw described eating disorders as a symptom of sexual abuse is instrumental, taking into consideration that the core goal of this study is to look at the link between sexual abuse and eating disorders among the young. This link will be looked at in depth at a later stage in this thesis. However, in the meantime it can be mentioned that among those who have been sexually abused, eating disorders potentially serve as a mechanism the victim turns to in his or her attempt to regain control. Bromley (2007:53) describes it in the following way: “Their eating disorder is their attempt to protect themselves by controlling the things they believe led to their abuse or to purge the pain they feel within.” Alongside all of these, feelings of worthless, feeling dirty, hateful towards oneself arise and often these feelings can easily impact spirituality in a sense that victims fail to see themselves the way God sees them. The following section strives to discuss the way spirituality is negatively influenced by sexual abuse.

2.10.3 The spiritual impact of sexual abuse on victims

Alongside the bodily and psychological effects brought about by sexual abuse, victims also experience negative effects of sexual abuse within the spiritual dimension of their beings. Addressing this is important, not only because of the theological focus of this thesis, but this is an area which cannot be ignored. In her book *Hush: Moving from silence to healing after childhood sexual abuse”* Bromley (2007:49) mentioned a lack of trust as one of the effects of sexual abuse. While this lack of trust is usually extended

towards others, it is also a common reaction which victims often extend towards God. This often comes through as blaming God (Bromley, 2007:65) for the abuse that the victim has experienced which ultimately results in spiritual disconnection. Spiritual disconnection often comes in because of feeling as if God did not provide protection during the ordeal. This is supported by Mendoza (2015:68) who had the following to say when sharing her story in her memoir *"When a good God allows rape":*

> The attack of the enemy in my mind was that it was useless to pray because God does not really answer our prayers, or He is not able to protect.

A question the author of this study is constantly asked while navigating her journey is "How could a good and loving God allowing this to happen?" Anger and disappointment towards God are common feelings which come with facing traumatic situations such as sexual abuse. Sexual abuse can distort an individual's perspective of God by painting God as unloving, cruel, uncaring etc. Viewing God from this perspective can also destroy an individual's sense of identity. The author says this because Genesis 1:27 tells us that we have been created in the image of God, but it essentially becomes difficult to know who we are if we are not rooted in Christ. This can then result in individuals asking the common question "Who am I?", constantly placing one's worth in the view that abuse can lead individuals into a spiral of trying to understand their identity, leaving voids in their heart which lead to reactive behaviours where individuals seek out all sorts of behaviours to try to cope with the pain. Yet moving forward without having a firm foundation in Christ is hard. In later chapters this is discussed with the view of showing how a good foundation in Christ can provide a restored sense of hope for those who have been abused.

2.11 Sexual abuse in the church

South Africa is a country which has a large Christian population. This line of argumentation comes from the statistics which show that approximately eighty percent of South Africans are of the Christian faith (Le Roux, 2013:ii). While the statistics of those who proclaim to be Christians is incredibly high, there are a massive number of Christians who do not attend church anymore due to hurts received by the church community. It is an unfortunate reality that for many, sexual abuse became one of the things they were exposed to within the church. This is a space meant to foster hope

and not hopelessness, it is a space meant to build and not to break. The church is meant to be a safe space where believers can commune and have fellowship with each other, yet evil continues to exist within the confines of the church. Sexual abuse is one of those crimes easily kept a secret in the church. When individuals attempt to speak up about it, victims are often silenced and the abuse gets swept under the rug. The following extract. although it is not from a South African denomination, points to an incident of sexual abuse occurring within the context of the church:

> Bishop Long was the senior pastor of a mega-church New Birth Missionary Baptist Church, which consists of thousands of congregants. The victims were all part of the Fellows Youth Academy, a group of teenage boys picked by Long for spiritual mentoring. According to the allegations, Long put the victims on the church's payroll, took them on trips around the world and bought them jewellery, electronics, cars and clothes. In return, the lawsuits allege that Long enticed the victims to engage in various unwanted sexual acts with him. The lawsuits further allege that Long would discuss the Holy Scripture to justify and support the sexual activity. The lawsuits allege that the defendant, through manipulation, coercion, deception and fraud resulting from the abuse of his confidential relationship with plaintiffs, convinced plaintiffs that engaging in sexual relationship was a health component of his spiritual life" (Buchhandler-Raphael, 2011:218).

From the extract above it is evident that sexual abuse within the context of the church is often tied in with over-spiritualising the matter. The problem with this is that the Bible is used as a tool to justify the behaviour and to brainwash victims into giving in to unwanted sexual advances. In the case of Long, it is evident that grooming played a central role in luring the young boys into sexually abusive scenarios. Grooming is a process used by perpetrators to deceive and manipulate individuals into engaging in sexually abusive situations. In her books *Suffering and the heart of God* and *Redeeming Power*, Diane Langberg mentioned that grooming is a process which not only involves giving victims gifts or money (Langberg, 2015:213), but perpetrators also tend to use words to groom victims into giving in to sexual advances (Langberg, 2020:63). Research shows that approximately thirty to forty-five percent of child abusers resort to grooming as one of their methods to coercing victims into abusive situations (Winters *et al.,* 2022:926).

Within the context of South Africa, it remains a fact that the rise in controversial churches has caused the rise in sexual abuse in the church. In many neo-Pentecostal churches women continue to face the risk of abuse within the church community (Banda, 2020:1; Kgatle, 2024:1). Equally, Conway (2014:318), also alleges that sexual abuse accusations run rampant in organized church structures, where staff members are often accused of perpetrating sexual abuse on congregants. This is a cause for concern as the church is meant to be a place of safety, community and worship. When sexual abuse occurs within the church, not only do abusers make use of and misinterpret the Bible to justify their ill behaviour, but the author of this study also believes that it can create an environment where those who are victims not only resent the Bible, but they may also develop false images of God, viewing God as unloving and not caring, among many other things. Sexual abuse in the church tarnishes the image of the church. The church was never meant to be an unsafe space; in fact the church should be a place of hope, where victims of sexual abuse can gain renewed strength. The church is intended to shine the image of Christ onto a broken world.

2.12 Conclusion

The following chapter was written in accordance with Osmer's first task of practical theological interpretation, where the focus is on answering the question "What is going on?" The goal was to gain knowledge on the nature, situations and context which influence sexual abuse in South Africa. This was a central starting point, which will later serve as a guideline to help the author define the interrelation between sexual abuse and eating disorders among South African youth. Being able to gain a deepened knowledge and understanding of this will help the author answer the aim of the study which is focused on designing a pastoral strategy aimed at assisting youth with eating disorders which occur because of sexual abuse.

The author first looked at understanding the complexity of sexual abuse where discussions of exploring the multiple definitions of sexual abuse were held. It is through taking a close look at the various existing definitions of sexual abuse that it was confirmed that there is no *one size fits all* approach in defining sexual abuse. The differences in definitions also play a pivotal role in intensifying the complexity of what constitutes sexual abuse. Definitions can differ within countries, cultures and

communities. The author went on to explore the various laws on sexual abuse put in place in South Africa. She found that South Africa is a country which has a rich constitution; however, even with such a constitution, existing gaps remain. These gaps are inclusive of the fact that in many ways the law seems to protect perpetrators over victims. It was found that in the context of South Africa rape myths and stereotypes are highly regarded and that these myths often play a pivotal role in the justice system when it comes to deciding whether to convict individuals of sexual crimes. Another issue having a negative impact on the conviction rate is corruption, where dockets disappear in an attempt to protect those perpetrating sexual abuse related crimes. The worst thing in all of this is that it carries within it a strong ripple effect of under-reporting as it leads victims to feeling silenced by those in charge of bringing the law into effect.

The second part of the discussion focussed on debunking rape myths in South Africa by taking into consideration that these myths are often used to justify the incidence of rape. It was found that rape myths are highly esteemed in society. The problem with this is that members of this society are the leaders in an environment where victims of rape are scorned and shamed for their experiences, while no blame is put on the perpetrators. At the core of rape myths is the belief that victims are not being honest about their experiences, but research has found that only a small fraction of reported rapes is false. It is a known fact that rape myths pose a problematic effect in society.

Thirdly, a discussion was done on South Africa being the rape capital of the world. From engaging with various forms of literature, it was found that it is difficult to validate this because South Africa is not the only country which has gained this title. It was also discussed that what is currently known on a statistical basis only reflects the tip of the iceberg in relation to understanding the full extent of sexual abuse in South Africa.

This was followed by a discussion of sexual abuse as a human rights violation. In this section, it was discussed that the notions of freedom, justice and peace are aspects which victims of sexual abuse are often deprived of. This deprivation comes in because of violation of rights such as freedom of movement and freedom of speech as well as the violation of bodily autonomy and integrity. Alongside this, it was also discussed that sexual abuse serves as a public health issue which places individuals at risk of contracting STDs such as HIV/AIDS and it poses a risk of unwanted pregnancies. From this study it was also derived that the economic impact of sexual

abuse cannot be ignored. It was found that approximately R28.4 billion to R42.4 billion was spent on costs related to sexual violence in South Africa in the year 2014.

Another discussion which was conducted was that taking strides towards achieving the sustainable development goals as proposed by the United Nations can be instrumental in the attempt to win the fight against sexual abuse. However, it was found that more work needs to be done to reach these goals. The author proposed that taking the initiative to tackle other issues in society such as addiction could be a fundamental starting point to not only effectively achieve these SDGs, but in reducing social issues such as sexual abuse.

The extent of sexual abuse in the country was discussed. In this section it was not only once again confirmed that sexual abuse is such a widespread problem, but it was also confirmed that both males and females are affected by abuse. It was found that in relation to other forms of sexual abuse, rape is often the most reported sexual crime in South Africa and approximately 784 967 young people between the ages of 15 and 17 have confessed to having been subjected to some form of sexual abuse. However, it was also found that we cannot fully know the extent of sexual abuse as the statistics provided by the South African Police services only give a guideline of sexual abuse based on the number of reported cases. This leaves behind a massive gap as many sexual abuse cases go unreported. Another gap by statistics provided by SAPS is that they do not paint a picture of how many of these cases are reported by South African youth.

It was found that sexual abuse affects individuals from a holistic perspective. The abuse not only affects individuals within their bodily dimensions, but it also imposes psychological and spiritual effects on individuals. Lastly, the role of sexual abuse in the church was discussed. In this section it was found that in cases where sexual abuse occurs in the church it is not uncommon for ministers who perpetrate these acts to resort to misinterpreting the Bible in the attempt to manipulate and coerce individuals into giving in to sexually abusive situations.

The following chapter strives to continue to answer the descriptive empirical task of Osmer with a specific focus on eating disorders in South Africa.

CHAPTER 3: DESCRIPTIVE STUDY OF EATING DISORDERS IN SOUTH AFRICA

3.1 Introduction

> I looked at myself in the mirror and for most part felt unworthy. I felt unworthy of love and affection and thought to myself that the next possible point of action was to lose weight. That led to a preoccupation about what I ate, how often I ate, the quantity of food I ate and how often I exercised. This got me stuck in a cycle of starving myself, over-eating and exercising. In as much as my behaviour was destructive, it also felt like the only thing I knew to do to stay in control because my whole life felt as if I had no control, but other people always had control over me. While this points to my personal story, I am certain that it is one which many people can relate with (Tshepang Mofokeng).

In this chapter the author continues to explore Osmer's (2008:4) first task of practical theological interpretation. As mentioned already in this thesis, the goal of the first practical theological task is to answer the question "What is going on?" In chapter two, this question was answered based on sexual abuse, while chapter three aims to further answer the question "What is going on?" through a descriptive analysis of eating disorders.

Firstly, the author conceptualizes the term *eating disorders* (EDs). Within this conceptualization the author discusses *anorexia nervosa, bulimia nervosa* and *binge-eating* disorder. This is followed by a discussion of eating disorder behaviours which are currently not in the diagnostic manuals, namely *orthorexia nervosa* and *bigorexia nervosa*.

Secondly, the author discusses eating disorders from a South African perspective. The aim in this section is to conduct a discussion of EDs as a public health issue. This is followed by an evaluation of the interrelation between EDs and the United Nations' (UN) sustainable development goals. To gain an understanding of how prevalent EDs are in SA, the author will discuss statistics of EDs in the country.

As someone who was personally impacted by eating disorders, the author shares a personal reflection of eating disorders. Lastly, the researcher deals with EDs from the perspective of the church.

3.2 Conceptualizing eating disorders

The *Merriam-Webster Online Dictionary* defines eating disorders as psychological disorders which are distinguished by serious disturbances in the eating behaviour of individuals (*Merriam-Webster Inc*., 2024). According to Van Bree *et al.* (2023:1241) it has been established that eating disorders pose a public health risk to those who are battling and these disorders usually have high mortality rates, treatment dropouts as well as unsatisfactory recovery rates. This was further reaffirmed by Kenny *et al.* (2022:2) who said that eating disorders were the deadliest among all other mental illnesses. Kenny *et al.* (2022:2) expanded further on his definition by stating that eating disorders are characterized by distressing eating patterns which comprise behaviours such as excessive food restrictions, binge eating as well as other compensatory behaviours and body image disturbance. Terhoeven *et al.* (2020:132) defined EDs as abnormal eating behaviours and often eating disorders are characterized by individuals struggling with over-valued ideas about body weight and shape. Not only do the clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neuro-developmental disorders align with these definitions, but they also highlight that we live in a society where individuals are preoccupied with weight and shape concerns (World Health Organization (WHO), 2024:398). However, living in a culture that is heavily preoccupied with body weight and shape places individuals at risk of engaging in disordered eating behaviours, with the goal often being low body weight for women and a muscular physique for men (WHO, 2024:398). From analysing these definitions, the author feels compelled to add that eating disorders are behaviours which involve inflicting self-harm upon oneself and this can either be done intentionally or unintentionally. Kline *et al.* (2023:2201) support this notion of eating disorders as a form of self-harm by stating the following:

> Eating disorders are often characterized as indirect forms of self-harm, as the harm enacted occurs downstream of the behaviours themselves and this harm is not assumed to be a primary intention of engagement.

Furthermore, while many definitions of eating disorders focus on food intake and weight, a factor which cannot be ignored when discussing EDs is compulsive exercise. Often exercise and EDs co-exist and this is done in an attempt to ensure that one is able to maintain body weight and shape (Dittmer *et al.,* 2018:1; Melissa *et al.,* 2020:1; Ioannidis *et al.,* 2021:216;) In the paper *Defining compulsive exercise in eating disorders: Acknowledging the exercise paradox and exercise obsessions* it was noted that a gap in eating disorders research is that the prevalence rates of exercise are lacking in these studies (Bratland-Sanda *et al.,* 2019:2). The author agrees with this view and argues that future research should look more deeply into the interconnection between compulsive exercise and EDs.

The most common EDs which are often discussed in research are *anorexia nervosa, binge eating disorders and bulimia* (Hay, 2019:24; Feng *et al.,* 2023:1; Bryston *et al.,* 2024:392). However, there are other EDs which are not yet included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and the *International Classification of Diseases* (ICD-11), such as *orthorexia* (Horovits & Argyrides, 2023:1; Mahfoud *et al*., 2023:2). The diagnostic criteria also recognize feeding disorders such as *pica, rumination disorder* and *restrictive food intake* (Schmidt *et al.,* 2025:4). Although these feeding disorders are not essentially characterized as eating disorders, the author argues that these can be interrelated with eating disorders.

EDs are not only complex (Mountford *et al.*, 2017:1), they are also recognized in a vast majority of fields, such as psychology, social work, nutrition and medicine (Keel, 2017:1). In the following section the author delves more deeply into each ED by defining the disorder, the clinical picture and co-morbidities associated with each and drawing a comparison of each ED by taking into consideration both the DSM-5 and ICD-11 criteria of diagnosis. However, it is important to first describe the importance of the diagnostic criteria. The diagnostic criteria are important within the clinical arena as they help clinicians to identify and accurately diagnose the various disorders which individuals present within clinical settings. This helps clinicians proceed with accurate treatment (WHO, 2024). While making a diagnosis is not within the scope of practice of pastoral counsellors, it is essentially useful to have an awareness of the diagnostic criteria so that the use of a multi-disciplinary team can be utilized in cases where an individual presents with a clear case of a mental health disorder.

3.2.1 Anorexia Nervosa

As established in the definition of EDs above, *anorexia nervosa* (AN) is a serious psychological disorder which is commonly known for having one of the highest mortality rates (Khalsa *et al.,* 2017:1). According to Burke (2019:480), women battling with AN are twelve times more likely to die as opposed to those who do not have struggles with this disorder. The factors contributing to mortality are usually medical complications and suicide (APA, 2013:342). AN is an ED which is largely associated with self-starvation (Keel, 2017:2) and excessive dietary restrictions (Stedal *et al.*, 2021:214). Anorexia is associated with low body weight which is rooted in the fear of gaining weight or becoming fat (Terhoeven *et al.,* 2020:132). This fear of gaining weight is often labelled as “intense” or “extreme” and researchers go on to maintain that anorexia results in a disturbance in the way one perceives one’s own body weight and shape (Stedal *et al.,* 2021:2; Burke, 2019:479). The notion of perception of body weight and shape leads the author to the conviction that body dysmorphia and an ED such as AN are inter-related. This conviction also comes from the author’s own life experience where she not only struggled with disordered eating behaviour, but where she also struggled with distorted perceptions related to her body weight and shape and could never see herself as thin enough even after having lost a significant amount of weight. Louw and Louw (2020:312) supported this statement by mentioning that individuals with anorexia may genuinely view themselves as obese - irrespective of having skeletal frames.

Khalsa *et al.* (2017:1) stated that the emergence of AN is likely to occur during adolescence. According to Louw and Louw (2020:312), the age of onset for AN is usually between puberty and twenty-five years of age. This is not surprising, because this is the stage of development where young people are trying to find their worth and identity. This was further reinforced by Louw and Louw (2020:311) who stated that adolescents have a great sense of awareness in relation to their body shapes and appearance. In the context of this study, where the goal is to look at the interrelation between EDs and sexual abuse, it is no surprise to assume that EDs occur because of not only losing the sense of one’s identity, but also as an attempt to try and reclaim what was lost. This will be explored further in Chapter 5 of this study.

Anorexia nervosa (AN) is widely recognised as occurring more frequently among females and is most commonly reported within highly industrialised, high-income

countries (Burke, 2019:484). However, while this may hold some truth, it is important to note that although sexual abuse disproportionately affects women, this does not mean that men do not experience similar struggles. Both sexual abuse and EDs can affect men as well (Strother *et al.,* 2012:346; Juyal *et al.,* 2017:187; Gorrell *et al.,* 2019:5; Houghton *et al.,* 2023:119) and both issues have the ability to affect individuals, irrespective of their gender, race or socio-economic background. This is the conviction that the author will carry with her throughout the writing of this thesis. The American Psychiatric Association (APA, 2013:402) asserts that eating disorders such as AN can also affect men cross-culturally and there is an increase globally in the number of men receiving treatment. In the following section focus will be placed on describing the diagnostic criteria for AN.

3.2.1.1 Diagnostic Criteria for anorexia nervosa: DSM-5 and ICD-11 comparison

The aim of this section is to show the diagnostic criteria for the diagnosis of EDs within both the DSM-5 and ICD-11 diagnostic criteria manuals. Alongside this, the author aims to discuss the co-morbid disorders associated with each ED. Although pastoral counsellors do not make formal diagnoses, it is helpful to be aware of the diagnostic criteria not only within the context of this study, but in practice this can give pastoral counsellors an edge in terms of developing an awareness of what EDs look like should they encounter counselees who present symptoms of these disorders.

The Table below shows the difference between the diagnosis of EDs between the DMS-5 and ICD -11 for AN.

Table 3.1: Comparison of Anorexia Nervosa diagnosis in the DSM-5 and ICD-11.

(Sources: APA, 2013:338–339; Burke, 2019:484–485; WHO, 2024:398)

DSM-5 diagnostic criteria	**ICD-11 diagnostic criteria**
A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health. Significantly low weight	For the diagnosis of AN, the following essential features should be presented: ➢ Significantly low body weight for the individual's height, age,

is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.	developmental stage or weight. Individuals with AN usually have a Body Mass Index (BMI) of less than 18.5. Adolescents may be unable to gain weight as they develop. ➢ Low body weight is not based on a medical condition or a lack/unavailability of food. ➢ Low body weight is linked with the fear of gaining weight. As a result, individuals are prone at reducing energy intake by engaging in behaviours such as "fasting, choosing low-calorie food, excessively slow eating of small amounts of food, and hiding or spitting out food, as well as by purging behaviours such as self-induced vomiting and use of laxatives, diuretics or enemas or omission of insulin doses in individuals with diabetes." Furthermore, individuals may attempt to increase energy expenditure through excessive exercising, motor hyperactivity and the use of medication usually used for weight loss.
B. Intense fear of gaining weight or of becoming fat or persistent behaviour that interferes with weight gain, even though at a significantly low weight.	
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.	

While the table above provides the diagnostic criteria for AN, it should be mentioned that both the DSM-5 and ICD-11 have subcategories for anorexia. The following table will show a comparison of how AN is categorized in the DSM-5 and the ICD-11.

Table 3.2: Comparison of the sub-categories of Anorexia Nervosa within the DSM-5 and ICD-11. (Sources: (APA, 2013:339; WHO, 2024:399)

DSM-5 Anorexia nervosa sub-categories	ICD-11 Anorexia nervosa sub-categories
➢ Restricting type: This type of AN typically involves individuals having not engaged in any kind of binge eating or purging within the last three months. This includes and is not limited to behaviours pertaining to "self-induced vomiting or the misuse of laxatives, diuretics, or enemas." In the case of restriction, weight loss is gained by actively engaging in behaviours such as consistent dieting, fasting and may be accompanied by excessive exercising. ➢ Binge-eating/purging type: This type of AN is different in the sense that individuals who fall within this criterion are prone to would have had recurrent episodes of binge eating or purging behaviours (i.e., self-induced vomiting, the misuse of laxative or diuretics, and the use of enemas) within the last three months	➢ Anorexia nervosa with significantly low body weight: Individuals qualifying under this specific criterion meet the relevant diagnostic criteria for AN and have a BMI which falls between the ranges of 18.5kg/m² and 14.kg/m² amongst adults. In children and adolescents, the BMI for age ranges the 5th and 0.3 percentile. ➢ Anorexia nervosa with dangerously low body weight: Adults who fall under this criterion have a BMI which is under 14.0kg/m². Amongst children and adolescents, the BMI for age is under the 0.3 percentile. ➢ Anorexia nervosa in recovery with normal body weight: Individuals recovering from AN and have achieved a healthy body weight should have this diagnosis kept until their weight continues to be maintained for a substantial period which is at least 1 full year.

Although the table above shows the different sub-categories of AN between both the DSM-5 and ICD-11 diagnostic criteria, it should be noted that along with the categories

the ICD-11 identifies, they have two more sub-categories which are *Other specified AN* and *Unspecified* (Burke, 2019:478). The ICD-11 did not break down what these two sub-types necessarily consist of; however, Dennis (2024) maintains that an unspecified ED comprises cases where individuals present symptoms of an ED that results in significant distress and impairment in important areas of life (i.e., social and occupational) but do not meet all the requirements to be formally diagnosed with a specific ED. Dennis (2024) continued to mention that in some cases clinicians may intentionally choose not to indicate reasons why the individual has not met the criteria for an ED, including the times when there is a lack of information to make a formal and specific diagnosis.

Furthermore, the ICD-11 and DSM-5 differ in the way they measure Body Mass Index (BMI). In accordance with the DSM-5, BMI is categorized in the following way (APA, 2013:339):

- Mild: ≥ 17kg/m²
- Moderate: 16-16.99 kg/m²
- Severe: 15.99 kg/m²
- Extreme: ≤ 15 kg/m²

BMI is a necessary tool to use to distinguish the severity of an individual's ED. According to the APA (2013:339), "the level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision".

The following section takes a further look at the clinical symptoms associated with AN.

3.2.1.2 Co-morbidities associated with *Anorexia Nervosa*

Co-morbid disorders are a common experience which is usually positively associated with eating disorders. According to Hambleton *et al.* (2022:2) the concept co-morbidity is defined as any "conditions or illnesses that occur concurrently to the ED". These usually take the form of physical and psychological problems. The following diagram provides a picture of some of the psychological and physical complications which could arise as a direct result of AN.

Figure 3.1: Comorbid illnesses and psychological disorders associated with *Anorexia Nervosa*. (Source:Harrington et al., 2015:49; Gibson & Mehler, 2024:538; Dang et al., 2024:554)

Physical effects of anorexia nervosa
• Amenorhea.
• Arrhythmia
• Bradycardia
• Brittle hair and nails
• Edema
• Hyperkeratosis
• Hypotension
• Hypothermia
• Lunago (fine white hairs on body.)
• Osteoporosis
• Pelvic floor disorders
• Fibromalygia
• Gastrointestinal symptoms
• Fatigue
• Insomia

Psychological effects of anorexia nervosa
• Suicidal ideation
• Depression
• Panic disorder (PD)
• Social anxiety
• Irritability
• Withdrawal
• Obsessive Compulsive Disorder (OCD)
• Generalized Anxiety Disorder (GAD)
• Post Traumatic Stress Disorder (PTSD)
• Alcohol Use Disorder
• Substance Use Disorder

Within the eating and feeding disorder criteria there are also diagnostic criteria for rumination disorder and pica. In the DSM-5, *Rumination Disorder* is defined as follows:

> Repeated regurgitation of food over a period of at least one month. Regurgitated food may be re-chewed, re-swallowed, or spit out. In rumination

> disorders, there is no evidence that an associated gastrointestinal or another medical condition (e.g., gastroesophageal reflux) is sufficient to account for the repeated regurgitation (APA, 2013:828).

It is noted that among those battling with AN and bulimia that the chance exists to engage in regurgitation as a method of spitting out food to rid themselves of calories they have taken in. This is done because of debilitating concerns about overweight gain (APA, 2013:333).

Pica, which is a feeding disorder associated with consuming non-nutritive, non-food substances can in some instances be present among patients with AN who consume things such as, e.g., tissues to try and achieve appetite control. The DSM-5 suggests that when individuals consume non-food substances to control weight, these individuals should be diagnosed with AN (APA, 2013:331). The author of this study argues that while *Pica* and *Rumination Disorders* do not necessarily qualify as "EDs", elements of these behaviours may still manifest themselves in other disorders such as AN and BN.

3.2.2 Bulimia Nervosa

BN is an eating disorder which is characterized by a combination of binge eating and compensatory behaviours in an attempt to control weight (Jain & Yilanli, 2023). These compensatory behaviours include engaging in behaviours such as purging, the misuse of laxatives or diuretics and over-exercising (Burke, 2019:479). As with all eating disorders, BN poses a threat to the livelihoods of those suffering from it (Hail, 2018:12). This statement was reiterated by Jain and Yilanli (2023) who agree with the fact that BN carries potentially dangerous effects for those who struggle with it. Just as with AN, those battling with BN often display an extreme fear of gaining weight (Levinson *et al.,* 2017:5).

The word *bulimia* translates to *ox hunger* which is associated with ravenous hunger (Burke, 2019:490; Bowie, 2021) and this is directly related to the binge-eating behaviour which is associated with BN. Binge eating typically involves eating an excessive amount of food, more than most people would eat at any given time (Burke, 2019:490). What this entails is that individuals struggling with binge-eating are prone

to having an excess of calories which go beyond the recommended daily intake, and this goes hand in hand with compensatory behaviours as described above.

According to Burke (2019:483), it is estimated that approximately 30% of individuals who have had a diagnosis of anorexia are most likely to cross over into BN. One could argue that this occurs because both disorders are associated with low serotonin levels (Burke, 2019:10). The likelihood of crossing over into other behaviours is not uncommon within the sphere of addiction and recovery. This notion of crossing from one compulsive behaviour to another is called cross-addiction (Dowd *et al.,* 2024:106), and McFadden (2010:145) also refers to this as an "addiction transfer" or alternatively a "substitute addiction". What is known about addiction is that it is motivated by seeking out pleasure (Matthews *et al.,* 2013:1). More will be said about this at a later stage in this chapter.

Research has pointed out that unlike AN, individuals with BN tend to maintain a body weight that is above a minimally normal level (Burke, 2019:344; APA, 2013:344). Equally so, BN also has the potential of causing weight gain among individuals (Burke, 2019:492). This, according to Burke, is likely to occur because purging does not rid an individual of all the calories they have consumed, instead it leads to a reduction of about 50 percent of calories and the use of laxatives has a minimal impact on the weight of individuals (Burke, 2019:492). Furthermore, bulimia nervosa (BN) is reported to occur more frequently among females. This is reflected in the ICD-11, which notes that the diagnosis of BN appears to be more prevalent in females (WHO, 2024:406). Louw and Louw (2020:312) have gone on to acknowledge that males are not excluded from suffering with BN; instead, they suggested that males suffer an approximation of one-tenth of the percentage of females. The ICD-11 continues to take note that purging behaviours are less prevalent within the male population of individuals struggling with BN as opposed to their female counterparts (WHO, 2024:406). Instead, males are most likely to resort to the use of steroids as a form of compensatory behaviour after a period of binge eating (WHO, 2024:406). Burke (2019:493) estimates the age of onset for BN to be approximately eighteen years old. Yet the ICD-11 estimates that BN is likely to occur shortly after the onset of puberty, arguing that younger children do not commonly struggle with binge eating because they have a lack of access to and control over food (WHO, 2024:405-406). The author of this study argues that although this might be true to some extent, it is an element which could differ within families.

In the following section, the focus is on drawing a comparison between the diagnostic criteria for BN within the DSM-5 and ICD-11 diagnostic criteria.

3.2.2.1 Diagnostic criteria for bulimia nervosa: DSM-5 and ICD-11 comparison

As mentioned above, this section focuses on drawing a comparison between the diagnosis of BN as defined by the DSM-5 and ICD-11 diagnostic criteria manuals. The aim is to see the differences and similarities which exist between the two diagnostic manuals in relation to the diagnosis of BN.

Table 3.3: Comparison of Bulimia Nervosa diagnosis in the DSM-5 and ICD-11. (Source: APA, 2013:338-339; Burke, 2019:484-485; WHO, 2024:398).

DSM-5 Diagnostic criteria	ICD-11 Diagnostic criteria
A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following: (1) Eating, in a discrete period (e.g. within any two-hour period), an amount of food that is larger than what most individuals would eat in a similar period under similar circumstances. (2) A sense of lack of control, overeating, during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).	For a diagnosis of BN, the following required features need to be considered: ➢ The individual engages in frequent, recurrent episodes of binge eating (e.g. once a week or more over a period of at least one month. Binge eating involves individuals eating notably more or different than usual over a discrete period (e.g. two- hourly). This cycle is characterized individuals experiencing a lack of control over the amount or type of food eaten and usually having trouble to stop eating once they have started. ➢ The individual displays inappropriate compensatory behaviours in the attempt to prevent weight gain (e.g. once a week or more over a period of at least one month). This results in individuals resorting to self-induced vomiting which most commonly occurs at least after an hour of binge eating. Compensatory behaviours also include fasting, the use of diuretics to bring about weight loss, the use of laxatives or
B. Recurrent inappropriate compensatory behaviours to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.	
C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.	
D. Self-evaluation is unduly influenced by body shape and weight.	
E. The disturbance does not occur exclusively during episodes of AN.	

	enemas to reduce the absorption of eating, omission of insulin doses in individuals with diabetes, and strenuous exercise to increase energy expenditure. ➢ Characterised by an excessive preoccupation with body weight and shape. This is usually accompanied by behaviours such as compulsively checking body weight on a scale; body shape using measuring tapes or mirror reflections; conducting constant calorie counts of food consumed; searching for weight loss information; displaying avoidant behaviours which include a refusal to have mirrors at home, refusing to wear tight fitting clothes, refusing to know one's weight or to purchase clothes which have specified sizing. ➢ Individuals display distress about the pattern of binge eating and inappropriate compensatory behaviour, or significant impairment in personal, family, social, educational, occupational or other areas of functioning. ➢ Symptoms do not meet the diagnostic criteria for anorexia nervosa.

The Table above shows that in many instances both the DSM-5 and ICD-11 have consistencies in terms of the nature of diagnosis and how terms are defined and slight differences are also evident. One of the noted differences is that the ICD-11 stated that individuals qualify for a diagnosis of BN when they show signs of compensatory behaviours within the period of a month, but on the other hand the DSM-5 states that an individual should display symptoms of compensatory behaviours within a three-month timeframe.

Both diagnostic criteria show that eating disorders are synonymous with addictive behaviour. The basis for this argument stems from the fact that in both the DSM-5 and ICD-11 BN is characterized with struggles to stop eating once an individual enters the binge phase. Equally so, individuals struggle to stop their compensatory behaviours as well. From the basis of the information provided in both diagnostic criteria, the elements which play a critical role in fuelling addictive behaviours are present in eating disorders as well. These include elements such as preoccupation, loss of control, unmanageability and powerlessness. This has also been supported by Louw and Louw (2020:312) who maintained that in all eating disorders the driving force is exhibiting a preoccupation with food and weight. One of the biggest issues which comes with addiction usually involves individuals feeling that once they start engaging in their behaviour of choice they cannot stop.

A significant difference which was found is that the ICD-11 went a step further in their core diagnostic features by including the fact that BN is also characterized by distress about binge eating patterns and compensatory behaviours. This is an important element to take note of not only in the context of BN, but also in the context of eating disorders. This distress paves the way for feelings of shame to emerge, which also plays a pivotal role in the continuation of the behaviour because of the shame cycle which will be discussed at a later stage in this study.

Another significant aspect to take note of which is not reflected in the Table above is that the DSM-5 has distinguished between the different levels of severity which are associated with BN. The levels of severity are determined by the frequency of inappropriate compensatory behaviours an individual presents with, and it may be increased based on symptomatology as well as the degree of functional disability (APA, 2013:345). The table below gives a summary of this:

Table 3.4 – Four levels of severity for bulimia nervosa. (Source: APA, 2013:345)

Severity level	**Number of inappropriate compensatory behaviours per week**
Mild	Individuals who fall under this category present with an average of one to three inappropriate behaviours on a weekly basis.
Moderate	These individuals have approximately four to seven episodes of inappropriate compensatory behaviours weekly.
Severe	Those who fall under the severe scale have between eight to thirteen inappropriate compensatory behaviours in a week.
Extreme	These individuals have fourteen or more inappropriate compensatory behaviours in a week.

3.2.2.2 Co-morbid disorders associated with *Bulimia Nervosa*

The following table provides an overview of some the medical and psychological conditions which tend to be co-morbid with BN.

Figure 3.2: Comorbid medical conditions and psychological disorders associated with Bulimia Nervosa. (Source: Source: Harrington, B.C et al., 2015:49).

Physical effects of bulimia nervosa	Psychological effects of bulimia nervosa
•Fluid and eloctrolyte imbalance	•Major Depressive Disorder (MDD)
•Erosion of dental enamel	•Anxiety
•Gum disease	•Borderline Personality Disorder (BPD)
•Edema	
•Calluses on the fingers or backs of the hands	
•Colon damage or severe constipation	
•Tearing of the oesophagus or the stomach	
•Gastroesophageal reflux disease	
•Irritable bowel syndrome (IBS)	
•Cardiac Arrhythmia	
•Diabetes	
•Salivary gland hypertrophy and swollen cheecks	
•Ruptured esophagus	
•Weight fluctuations	
•Parotid gland enlargement	

Feelings of depression and anxiety arise for several different reasons among those battling with BN. According to Levinson *et al*. (2017:16), the anxiety symptoms which are closely related to BN are as follows:

Table 3.5 Anxiety symptoms and closely related bulimia nervosa symptoms (Levinson *et al.,* 2017:16).

Anxiety symptoms	**Associated *Bulimia Nervosa* Symptoms**
Feelings of wobbliness	Avoidance of eating.
Fear of losing control	Associated with guilt over-eating and eating in secret.
Feelings of unsteadiness	Associated with guilt over-eating and avoidance of social eating.
Terrified	Avoidance of social eating and eating in secret.

Although eating behaviour plays such an integral part in BN, the author of this study argues that the feelings of anxiety experienced by individuals are not only limited to eating behaviours, but individuals are also prone to experience anxiety because of the compensatory behaviours which are associated with the disorder. Equally so, feelings of anxiety may also arise due to the medical complications caused by BN. Levinson *et al.* (2017:17) have continued to mention that symptoms of depression which are closely related to BN include the following:

> Feeling like crying, self-dislike, self-criticalness, change in appetite, thinking of suicide, guilty feelings" and these occur as a result of behaviours such as "over-evaluation of weight, over-evaluation of shape, preoccupation with weight, desire to have an empty stomach, preoccupation with shape, and binge eating.

It goes without saying that there is a correlation between the behaviours of these individuals and their mental health. Within the context of this study, it can be argued that although an eating disorder is likely to have an impact on mental health, because of the nature of this study there could be a possibility of the individual already suffering from a mental health disorder due to having experienced a traumatic event. In this regard it could be argued that the eating disorder is likely to be a coping mechanism to some (Wagener & Much, 2010:203), a coping mechanism to try and deal with the nature of the abuse they have experienced or to try and control those uncomfortable

feelings associated with mental health issues. As a result, what this shows is that a lot of the time individuals are prone to act out because of underlying issues (Wagenar & Much, 2010:203). In this case, the eating disorder serves as a deconstructive coping mechanism which instead of helping the individual as they perceive, it only breaks them down further, resulting in a large array of emotional and physical problems.

3.2.3 *Binge Eating Disorder*

Binge eating disorder (BED) is defined as a behavioural disorder which is typically characterized by excessive overeating (Mehta & Tyagi, 2024:1). This definition resonates with the author who argues that all eating disorders fall within the spectrum of behavioural disorders. The basis for this argument stems from the fact that in many ways eating disorders share similar characteristics with other addictive behaviours. Chamberlain *et al.* (2015:841) support this by mentioning that some psychiatric disorders share parallels with substance addiction, and this is what characterizes them as behavioural disorders. Some of these parallels which are synonymous with eating disorders is that they involve constant repetitive engagement with the behaviour, loss of control, persisting in behaviour, regardless of the consequences that could occur because of acting out and tolerance (Chamberlain *et al*., 2015:841,842). *The Merriam-Webster Online Dictionary* (2024) reaffirms this notion of loss of control by defining BED as:

> An eating disorder characterized by recurring episodes of binge eating accompanied by a sense of lack of control and often negative feelings about oneself without intervening periods of compensatory behaviour (as self-induced vomiting, purging by laxatives, fasting or prolonged exercise).

Researchers (Vinai *et al.,* 2016:107; Olguin *et al.,* 2017:13; Burke, 2019:494) support this definition given by the *Merriam-Webster Online Dictionary* by emphasising that BED not only consists of binge eating behaviour without engaging in compensatory behaviours, but there are an incredible amount of psychological distress and a reduced quality of life associated with it. The definition provided by the *Merriam-Webster Dictionary* carries so much weight within it because it not only points to the addictive nature of BED (Harb & Almeida, 2014:1) by mentioning that it is accompanied by “a sense of lack of control” but the definition also indicates the very

fact that BED is linked to negative self-worth. This notion of negative self-worth is applicable to eating disorder pathology in general (Mendoza *et al.,* 2022:23). Eating disorders are mostly rooted in flawed perceptions of how we see ourselves. This will be discussed further in chapter 5 of this study.

While individuals with BED do not necessarily engage in compensatory behaviours, research shows that these individuals are prone to seek out weight loss treatment after the initial onset of the disorder (WHO, 2024:409). This is because weight gain is likely to occur as a direct result of binge eating. However, on the other end of the spectrum are individuals who engage in binge eating behaviours but do not gain weight. An adverse effect of BED is obesity. This was supported by McCuen-Wurst *et al.,* (2018:96) who mentioned that both BED and night eating syndrome (NES) play a role in the development of eating disorders.

Research suggests that the age of onset for BED is predominantly twenty-five years (Mehta & Tyagi, 2024:1). However, in the ICD-11 it is stated that the common age of onset for BED is usually during adolescence or young adulthood, but at times symptoms may manifest in later adulthood (WHO, 2024:409; Burke, 2019:494). The ICD-11 gives a better description of the age of onset as it acknowledges that BED can occur at any moment in a person's life and that age is not necessarily a deciding factor for the risk of developing eating disorders. It has also been found that with regards to BED women tend to report experiencing distress and loss of control at a slightly higher rate than their male counterparts (Burke, 2019:494).

3.2.3.1 Diagnostic criteria for binge eating disorder: DSM-5 and ICD-11 comparison

The following table shows a comparison of the diagnostic criteria for eating disorders within the DSM-5 and ICD-11[5].

[5] Source: American Psychiatric Association (APA). 2013. *Diagnostic and Statistical Manuel of Mental Disorders, fifth edition (DSM 5)*. Pp. 350 & World Health Organization (WHO). 2024. *Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders*. P.407.

Table 3.6: Comparing *Binge Eating Disorder* within the DSM-5 and ICD-11 diagnostic criteria

DSM-5 Diagnostic criteria	**ICD-11 Diagnostic criteria**
A. Recurrent episodes of binge-eating disorder. Episodes of binge eating disorder are characterized by the following: 1. Eating in a discrete period (e.g. within any 2-hour period), an amount of food that is larger than what most people would eat in a similar period under similar circumstances. 2. A sense of lack of control over-eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating.)	For a diagnosis of bulimia nervosa, the following required features need to be considered: ➢ Frequent, recurrent episodes of binge eating (e.g. once a week or more over a period of three months) are required for diagnosis. Binge eating is defined as a discrete period (e.g. two hours) during which the individual experiences a loss of control over their eating behaviour and eats notably more or differently than usual. Loss of control overeating may be described by the individual as feeling like they cannot stop or limit the amount or type of food eaten; having difficulty stopping eating once they have started; or giving up even trying to control their eating because they know they will end up overeating. ➢ The binge-eating episodes are not regularly accompanied by inappropriate compensatory behaviours aimed at preventing weight gain. ➢ The symptoms and behaviours are not better accounted for by another medical condition (e.g. Prader-Willi syndrome) or mental disorder (e.g. a depressive disorder) and are not
B. The binge eating episodes are associated with three (or more) of the following: 1. Eating much more rapidly than normal. 2. Eating until uncomfortably full. 3. Eating large amounts of food when not feeling physically hungry. 4. Eating alone because of feeling embarrassed by how much one is eating. 5. Feeling disgusted with oneself, depressed or very guilty afterward.	
C. Marked distress regarding binge eating is present.	
D. The binge eating occurs on average, at least once a week for three months.	
E. The binge eating is not associated with the recurrent use of inappropriate	

compensatory behaviour as in *bulimia nervosa* and does not occur exclusively during bulimia nervosa or anorexia nervosa.	because the effect of a substance or medication on the central nervous system, including withdrawal effects. ➢ There is marked distress about the pattern of binge eating, or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. During the earlier phases of the disorder, symptoms may be concealed and functioning maintained through significant additional effort.

In the ICD-11 (WHO, 2024:407) the diagnostic criteria suggest that individuals battling with BED tend to give up control over what they are eating because of having an awareness that they will overeat regardless. This statement is indicative of the reality that there is a sense of hopelessness and powerlessness that comes with individuals battling with an eating disorder. This is supported by criteria B of the DSM-5 which clearly indicates that one of the core symptoms of BED is that individuals are likely to experience feelings of embarrassment, guilt, depression or disgust due to the rate at which they are eating (APA, 2013:350). Based on this, it goes without saying that shame is another key factor that those with eating disorders are likely to present with (Nechita *et al.,* 2021:1899). This is an area that the author will delve into in depth at a later stage in this thesis. In the following section, the author will be discussing the co-morbid disorders which are associated with BED. Just as with the presentation of the diagnostic criteria of AN and BN, the DSM-5 included the minimum level of severity of BED based on the frequency of episodes (APA, 2013:350) which will be summarised in the table below.

Table 3.7: Four levels of severity for Binge Eating Disorder (Source: APA, 2013: 350)

Severity Level	Frequency of BED episodes
Mild	1-3 Binge eating episodes per week
Moderate	4-7 Binge eating episodes per week
Severe	8-13 Binge eating episodes per week
Extreme	14 or more Binge eating episodes per week

The author of this study believes that the higher the ED severity, the more likely an individual is prone to experiencing co-morbid disorders. According to Spindler and Milos (2007:365) it was discussed that “high levels of eating disorder severity are linked with a greater propensity to develop or aggravate co-morbid disorders”. In the following section the researcher will be discussing the co-morbid disorders which are interlinked with BED.

3.2.3.2 Co-morbid disorders associated with binge eating disorder

As shown throughout this chapter, eating disorders do not function in isolation. They are usually accompanied by several co-morbid disorders because of the effect that they have on the entire well-being of the individual (Spindler & Milos, 2007:364; Brewerton, 2023:1). This section looks at the psychological and medical complications which are likely to occur because of binge eating disorder.

The following figure shows the physiological and psychological issues which go hand in hand with BED.

Figure 3.3: Co-morbid disorders related to Binge Eating Disorder (Source: Metha and Tyagi, 2024:1; Olguin et al., 2017:13, 14; Vinai et al., 2016:108)

Physical effects of BED	Psychological effects of BED
•Hypertension •Cardiovascular disease •Lipid abnormalities •Type 2 diabetes •Obesity •Sleep problems •Pain conditions (chronic headaches, back/neck pain, fibromalagyia) •Astma •Gastro-intestinal symptoms (ulcer, irritable bowel syndrome) •Arthritis •Menstrual dysfunction •Pregnancy complications •Polycystic ovarian syndrome	•Depression •Anxiety

While the sources reviewed do not mention that BED is associated with obsessive or compulsive behaviour, the author of this study argues that in all eating disorders obsession and compulsion play a key role to maintain the behaviour. These could be obsessions over body weight and shape, but in the case of BED the obsession and compulsive behaviour could be directly related to food intake and potentially weight loss measures held by individuals. In relation to mental health, while anxiety and depression have been recognized as the key psychiatric conditions which individuals battle with as a direct result of BED, researchers have also noted that those battling with BED are prone to experience greater functional impairment, feelings of guilt, embarrassment and disgust due to their eating behaviour (Vinai *et al.,* 2016:107) This is also supported by the DSM-5 diagnostic criteria where it is mentioned that for a

diagnosis of BED individuals are likely to reflect three of the following characteristics (Vinai *et al.,* 2016:107; APA, 2013:350; Burke, 2019:495):

- Individuals eat until they reach a point where they are uncomfortably full.
- Individuals continue to eat large amounts of food even when they are not necessarily hungry.
- Individuals eat much more rapidly than usual.
- Individuals resort to eating alone due to feelings of embarrassment by the amount of food they are eating.
- Eating behaviour causes individuals to feel disgusted, depressed, or guilty, after overeating.

Poor emotional regulation (which will be discussed further in Chapter 5 of this thesis) can go on to be a factor which continues to influence eating disordered related behaviours (Zhou *et al.,* 2025:1). As mentioned earlier in this chapter, individuals often resort to unhealthy coping mechanisms after exposure to traumatic events such as sexual abuse often to try and deal with the emotions associated with the trauma.

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3.2.4 Eating disordered related behaviours not in the diagnostic manuals

Although the author has provided a rather broad description of the three main eating disorders which are AN, BN and BED, it is important to briefly discuss other behavioural disorders which are not mentioned as eating disorders in the diagnostic manuals. In this section the author will be discussing orthorexia, otherwise known as *orthorexia nervosa* and *bigorexia*.

3.2.4.1 *Orthorexia nervosa*

Orthorexia nervosa (ON) is an eating disorder which was described in 1997 by Bratman (Barnes & Caltabiano, 2017:177; Brytek-Matera, 2012:56; Moroze *et al.,* 2015:397; Scarff, 2017:36; Zagaria *et al.,* 2021:295). The term derives from the Greek words *ortho* which means *correct* and *orexi* which refers to *appetite* (Brytek-Matera, 2012:56; Moroze *et al.,* 2015:397; Zagaria *et al.,* 2021:295). This can then be directly translated to an eating disorder associated with correct or healthy eating as part of the attempt to achieve improved health (Brytek-Matera, 2012:56). These individuals are

prone to be obsessed about eating only foods which are regarded as healthy and pure such as vegetables and fruits and as a result deeming other types of food impure (Barnes & Caltabiano, 2017:177). While eating healthily is necessary, it can easily become problematic when this practice is pathological and individuals develop food-related obsessions as presented among those who battle with ON. Equally so, while health seems to be the core focus of ON, the contradiction remains in the fact that many of those struggling with this disorder are prone to experiencing malnutrition as a direct result of their dietary choices. preventing them from receiving proper nutrition from all food groups (Dunn & Bratman, 2016:11; Moroze *et al.,* 2015:397). These individuals are not only prone to eliminate complete food groups from their diets, but they are also likely to spend an excessive amount of time conducting research on the correct preparation of food and analysing food content (Barnes & Caltabiano, 2017:178). This analysis of food content goes as far as individuals religiously taking note of how different food products are cut and the type of materials used when preparing food (Moroze *et al.,* 2015:397). Based on this it is understood that a large part of the disorder involves characteristics of obsessive and compulsive behaviour. This is supported by several studies which show that ON is rooted in obsessive and compulsive behaviour, to such an extent that OCD is regarded as one of the co-morbid disorders that goes hand in hand with ON (Scarff, 2017:37). Other co-morbid disorders are inclusive of *obsessive-compulsive personality disorder* (OCPD), *somatic symptom disorder*, *illness anxiety disorder* and *psychotic disorder* (Koven & Abry, 2015:385). Although not much research exists on the nature of co-morbid disorders among those perceived to present with symptoms of orthorexia, Koven and Abry (2015:388) hypothesized that due to the magical ideation that individuals with ON tend to present with, these individuals are also prone to experiencing mental health disorders such as schizophrenia. The prominent argument for this stems from the belief that “elevated magical ideation, regardless of its content, is a common symptom of schizotypal personality disorder and a good predictor of future psychosis” (Koven & Abry, 2015:388).

While ON is not recognized as a diagnosable disorder within the context of the current diagnostic criteria available in both the medical field and in Psychology (Barnes & Caltabiano, 2017:177; Sfeir *et al.,* 2022:1-2; Foyster *et al.,* 2023:1), it is important to point out that research shows that *orthorexia* is likely to have direct links with both AN

and BN (Scarff, 2017:36; Barnes & Caltabiano, 2016:177). The common characteristic that is present with *anorexia* and *orthorexia* is the avoidance of food (Moroze *et al.,* 2015:397). In both cases this avoidance poses a risk of malnutrition which has the potential of being fatal (Moroze *et al.,* 2015:397). In fact, research has pointed out that between patients battling with orthorexia and those battling with anorexia, some of the notable similarities is that these individuals tend to display characteristics such as having an intense desire to be in control, perfectionism and anxiety related to the behaviour (Barnes & Caltabiano, 2017:177; Scarff, 2017:37). These characteristics are defined further in Chapter 5 of this study as they serve as possible reasons as to why those battling with eating disorders are likely to engage in this kind of behaviour. Equally so, there are notable differences which exist between ON and AN and the table below highlights these differences.

Table 3.8: Differences between Orthorexia Nervosa and Anorexia Nervosa (Source: Scarff 2017:37).

Orthorexia Nervosa	***Anorexia Nervosa***
Weight could remain normal or be within the low-normal range.	Weight is seriously low.
Focus is placed on food quality.	Focus is placed on food quantity.
Advocating their eating behaviours.	Associated with shame.
No skipping of meals unless under circumstances where they are fasting.	Skipping meals.
While food avoidance is evident among those battling with ON, these individuals only avoid the food that they regard as bad. There is another element where healthy food is the only source of food which these individuals embrace.	Food avoidance is the core focus.

While research has concluded that the primary focus for orthorexia is not necessarily on weight management (Horovits & Argyrides, 2023:3) we cannot shy away from the

fact that people's motivations for engaging in a particular behaviour will differ. Not everyone who engages in extremely healthy eating is doing it for the sake of weight management, but it is likely that some people will have that agenda in mind. As someone who has previously had struggles with eating disordered behaviour, my common rationale has always been located in the belief that "if I eat extremely clean, then it gives me a greater chance of exhibiting weight loss". This is not to say that my initial behaviour was interlinked with orthorexia, but the element of being highly fixated on healthy eating was there with the sole motivation of weight loss. Brytek-Matera *et al.* (2018:442) said that "sometimes, all behaviours may be associated with unintentional weight loss, with no desire to lose weight (losing weight is subordinated to ideation about healthy food)." Foyster *et al.* (2023:9) have noted the existing conflict in research studies where some research holds on to the belief that weight loss and ON are not interrelated, while others beg to differ. In their study, Foyster *et al.* (2023:9) stand by the view that there is a definite correlation between orthorexia and weight management as individuals tend to regard weight as one of the markers for health. Furthermore, it has been established that those prone to dieting and those in larger bodies are more at risk of the development of *orthorexia* (Foyster *et al.,* 2023:10). Due to the differences which exist pertaining to weight motivations among those with *orthorexia* the author of this study not only acknowledges a clear research gap relating to this topic, but she also acknowledges that further investigations need to take place in the future to effectively address this gap.

As mentioned earlier, that *orthorexia* is not recognized as a diagnosable disorder, it is important that researchers have developed a proposed schedule criterion for ON. The table below provides a proposed diagnostic criterion for ON.

Table 3.8: Proposed diagnostic criteria for ON (Dunn and Bratman, 2016:13; Koven and Abry, 2015:386; Moroze et al., 2015:401)

Criterion A. Obsessional preoccupation with eating "healthy foods", focussing on concerns regarding the quality and composition of meals (two or more of the following): - Consuming a nutritionally unbalanced diet owing to preoccupying beliefs about food "purity". - Preoccupation and worries about eating impure or unhealthy foods and of the effect of food quality and composition on physical or emotional health or both.

- Rigid avoidance of foods believed by the patient to be “unhealthy”, which may include foods containing any fat, preservatives, food additives, animal products or other ingredients considered by the subject to be unhealthy.
- For individuals who are not food professionals, excessive amounts of time (e.g. three or more hours per day) spent reading about, acquiring and preparing specific types of foods based on their perceived quality and composition.
- Guilt feelings and worries after transgressions in which “unhealthy” or “impure’ foods have been consumed.
- Intolerance to others’ food beliefs.
- Spending excessive amounts of money relative to one’s income on foods because of their perceived quality and composition.

Criterion B. The obsessional preoccupation becomes impairing by either of the following:

- Impairment of physical health owing to nutritional imbalances, e.g. developing malnutrition because of an unbalanced diet.
- Severe distress or impairment of social, academic or vocational functioning owing to obsessional thoughts and behaviours focussing on patient’s beliefs about “healthy” eating.

Criterion C. The disturbance is not merely an exacerbation of the symptoms of another disorder such as obsessive-compulsive disorder or of schizophrenia or another psychotic disorder.

Criterion D. The behaviour is not better accounted for by the exclusive observation of organized orthodox religious food observance or when concerns with specialized food requirements are in relation to professionally diagnosed food allergies or medical conditions requiring a specific diet.

An existing limitation in relation to ON is that not much is known about it from a South African perspective and there is still much controversy (Lopez-Gill *et al.,* 2023:2) on the efficiency of recognizing this as an eating disorder. Research on this topic is largely seen in studies from Italy, Portugal, Spain, Poland, Turkey, Brazil, Australia and the USA (Lopez-Gill *et al.,* 2023:5-6).

In the following section the author conducts a discussion of bigorexia nervosa.

3.2.4.2 *Bigorexia nervosa*

Just like with ON, *bigorexia nervosa* (BN) serves as another controversial sub-type[6] of feeding and eating disorders (FEDs) (Vasiliu, 2023:1). This controversy is likely to arise

[6] Other controversial sub-types of EDS which are yet to be researched further and are not included in our existing diagnostic manuals is *diabulimia* (Coleman & Caswell, 2020:1). This is a condition where individuals with diabetes stop taking insulin in the attempt to lose weight.

because *bigorexia* as a concept is not included in diagnostic manuals. However, due to individuals with *bigorexia* being so highly fixated on gaining muscularity, most studies discuss *bigorexia* from the context of *muscle dysmorphia*. This is fitting as BN is also largely known as "*muscle dysmorphia"* (Golden *et al.,* 2009:21; Duran *et al.,* 2020:878; Vasiliu, 2023:2; Duran & Oz, 2022:1720). The *Merriam-Webster Online Dictionary* also recognizes this concept as their definition of *bigorexia* states that while most individuals would engage in exercise and strive to improve their diets, there is another group of individuals who struggle with *bigorexia* which is also known as *muscle dysmorphia* and these people are prone to experiencing feelings of shame and embarrassment with regards to their perceived smallness (Merriam-Webster Inc, 2025). The concept of *muscle dysmorphia* is also one which is briefly discussed within the diagnostic manuals (APA, 2013:243; WHO, 2024:309). The author of this study agrees that the classification of BN as a form of muscle dysmorphia is accurate because the DSM-5 explains that individuals with *muscle dysmorphia* are often fixated with the idea that their body build is either too small or not muscular enough (APA, 2013:243). According to Arslan *et al.* (2022:1) it is stated that those who battle with *bigorexia* carry the desire to have less fat and they obsess about an increased muscle mass. This preoccupation with their body build goes as far as individuals failing to see themselves through the lens of what other people see. This is a common struggle among those with eating disorders where individuals tend to perceive themselves as being completely different from how others perceive them (Hepworth, 2010:239; Duran & Oz, 2022:1721). The same can be seen among some with AN who see themselves as overweight regardless of being completely underweight. These examples are supported by Golden *et al.* (2009:21) who reiterated that:

> Bigorexia has to do with what your body looks like and the way you perceive your body … While anorexics look in a mirror and despair that they are not thinner and smaller, *bigorexics* see someone scrawny and weak and wished they look looked stronger and more muscular."

This statement reinforces the very fact that bigorexia (as with the rest of the eating disorders) is rooted in an extreme dissatisfaction with one's own body (Gay, 2009:3; Duran & Oz, 2022:1720; Devrim *et al.,* 2018:1746; Pallotti *et al.,* 2018:1166) which

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Pregorexia nervosa involves individuals significantly reducing energy intake during pregnancy to avoid gaining weight (Tuncer *et al*., 2020:186).

results in individuals displaying a preoccupation and obsessions about their body shape and size.

Existing literature on BN has pointed out that the disorder is likely to be common among males, but more so among bodybuilders and weightlifters (Vasiliu, 2023:1; Dervim *et al.,* 2018:1747; Duran & Oz, 2022:1721). However, this is not to say that females are exempt from battling with this disorder. In fact, in their study *The effect of bigorexia nervosa on eating disorder attitudes and physical activity: A study on university students*, Arslan *et al.* (2022:6) pointed out that there have been reports that muscle dysmorphia is also found in females. This notion has also been recognised within several studies, such as those of Hale *et al.* (2013:244) and Tod *et al.* (2016:181) which agree that muscle dysmorphia can be found among the female population although not in greater numbers like the other eating disorders.

The author argues that acknowledging the likelihood of bigorexia among the female population is pertinent within the context of this study.[7] This is mainly because it serves as a reminder that eating disorders, as well as body image related issues, do not discriminate based on an individual's gender or socio-economic background (Welch *et al*., 2015:1). Such an approach, in my view, is useful as it helps one gain a broader view of the issues mentioned within the context of this thesis without limiting them to one gender.

Taking all of this into consideration, one might ask how muscle dysmorphia relates to eating disordered behaviours?

Firstly, the concept "eating attitudes" is defined by Arslan *et al.* (2022:2) as "a complex phenomenon affected by environmental factors as well as motor, cognitive, social and emotional development and is described as beliefs, thoughts, feelings and behaviours towards foods". Alvarenga *et al.* (2012:435) agree with the definition provided by Arslan *et al.*, but the authors took the concept a step further and went on to mention that eating attitudes have to do with the type of relationship that individuals have with food and thus this relationship can play a pivotal role in influencing people's food choices.

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[7] The author of this study uses the words *bigorexia*, *bigorexia nervosa* and *muscle dysmorphia* interchangeably within this section but these words all point to the same idea. As stated in the text, these words refer to an individual's desire to gain increased muscularity.

What would this look like in the context of *bigorexia nervosa*? Individuals struggling with *bigorexia* are more likely to alter their diets which may result in an exhibition of unusual eating behaviours. According to Lechner *et al.* (2019:990), individuals with eating disorders tend to have a fixation on diets consisting mainly of high protein food produce which often results in a reduction of products low in protein and going as far as eating even on occasions when one is not hungry. This behaviour manifestation of "overeating" or "reducing or removing" certain foods content in one's diet is seen repeatedly in eating disorder criteria. Although the focus here is not necessarily on weight loss, there is indeed a clear correlation between eating disorders and BN - a correlation which has the author of this study convinced that mental disorders and eating disorders should never be viewed in isolation.

The complexity with a disorder like bigorexia not only lies in the disorder not being formally recognized within our current diagnostic criteria, it also lies in the reality that although maintaining a low body weight is not the core motivator but rather gaining muscularity seems to be the key element, these individuals still exhibit a fixation on food and exercise - factors which are prevalent in eating disorder criteria. With this knowledge in mind, the author of this study argues that the eating disorder element which is clear within the nature of *bigorexia* and other muscle dysmorphic disorders should not be overlooked. In fact, in the study *The effect of Bigorexia Nervosa on eating attitudes and physical activity: A study on university students* the authors went on to mention that the similarities between BN and AN are inclusive of the following factors: both disorders involve individuals displaying an impaired body image, disordered eating behaviours as well as over-exercising (Arsalan *et al.,* 2012:2). BN is fondly known as *reverse anorexia* (Nagata, 2025; Kinnaird, 2017:2) which refers to the idea that those with this disorder are driven towards muscularity as opposed to thinness.

3.3 Eating disorders in South Africa

In Chapter one of this study, the author gave an overview of eating disorders within a South African context. The discussion in Chapter 1 debunked the myth that eating disorders are a problem most likely to be experienced by white females as opposed to their black counterparts. This was because eating disorders among black South

African women were only first reported in 1995 (Delport & Szabo, 2008:272). As mentioned, multiple times most existing literature on eating disorders focus on the issue from a female perspective, with very little literature acknowledging that this is an issue which males might experience too. This is reaffirmed by Freeman and Szabo (2005:601) in their paper titled *Eating disorders in South African males: A review of the clinical presentation of hospitalised patients*, who mentioned that research on males with eating disorders is scarce within the South African context. Regardless of gender and the socio-economic context, eating disorders pose a problem for those struggling with them. This is discussed further in this section where the focus will be on discussing eating disorders as a public health issue. This is followed by a discussion of the relation between eating disorders and sustainable development goals. Lastly, the prevalence rates of eating disorders among South African youth are discussed.

3.3.1 Eating disorders as a public health crisis

Eating disorders, just like sexual abuse as discussed in Chapter 2 have been identified as a public health concern (Austin, 2012:1; Wu *et al*., 2020:1). Firstly, the concept of public health refers to "significant events that threaten the health and well-being of a population, often requiring urgent governmental and societal response" (Public Health Crisis, 2025). This definition is fitting in the context of eating disorders. The reason for this distinction stems from the fact that eating disorders pose a significant threat to the health and well-being of those struggling with them. In the paper *Testimony of the eating disorders coalition for research, policy and action*, it is mentioned that eating disorders are a growing public health threat (*Sub-Committee on Public Health* – US Senate, 2002:2). Although this paper is not necessarily a recent one, it still acknowledges a factor that is often so overlooked and not spoken about enough in our current discourse. The nature of eating disorders as a public health concern cannot be ignored. According to the same paper by the Sub-Committee on Public Health, it is estimated that alongside the physical and mental effects that eating disorders have on individuals, young women with eating disorders have an increased risk of suicide as opposed to those without eating disorders. It was further suggested that young women with anorexia are twelve times more likely to die than young women who do not battle with eating disorders (*Subcommittee on Public Health* – US Senate, 2002:2). In another study the following was said:

> EDs present a significant threat to the health of adolescents and young adults, yet remain under-diagnosed and under-treated at population level… As such higher weight individuals, racial/ethnic minorities, those from socioeconomically disadvantaged backgrounds, and males may not recognize their need for treatment, may or may not be properly screened for EDs, and may/may not be referred to treatment (Sonneville & Lipson, 2018:518).

The author of this study argues that the reason EDs can be under-diagnosed at times is because those battling with eating disorders are not always forthcoming when it comes to reaching out for help which can result in a significant under-reporting of these disorders among both males and females. With the lesser-known disordered eating habits, there are no diagnostic criteria or evidence to clinically support the view that the individual might be battling with eating disorder related behaviours. This under-reporting could likely come at the risk of physical and mental health issues related to EDs not being treated as well, which ultimately has a ripple effect on the overall health and well-being of individuals (Sonneville & Lipson, 2018:525).

According to Sonneville and Lipson (2018:518), treatment outcomes are influenced by several factors, one of which is the failure to refer individuals to appropriate services. While this is true in many ways, another big discrepancy is the affordability of treatment. Treatment comes at a cost, and it is therefore not accessible to everyone. It is suggested that only one in three individuals with an eating disorder receive the help that they need (Sonneville & Lipson, 2018:518). Alongside those who do not reach out for support, individuals without access to essential treatment resources face substantial barriers to care. South Africa has a limited number of free rehabilitation programmes, yet even with the existence of free rehabilitations many of these provide their services for those battling with substance abuse related problems as opposed to behavioural addictions like eating disorders. The number of rehabilitation facilities which can accommodate individuals younger than 18 are also limited, which is another factor that can create a gap in terms of treatment. In Chapter 4 we will not only explore the complexity of eating disorder treatment, but also the fact that treatment does not always look the same from one person to another, because what works for one person might not necessarily work for the next.

The nature of eating disorders as a public health issue is one which has a lot of existing gaps in research as it is an under-researched topic. This is an area of research which

could benefit from further study to gain a deepened understanding of the public health responses which will be the most appropriate to take when tackling eating disorders in the South African context.

3.3.2 Eating disorders and sustainable development goals

In Chapter 2 of this study, the author discussed sustainable development goals (SDG) in relation to sexual abuse. In this section the author continues the discussion of the sustainable development goals with an attempt to explore how eating disorders fit in within the framework of SDGs.

Taking into consideration that eating disorders affect both the mental and physical well-being of individuals, it is only fitting to discuss them within the perspective of SDG Target 3[8] which focuses on attaining good health and well-being (UN DESA, 2024). While this is only one goal to discuss, the United Nations acknowledges that all the goals are integrated and interconnected (UNDP, 2025; United Nations, 2025). As mentioned in Chapter 2, the key focus of SDG Target 3 is on "ensuring healthy lives and promoting the well-being for all at all ages" as this is essential for sustainable development (UN DESA, 2024). Eating disorders as seen in the context of this chapter often have a dire effect on the overall physical and mental health of those battling with them (Klein *et al.,* 2021:22). Not only that, but they pose a huge threat to the actual livelihoods of individuals (Klein *et al.,* 2021:22; Visser *et al.,* 2014:208). Research shows that EDs are mostly prevalent between adolescence and early adulthood (Klein *et al.,* 2021:22). This means that youth battling with eating disorders are at a higher risk of developing chronic health conditions at a young age. Equally so, youth with eating disorders are at risk of increased mortality rates. This is supported by Klein *et al.* (2021:22) who mentioned that among those battling with AN or BN, there is a "two-to-six-fold increase in age-adjusted mortality attributed to medical complications and have suicide completion rates up to 18 times the completion rates of peers". From this statement made by Klein, it is clear how EDs pose a risk to the good health and wellbeing of young people.

8 SDG 3 – Ensure healthy lives and promote well-being for all at all ages (UN DESA, 2024).

SDG Target 3.4 is aimed at “reducing by one-third premature mortality from non-communicable diseases through prevention and treatment and promoting mental health and well-being” (WHO, 2018:1). This cannot be fully achieved if some aspects of mental health are not given as much attention as others. There is a lack of eating disorder research as it pertains to SDGs, and this is an area which I as the author of this study believe needs further research - research that will be solution-orientated as to how to effectively tackle the issue of eating disorders among the youth in order to have a thriving society of young people who are healthy both physically and mentally. While some solutions in this matter are most likely to look at the role education or the type of media produced can play as preventative measures in tackling eating disorders, I do argue that more needs to be done in actioning out effective preventative and public health efforts to help mitigate the increase and effects of eating disorders in our communities.

On the goal of gender equality, it is once again important to normalize speaking about eating disorders from a gender-neutral perspective. Yes, these disorders are known to be mostly prevalent in women, but this does not mean that men are exempted from the possibility of battling with an ED. The aetiology and symptomatology might present itself in a slightly different way among males and females. Striving for gender equality in my perspective means realizing that gender does not decide which one person is likely to struggle with ED based on sexuality. Having such an approach is not only discriminatory, but it holds within it a host of limitations which then goes on to be evident when someone is misdiagnosed or receives inadequate treatment for an eating disorder because of their gender. The same applies within the context of Chapter 2 where males are mistreated for reporting sexual abuse at all because societal norms do not conform to the possibility of these issues being an actual reality among men.

My point for including this section is that for us to achieve the SDGs, it is important to address these other issues which are often overlooked. Writing this is making me think of the fact that for many with eating disorders, not only will their health be impacted but this will go on to influence their education, an effect on their ability to get employment or sustain employment and often things like these can get ignored or forgotten about. Addressing issues in their totality, in my perspective, is key to effectively achieving the SDGs. While these goals are set to be achieved by 2030, I

am convinced that more work still needs to be done in several key areas and that is perfectly fine, but we as a collective need to be open-minded enough to recognize the gaps and play our collective roles in addressing them.

In the following section, the author will be discussing the prevalence of eating disorders within a South African context.

Eating disorders within the context of South Africa continue to lack research and without an adequate amount of research, it becomes difficult to find effective and current solutions to solving the crisis that we face within our homes, schools, churches and communities at large.

3.3.3 Prevalence rate of eating disorders in the context of South Africa

As mentioned, at countless times in this study, eating disorders have been seen to be a common reality among South Africans. Furthermore, the study also mentioned the notion of eating disorders as a problem which affects both men and women. The issue is known to be mostly prevalent among adolescents as young as 12-years of age (Sanzari *et al.,* 2022:2975). In a *South African Study* by Mould *et al.* (2011:137) the age of onset was estimated to be between 13.7 to 16.7 across different ethnic backgrounds. Based on a publication by *Harvard Health*, it was mentioned that one in seven men and one in five women experience eating disorders by the age of 40 and 95% of those cases will have occurred by the age of 25 (McCarthy, 2022).

According to an article published in *Times Live,* it is suggested that approximately a little over one in five children and adolescents have been affected by disordered eating patterns based on a global analysis that included sixteen countries (Keeton, 2023). While this was based on a limited point of view as the study only comprised 63000 (Keeton, 2023) participants, it gives a clear view of the eating disorder problem that young people are faced with. Research not only acknowledges that eating disorders are a problem, but it has also been noted that eating disorder prevalence is seemingly increasing among adolescents (McCarthy, 2022). Yet these disorders continue to remain under-reported and under-treated, especially among males (Strother *et al.,* 2012:346).

The prevalence rates of eating disorders in South Africa also continue to be under-reported, even though eating disorder research in the country dates back to the 1970s (as discussed in Chapter 1). Furthermore, as shown in Chapter 1, eating disorder prevalence among patients admitted at Tygerberg Hospital in Cape Town is as follows, according to the study by Williams *et al*. (2020:1).

Table 3:9: Prevalence rate of eating disorders as seen among patients in the eating disorder unit at Tygerberg Hospital (Cape Town) (Williams *et al*., 2020:1).

Type of eating disorder	**Prevalence rate (n=162)[9]**
Bulimia nervosa	40.1 %
Eating disorder not otherwise specified (EDNOS).	33%
Anorexia nervosa	26.5%

A limitation with this table is that it does not give the prevalence rate of BED and the stats do not show how different age groups are affected by eating disorders. Williams *et al*. (2020:3) did mention, though, that the average age of the participants who took part in the study was 26.2, which supports what was mentioned earlier, viz. that EDs are most likely to occur at higher rates among individuals ranging between the ages of 12-26. What was interesting in the study is that Williams *et al*. (2020:1) mention that among those with EDs, approximately 71% used at least one substance, with alcohol being the most common substance (54.8%) that these individuals resort to. Alongside this, it was pointed out that among those with EDs, approximately 63.2% had a psychiatric condition with major depressive disorder (MDD) being the most common as it affected 46.3% of the sample population. It was further mentioned that most participants in this sample were female (95.7%), which further proves the existing gap in research when it comes to understanding prevalence rates of eating disorders

[9] n=162 refers to the number of participants who took part in the study by Williams *et al.* (2020) in the paper titled: *Eating disorders and substance use at a South African tertiary hospital over a 21-year period*.

among males. However, it is important to take note that some of the limitations which exist on the results produced in the study by Williams *et al.*, (2020:1) could be due to the fact that the data looked at patients who had been admitted from EDs at Tygerberg Hospital from 1990 to 2014, which means that there was a change in DSM-5 diagnostic criteria during that time. The researchers themselves acknowledged that they hoped to be able to align the trends with the recent DSM-5 diagnostic criteria in the future (Williams *et al.,* 2020:6).

A study of *Abnormal eating attitudes and weight-loss behaviour of adolescent girls attending a 'traditional' Jewish High School in Johannesburg, South Africa* highlighted the fact that the prevalence rate of disordered eating patterns and behaviours among high schoolers in Grades 8-11 with a sample size of 220 learners (Visser *et al*., 2014:208) are as follows:

Table 3.10. Abnormal eating attitudes and weight-loss behaviour of adolescent girls attending a "traditional" Jewish high school in Johannesburg, South Africa (Visser *et al*., 2014:208).

Scenario	Number of learners based on sample size of (n=220)	Prevalence in percentages (%)
Suggestive of a possible eating disorder.	43	20
Required clinical evaluation for a possible eating disorder.	65	30.2
Considered themselves to be overweight.	72	33
Trying to lose weight.	139	64
Engaged in one or more extreme ways of weight loss in the past 12 months	42	42

The results of this study show the reality of body image problems among young people. Although these results are not indicative of eating disorder rates nationally, they still do show how it is a worrying problem in society today. This only results in leaving the author with the question: How many more young people are sitting in our communities, whether be it at church or at school, who are battling with eating disorders?

The limitation of these results is that they only look at the female population (Visser *et al*., 2014:208), once again leaving us with questions regarding prevalence rates among the male population. The high rate of young people attempting to lose weight or who have taken extreme measures to lose weight is not only heart-breaking but also serves as an indication that early dieting puts individuals at an extreme risk of developing eating disorders at some point in life. I write this with great conviction as I began drinking weight loss pills early on in life which then led to engaging in extreme dieting and exercise. Having hidden my struggle from everyone, I agree with the notion that eating disorders tend to be under-reported and under-treated, which makes it difficult not to have discrepancies in statistical responses.

I identified an extreme gap with regards to the reporting of current eating disorder statistics within the South African context. This is a gap which needs to be addressed with urgency as doing so may help us to understand how widespread the issue is and may encourage public health responses to be strengthened. In the following section, I will be discussing the impact of eating disorders based on my own personal reflections as someone who has been impacted by these disorders.

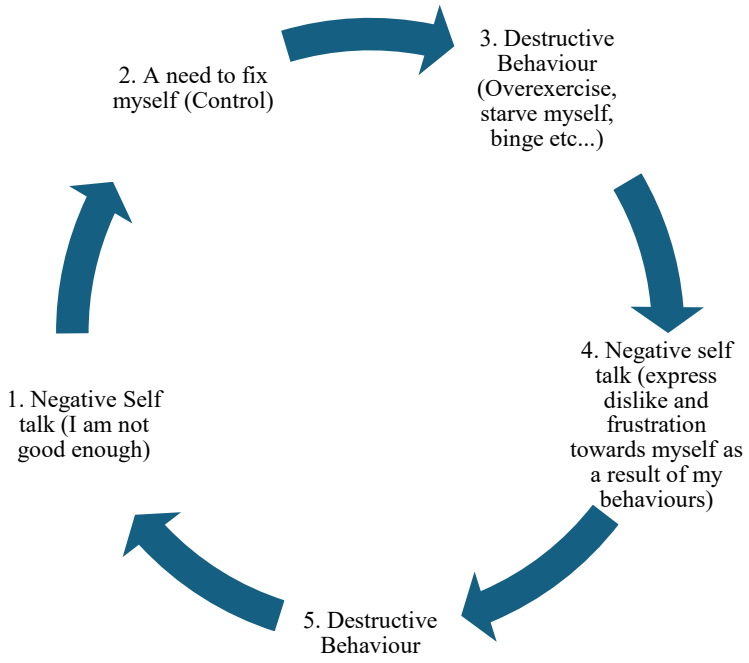
3.4 The impact of eating disorders: A personal reflection

In this section I will be discussing the impact of eating disorders based on a personal reflection. While this chapter has continued to deal with the various physical and mental effects of EDs, the author draws from her own experience with disordered eating cycles to try and fill in some of the gaps related to the impact of eating disorders that have not been touched on.

From her own journey the author found that eating disorders have a negative effect on one’s self-esteem. A lot of the times research studies look at self-esteem as the direct

cause of eating disorders. This is not wrong and it will be discussed further in Chapter 5 of this study. However, not much research has been done on eating disorders in themselves, resulting in a negative impact on the self-esteem of individuals. Krauss *et al.* (2023:1141) agree with this and mention that “the potential role of eating disorders in the development of self-esteem has been largely ignored in the literature”. The author argues that while self-esteem can be influential in the development of an eating disorder as research suggests, it can also be influenced by the eating disorder itself or at times both scenarios may present themselves. The latter scenario seems to be one that presented itself in my own journey where my self-esteem was gutted and I resorted to eating disordered behaviours, but while engaging in the disordered eating patterns my self-esteem was more negatively influenced. I see this as a cycle that continued to motivate my disordered behaviour. The following diagram is a representation of how this cycle played out in my life.

Figure 3.4: A link between low self-esteem and eating disorders in my personal journey.



The following discussion serves as a brief discussion to how this cycle played itself out in my journey:

Negative self-talk (I am not good enough)

Exposure to trauma played a pivotal role in influencing how I saw myself. I lost a sense of myself (identity) and often had nothing good to say about myself. This not only influenced how I saw myself, but it also imparted a deep-seated desire in me to change myself. I needed to be different so that I could fit in and reach the desired societal standards of beauty and perfection. This would then lead to me feeling an intense desire to fix myself and be in control.

A need to fix myself (*Control*)

The trauma informed a thought pattern in me where I believed that something was wrong with me and because of that I needed to fix myself. Maybe if I fixed myself then no one would go on to take advantage of me and my body again. I firmly believed that the only way to fix myself was to change how I looked and in that way I would have

control over my body so that everyone else could lose the power they had gained over me.

Destructive behaviour (over-exercising, starving myself, binge eating, etc…)

As I was looking to reach a perfect physique, I would vigorously spend a few years of my life going through the cycle of over-exercising, starving myself, binge eating, abusing laxatives, etc… all this so that I could become thinner and feel beautiful. Momentarily, I would celebrate each time I got certain things right such as my exercise routine, which comprised exercising a minimum of three hours each day, but a lot of the times this was short-lived as I would once again find reason to criticize myself. The ripple effect of that then became feelings of unworthiness, guilt, shame, self-hatred and anger towards me, among many other things which would then lead to more negative self-talk.

Negative self-talk (expressing frustration towards myself because of my behaviours) and destructive behaviours

A lot of the times I would find myself frustrated because of my destructive self-abusive behaviours. Even though I was looking to be in control, it often felt like I was powerless and out of control. I did not know how to stop counting my calories, I did not know how to reduce my exercise behaviours. It felt as if I was controlled by my preconceived notions of beauty, that I forgot about everything else that mattered. That led to my beating myself up due to experiencing utter frustration, but even that would not change anything. Instead, I kept falling right back to the destructive cycle time and time again. I needed to learn to accept myself, I needed to learn my worth again.

Eating disorders pose a threat to identity. This was supported by Biberdzic *et al.* (2021:1) who found that there was an existing link between eating disorders and identity disturbance. I not only lost a sense of who I was, but I forgot who God truly is. Jessica Harris speaking on female recovery from pornography uttered the following words:

> The most important thing in a woman's journey for recovery is that she finds her identity in who she truly is without pornography. So many times, women find their identity in pornography, and we get so worried about "stop watching

> it and take it away" that we don't teach them who they are without it (Set Free Summit, 2019).

Although this was written in the context of a completely different issue, the reality is that my identity was informed by the eating disorder as well as societal norms, and that broke me. I am certain that many young girls can relate with this. As we move ahead with the chapters, I intend to take the reader on a further journey in relation to identity with a specific focus on Genesis 1:27.

Alongside this, a struggle with eating disorders can result in spiritual disconnection. How spiritual disconnection played out in my journey is that my relationship with God became inauthentic - in fact, I spent all my days frustrated with God for not letting me lose weight or blaming God for making me gain weight. I worshipped my weight and behaviour more than I worshipped God. My body and image became my idol as they were the one thing I put first, over and above my relationship with God. This eventually led to me feeling convicted because Exodus 34:14 gives a clear instruction to only worship God and nothing else. It reads as follows: "Do not worship any other god, for the Lord whose name is jealous is a Jealous God."

In the following section the author conducts a discussion on EDs within the context of the church. Due to this thesis having a theological paradigm looking at EDs from this perspective, it is useful in helping the author effectively answer the central theological argument of this thesis.

3.5 The church and eating disorders

Trying to discuss EDs from a spiritual perspective is a rather complex task. This is largely due to EDs not being directly discussed within the Biblical context, which ultimately means that in most church communities this is a topic that will not be addressed during a sermon. Christianity does not impose any dietary conditions on individuals (Chouraqui *et al.,* 2021:16). While this may be true for many, research asserts that in some Christian circles there may be some religious practices which influence diet (Dominguez *et al.,* 2024:1). An example of this would be that in the Seventh-Day Adventist Church, members are encouraged to follow a vegetarian diet and to avoid the consumption of alcohol and products containing caffeine in order to

obtain optimal health (*Seventh-Day Adventist*, 2025). They have based their dietary restrictions based on the following scriptural references:

- Genesis 1:29, which reads as follows: Then God said, “I give you every seed-bearing plant on the face of the whole earth and every tree that has fruit with seed in it. They will be yours for food.”
- 1 Corinthians 10:31 reads as follows “So whether you eat or drink or whatever you do, do it all for the glory God.”

The author argues that using the Bible in this way may be limiting and for others it would be a means for justifying their behaviour. I say this, because in my journey over-spiritualising everything was fundamental in justifying my behaviour and in maintaining my addictive cycles whether it was obsessively counting my calories or over-exercising. When looking at a verse like Genesis 1:29, although it does suggest a plant-based diet, the other side of the spectrum is Genesis 9:3 which reads “Everything that lives and moves about will be food for you. Just as I gave you the green plants, I now give you everything” (Constable, 2012). While it is important to note that none of these scriptures directly relate to eating disorders as such, 1 Corinthians 10:31 is one verse that always reminds me of the importance of having a heart posture that is wholeheartedly devoted to God in all our actions. I would like to argue that we need to exercise caution when using the Scriptures as a tool to support the reasons for following a specific diet. While the verses in Genesis might have pointed to diet, it is my perspective that the key lies in stewardship and intentionally choosing not to make an idol of our diet. The same level of mindfulness should also be practised in relation to spiritual disciplines such as fasting.

A lot of Christian churches make use of the practice of fasting as a spiritual discipline which is of course the intended reason for this practice, but what happens when these spiritual practices get to the point where individuals destructively engage in them for purposes of weight loss instead of a pursuit for intimacy with Christ? In a lot of the eating disorder criteria, we see long periods of fasting as one of the diagnostic markers for EDs. This is something which rings true to me as it takes me back to moments in my youth when I was so concerned about my body image and I was always fixated on the idea of fasting for weight loss instead of its intended purpose. This only leaves me with the question as to how many young people are sitting in the pews of the church today battling with the same pattern of behaviour?

EDs, a construct which is barely heard about in churches today, are a reality in our day and age, which like any other social problem faced are a reality in our churches too. This is a reality which the churches should be cognisant of, and one which they should strive to address. Hopefully at the end of this thesis, we will find ways to develop a strategy which pastoral counsellors and pastors can explore in their congregations should they encounter individuals struggling with EDs within their churches and respective communities.

In their study, although not directly written from a theological perspective, Beaulieu and Best (2022:1) found that religiosity plays a role in disordered eating cycles among both men and women. These authors further mention that “religious participants who indicated changing their eating habits for religious purposes experienced greater disordered eating and appearance related pressures” (Beaulieu & Best, 2022:1). With humanity known to be created in the image of God, as we read in Genesis 1:27, the author of this study has no doubt that the enemy will at all costs do his very best to taint this image.

When the author prompted ChatGPT (OpenAI, 2024) with the following question: “If you were the devil, how would you taint the image of God amongst humans taking into consideration that humans are created in the image of God.” ChatGPT’s (Open AI, 2024) response was,

> If humans are made in God’s image, I would attack their sense of identity. I’d make them feel worthless, inadequate, and lost. I’d promote self-hatred and confusion, so they’d doubt their own divine nature. I’d create a culture of comparison, making people obsess over external beauty, wealth, and status rather than their inherent dignity… Ultimately, the goal would be to make humans forget who they truly are—children of God—and replace that with a false, distorted image of themselves and their Creator.

While this was not necessarily a scientific question or even a scientific approach to research, the response given by ChatGPT is in many ways thought-provoking, as it points to the reality of Ephesians 6:12 which reads as follows, “For our struggle is not against flesh and blood, but against the rulers, against the authorities, against the

powers of this dark world and against the spiritual forces of evil in the heavenly realms."[10]

Eating disorders within the body of Christ cause those struggling with them to not only develop a flawed view of themselves (Carey & Preston, 2019:2), but a flawed perspective of what God says they are, which at times can undermine the very way in which we perceive God. At a later stage in this thesis, I will be exploring this in depth by looking further into the images that we have of ourselves and God, which can influence engaging in destructive cycles of behaviours such as eating disorders.

Speaking about eating disorders from the pulpit is not something that is often experienced in churches, maybe due to a lack of awareness or maybe not regarding eating disorders as a church issue. Equally so, another reason could be that church leaders might not feel equipped to handle an issue like eating disorders. All these are relevant and important points to make, but the journey I have walked in the past year is one which taught me not to let these be limiting factors. I argue that for as long as a problem is a societal issue, it qualifies as a church issue as the church is a place filled with people who all bear different burdens. Acknowledging this as a ministerial issue is essential. In conversations I had with a few ministry leaders, something which struck me was a comment made by a pastor who said: "My church is okay. It does not have problems with addiction or anything of that sort." Yet, truth be told, addiction is a problem of our day, sexual abuse is a problem of our day, eating disorders are a problem of our day, and so we can continue. Choosing to accept reality and doing something about it, can reap breakthroughs in so many areas. The author argues that the church of Christ has a responsibility to create safe spaces where taboo subjects are not only addressed, but safe spaces are constructed where the stigma can be broken. Whether be it within the counselling room, a recovery group, support groups or a mixture of these, the church must foster and cultivate spaces where things like eating disorders and sexual abuse do not have to be taboo subjects within the church. Romans 8:1-2 reads that "Therefore, there is now no condemnation for those who are in Christ Jesus, because through Christ Jesus, the law of the Spirit who gives life has set you free from the law of sin and death."

10 All Scripture references in this chapter are from the *New International Version* (NIV).

If the church can be pro-active in this, it will not only create a culture where shame can be broken, but one where the church can start to feel relatable to many. It will become a place where people know that they can come as they are. Jesus offers us the same opportunity to come before His throne of grace as we are and to find rest in Christ. In Matthew 11:28, Jesus spoke the following words: “Come to me, all you who are weary and burdened, and I will give you rest.” Furthermore, if the church does not shy away from addressing issues like trauma (in the context of this study, sexual abuse), addiction and other related behaviours (e.g. eating disorders) it will very well become a place where people can find healing, hope, restoration and freedom.

3.6 Conclusion

This chapter focused on answering the question “What is going on?” based on eating disorders within the South African context. Although the author feels that the most part of this discussion is generalized and not much focus was placed on South Africa and its youth, with further research, moving forward, this is something which can be rectified.

In this chapter, it was considered that eating disorders are a complex phenomenon and can affect individuals of all ages and backgrounds. The three common eating disorders as recognized by the DSM-5 are AN, BN and BED. In the contextualization of eating disorders, the author looked at the diagnostic criteria for the eating disorders and found that the eating disorders are associated not only with distortion in the way that individuals perceive their body image, but they are also fuelled by a high level of powerlessness from stopping the behaviour. The eating disorders often go hand in hand with several co-morbid disorders which threaten the physical and mental health of individuals. As discussed in this study, eating disorders are life-threatening and have the highest mortality rate in comparison to other psychiatric conditions.

The author took the discussion a step further by looking at eating disordered behaviours which are recognized as psychiatric conditions in either the DSM-5 or ICS-11 but pose similar behavioural patterns to the eating disorders. These eating disordered related behaviours are *orthorexia nervosa* and *bigorexia nervosa*. It was found that these behaviours have similarities with other EDs such as *anorexia*, with *bigorexia* known as *reverse anorexia*. Equally so, like EDs recognized within the

diagnostic manuals, these disorders go hand in hand with several co-morbid disorders such as obsessive-compulsive disorder, depression and anxiety. It was also found that although the common population of people likely to be affected by eating disorders is female, males are also impacted on but there are existing gaps which remain with regards to prevalence rates in this population.

The author identified eating disorders as a public health concern as it threatens the health and well-being of individuals and recognizing the need for public health measures in treating eating disorders to be strengthened. That discussion was followed by one which viewed eating disorders from the viewpoint of the sustainable development goals, whereby the author mentioned that in order for us to achieve these goals, we should be both cognisant in being aware of the issues facing us today, and through communicative action play a key role in addressing these issues. By actively choosing to find effective ways to address eating disorders in our communities, we add a layer to SDG 3 where the goal is to promote health and well-being for all people.

Furthermore, the author discussed the prevalence rate of eating disorders in the country. This is yet another area where she feels that the data provided does not necessarily give an adequate picture of eating disorders in South Africa. She found that there is currently a big gap in the literature on existing studies which show the prevalence of eating disorders not only within the context of South Africa but within the youth, although it was shown that females are once again prone to be affected by EDs more than males, and that those with EDs have a higher risk of mortality in comparison to those who do not struggle.

Through a personal reflection of my own struggles with eating disordered cycles, I gave a personal reflection on the impact eating disorders had on me and one that I believe many with a similar journey can identify with. The impact includes struggles with self-esteem and how that played a role in perpetuating the cycle of engaging in the disordered eating behaviour. Finally, the chapter went on to discuss eating disorders as they relate to the church, where I discussed the importance of the church in playing an effective role in speaking out about potent issues affecting our communities such as eating disorders. Within that discussion was an acknowledgement that eating disorders pose a threat to our identity as beings created in the image of God.

The next chapter explores the link between eating disorders and sexual abuse among South African youth. It will be the final chapter focused on Osmer's first task of practical theology and through an empirical study and focus on understanding the current treatment methodologies in treating sexual abuse and eating disorders in youth.

CHAPTER 4: DESCRIPTIVE-EMPIRICAL STUDY ON THE LINK BETWEEN SEXUAL ABUSE AND EATING DISORDERS

4.1 Introduction

This chapter concludes Osmer's (2008:4) first task of practical theological interpretation which seeks to answer the question: What is going on? Now that the core concepts of sexual abuse and EDs have been studied. This chapter now moves on to developing a connection between these concepts. This is done by examining the existing link between sexual abuse and EDs. As part of this discussion, the focus will be on discussing the prevalence of EDs among those with a history of sexual abuse. This is followed by a discussion that investigates the problem of establishing a clear link between ED disorders and sexual abuse and concludes with a discussion focussed on whether there really is a link between the two phenomena.

Secondly, the chapter explores some of the current treatment methods used when working with individuals with histories of sexual abuse and EDs (based on literature).

Finally, findings and results from an empirical study involving members of a multi-disciplinary team who work with individuals battling with EDs and sexual abuse histories are discussed.

4.2 The link between sexual abuse and eating disorders

In Chapter 1 the author conducted a brief discussion of the link between sexual abuse and EDs. In this discussion, it was discussed that there is an existing link between sexual abuse and EDs. The author conducted further research on this to gain a broadened knowledge on the factors which play a role in contributing to this link. Such an understanding could be helpful when designing a pastoral strategy, and not only that, but it also helps to answer the central theoretical argument (CTA) of this study which states that there is an existing link between sexual abuse and the possible development of EDs among South African youth.

While a clear limitation from this study based on the first three chapters is that not much emphasis has been placed specifically on South African youth, the author of this study has established that research looking at the existing link between sexual abuse

and EDs goes back a long way. In the paper *Eating Disorders as sequelae of sexual abuse: A review of relevant literature,* White (1991:7) pointed out that from as early as 1902 analytical literature studies were already looking at the links between sexual abuse and EDs and the first empirical study addressing this topic was conducted in 1985. To see how far back research on this topic goes highlights the importance of research in this area. Yet despite the longevity of research in this area, no clear answers have been established as various studies differ on findings as to whether there truly is an existing link between sexual abuse and EDs. This statement is supported by Connors and Morse (1993:1) who stated that there are great discrepancies within studies investigating the relationship between sexual abuse and EDs. This points to the complexities which may arise when attempting to define a link between EDs and sexual abuse.

In this section the author deals with the prevalence rate of ED incidence among those with a history of sexual abuse. This is followed by a discussion focused on defining the problem related to establishing a clear link with regards to the relationship between EDs and sexual abuse.

4.2.1 Prevalence of eating disorders among those with a history of sexual abuse

In Chapter 1 of this study, the author states that 30 percent of individuals with EDs have experienced sexual abuse (Conners & Morse, 1993:1; Cowden, 2020; Behar *et al.,* 2016:149; Talago, 2024). Yet this is not an adequate picture as studies differ on the prevalence rates of EDs among those who have encountered sexual abuse (van Gerko *et al.,* 2005:375; Waller *et al.,* 2015:78). In the study conducted by White (1991:7) it is stated that approximately two-thirds of females who presented with EDs in their study indicated that they had experienced sexual abuse earlier on in their lives. Waller *et al.* (2015:78) mentioned that some studies reported that the prevalence rate could be as high as 64%; however, there are studies that report lower prevalence rates. Kjaersdam Telleus *et al.,* (2021:1) in their study state that nineteen percent of those who presented with ED symptomatology also reported exposure to sexual trauma. The authors went on to break down this exposure as follows:

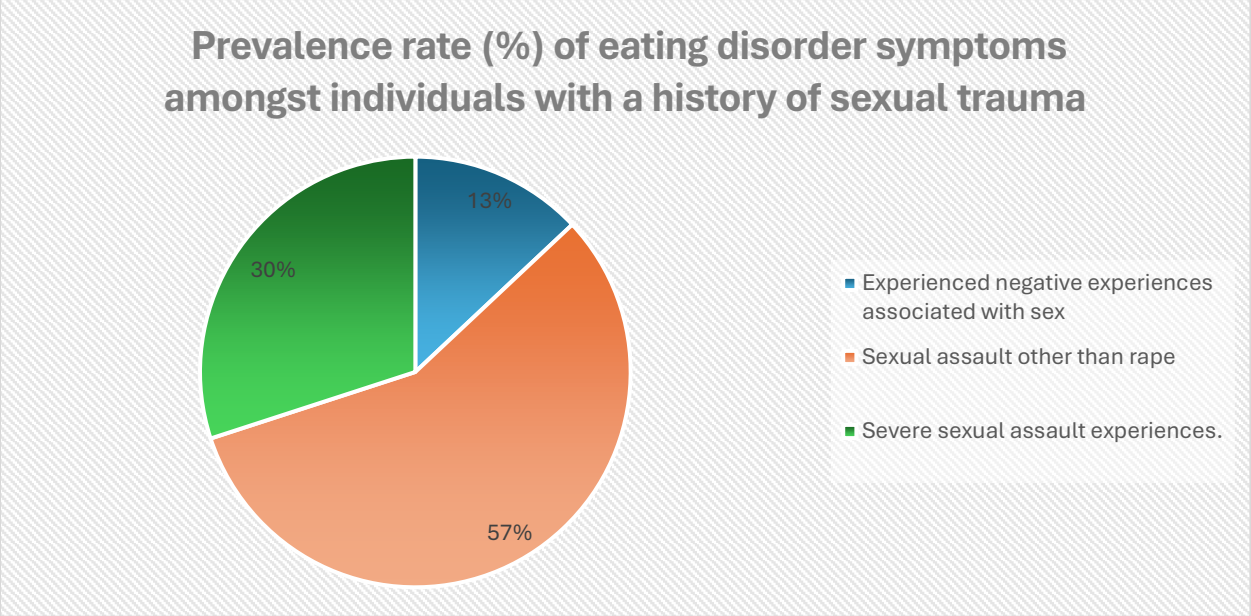


Figure 4.1: Source: Kjaersdam Telléus *et al.* (2021:1).

Based on this chart it is established that those who have been victims of a sexual assault other than rape are more prone to develop EDs because of the trauma they have suffered, while those who have had general negative experiences associated with sex have a lower chance of developing EDs. Furthermore, studies such as those of Chuku *et al.* (2023:1) have reported lower prevalence rates where it was established that approximately 5.6% of individuals who have experienced sexual abuse are prone to battling with EDs. Although the study by van Gerko *et al.* (2005) is an older study, the researchers went a step further by showing the possible prevalence rate of different ED sub-types among those who reported a history of sexual abuse. This data is reflected in the graph below:

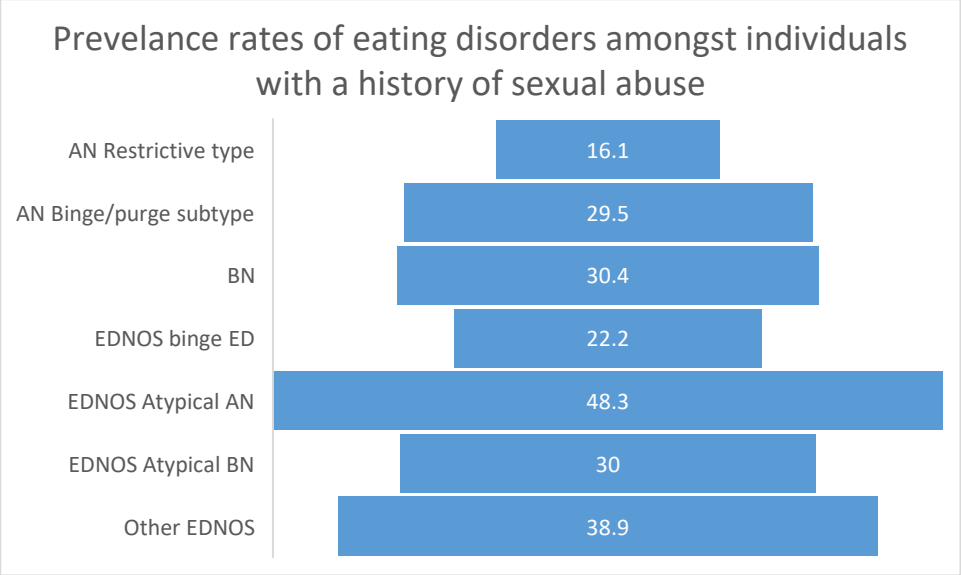


Figure 4.2: Source: Van Gerko *et al.* (2005:378).

In the graph above, it is seen that the likelihood of individuals falling back into anorexia after exposure to sexual abuse is low. It is suggested that sexual abuse is largely associated with *bulimia nervosa* and *binge-eating disorder* as opposed to restrictive *anorexia nervosa* (Behar *et al.,* 2016:149-150; Aloi, 2025:6). However, van Gerko *et al.* (2005:378) also showed that individuals with past sexual abuse scored higher on the diagnosis of EDNOS *atypical anorexia*. The limitation with this data, though, is that van Gerko *et al.* (2005) made use of the DSM-IV, and that poses a challenge with regard to the diagnostic criteria used. This is a challenge which will be discussed further in the following section. While the data provided gives guidance on the risk factor between sexual abuse and EDs, it is important to mention that it is limited in nature as it does not give any indication of the risk within a South African perspective which is inconclusive in showing how South African youth are affected. It is only helpful in terms of giving a general guideline of how EDs may be influenced by sexual abuse experiences. Another fundamental problem with a lot of the data provided is that it puts a focus on the female population and not much research is done on how males are impacted on by both EDs and sexual abuse (Waller *et al.,* 2015:78). This then goes on to make it difficult to understand the full effect resulting from how the males are affected by the link between sexual abuse and EDs. It is imperative to mention that these statistics are not absolute and equally so, different studies make use of a host of methods when gathering data as well as using different approaches and theories

(White, 1991:11; Waller *et al.,* 2015:78). The following section focuses particularly on discussing the problem of establishing a clear link between sexual abuse and EDs.

4.2.2 The problem of establishing a clear link between sexual abuse and eating disorders

This study has mentioned the complexity of both sexual abuse and EDs multiple times. Yet the author of this study has found it interesting that different studies have completely different views on the relationship between sexual abuse and EDs. In the CTA of this study, the author hypothesized that there was a link between sexual abuse and the development of Eds, but while this is not completely incorrect, it is important to mention that it is not as clear-cut as it seems. Waller *et al.* (2015:91) support this statement by mentioning that contextualising whether sexual abuse is related to EDs is a rather difficult road to explore, it is one that is not as simple and because of this "the answer is far from clear", In their study, *Sexual abuse and eating disorders: A review,* Connors and Morse (1993:4-5) acknowledged that the problem related to the link between sexual abuse and EDs is tied to methodological issues, diagnostic criteria and the assessment of sexual abuse. This was confirmed in other studies where it was found that the reason prevalence rates across studies are attributed to factors such as the diagnostic criteria used as well as the different methods of inquiry and definitions of sexual abuse (Waller, 1991:664; Waller et al., 2015:78). The author agrees with this three-fold problem identified by Connors and Morse for several different reasons:

Firstly, the methodological differences present within research studies lead to inconsistencies with regards to results on the link between sexual abuse and EDs (Connors & Morse, 1993:4; Waller, 1991:664). In older studies results vary greatly from some authors stating that there is no link between sexual abuse (Chuku *et al.,* 2023:7) and EDs to some authors arguing that there is an existing link between the two phenomena (Groth *et al.,* 2020:444; Heilman & Bright, 2022). Current studies on the topic, although limited, hold onto the notion that there has been an increase in prevalence when it comes to the link between sexual abuse and EDs (Madowitz *et al.,* 2015:281).

The author of this study argues that one cannot discuss methodology without addressing the fact that the sample sizes differ across studies. Considering that a lot of these studies were written from different contexts, the ripple effect comes through

as variations in prevalence. When discussing the issue of prevalence, Waller *et al.* (2015:80) mentioned that making a comparison with other groups is a critical component of studies investigating the link between sexual abuse and EDs. This they argued can be done by asking the following two questions:

> Is the prevalence of sexual abuse any greater in women with EDs than in the remainder of the population with psychological/psychiatric disorders? Second, Is the prevalence of abuse any greater in eating-disordered women than in the general population?

Waller *et al.* (2015:80) went on to answer these questions by maintaining that among women with EDs, the prevalence rate of developing ED pathology was lower than other psychiatric disorders. Take note that this finding does not deny the possibility of ED pathology, but it does take into consideration that individuals may encounter different psychopathological effects after experiencing sexual abuse. This is completely fine because how individuals react to traumatic experiences is not a *one-size-fits-all*. While others might end up experiencing EDs after sexual abuse, someone else might only struggle with the emotional symptomatology such as depression and anxiety. Waller *et al.* (2015:81) went on to further explain that prevalence rates can be influenced by the "coincidence hypothesis" which implies that sexual abuse is unlikely to be a causal factor of EDs, but rather an equal proportion of such cases will be present in the general population and will not have a direct impact on eating psychology. The author of this study argues that while the coincidence hypothesis proves itself to be partly correct by acknowledging that sexual abuse is unlikely to be a causal factor in ED psychopathology, this theory also has limitations as it fails to mention that in fact sexual abuse may be a probable risk factor for the development of EDs. To hold solely onto the coincidence hypothesis would be naïve and ignorant of the experiences of those who developed EDs as a direct result of sexual abuse experiences.

Another factor which the author of this study does not want to ignore is that we do not know much of how males are impacted as discussed earlier, and so prevalence rates continue to be limited in their nature as they do not give us a full picture of the problem. Equally so, when considering the challenges in methodology and prevalence rates, the author has also come to ask the question: "Do all participants walk into these

studies with a willingness to be completely open and vulnerable about their experiences with either sexual abuse, EDs or both?" This question comes from understanding how taboo and shameful these topics can be to speak about. This in my perspective shows itself in how under-reported issues such as sexual abuse continue to be prevalent in society today.

Secondly, another problem which was identified, is related to the diagnostic criteria used across studies. This problem has been identified based on the fact that a lot of the existing research that studies phenomena of sexual abuse and EDs is old and outdated. As a result, most of these studies made diagnoses of EDs within the context of DSM-III and DSM-III-R (Connors & Morse, 1993:5). This poses a challenge when trying to accurately assess the link because there are newer versions of DSM available and as a result it is imperative for current literature to be updated so that results are aligned with the newer diagnostic criteria (Madowitz *et al.,* 2015:282). Equally so, a lot of the studies only look at the link based on some eating disordered behaviours such as *bulimia* and *binge eating*, while others look at it specifically from the lens of anorexia. This can be limiting, as most of these studies do not study this link from the perspectives of EDs. What I mean by this is that sometimes research studies can miss the mark if analysis is not inclusive of other ED sub-types. This was confirmed by Madowitz *et al.* (2015:282) who referred to the fact that meta-analytical studies did not take a diagnosis such as EDNOS into consideration. Waller *et al.* (2015:81) also agree with this as they mentioned that research tends to make use of the DSM criteria for bulimia and anorexia, which in turn results in failure to refine concepts of eating psychopathology related to considering other ED sub-types and different dimensions of eating attitudes.

Lastly, the way studies assess sexual abuse poses a problem to establishing a clear link between sexual abuse and EDs. The first problem is related to the way in which different studies go about defining sexual abuse. A big part of this is related to the fact that there are so many ways to define sexual abuse. As identified in earlier chapters, the definition of sexual abuse is one that can be both broad and complex (Bagwell-Gray, 2015:317; United Nations, 2017:5). This complexity arises based on countries differing on factors related to what constitutes abuse and age of consent. According to Waller *et al.* (2015:79) it was mentioned that research studying the link between sexual

abuse and EDs tends to make use of three strategies when defining sexual abuse and these are inclusive of the following:

- The first strategy involves defining abuse in legal terms and taking into consideration events such as incest and rape.
- Other studies define abuse as something which takes place “when the abuser acts in order to achieve sexual gratification”.
- The third strategy is one which maintains that victims of abuse should have regarded the experience as both sexual and unwanted.

While each of these three points refers to an element of sexual abuse, the author of this study cannot help but point to the limitation that exists in each of these strategies. Firstly, laws and legislation on sexual abuse differ globally and because a lot of the existing research on this looked at adolescence, it is the author’s assumption that not every young person is aware of whether what they experienced was abusive or not. Equally so, there could be a level of denial for some where they are not ready to acknowledge their experiences as abusive. I write this as something that I did for years because I believed that if I denied it long enough then it would fade away and it would feel as if nothing had happened after all. Waller *et al.* (2015:79) pointed out that studies which went on to utilise the legal definition tend to report lower rates of sexual abuse. Secondly, none of these definitions really point to whether there is an existing link to sexual abuse and EDs or any other psychological construct. Yet in his older paper, Waller (1991:664) explained that the definitions used across studies might influence the outcome of the results and therefore argued that researchers needed to make use of related definitions for meaningful comparisons to be achieved. Furthermore, it has been found that among studies which considered age, it was done in such a way that the focus was on perpetrators being older than victims (Waller et al., 2015:79). Such an approach is problematic as it discounts the fact that age is not a defining factor in the perpetration of sexual abuse, in fact anyone can perpetrate sexual abuse regardless of age, as seen in Chapter 2 where child-on-child sexual abuse was discussed.

Additionally, the nature of inquiry also has an influence on research results. According to Waller *et al.* (2015:79) the questions researchers ask are a key determinant of the abuse rates likely to be reported among participants. The author of this study believes that asking more open-ended questions as opposed to closed-ended questions might

be a critical determinant in research studies and this also comes from a statement made by Waller *et al.* (2015:79) which suggests that: “Interviews are likely to lead to greater reported rates of abuse than questionnaires.” The author of this study takes this argument a step further by maintaining that other factors which can influence results are related to the level of trust that is established during the data-collection process. The reason for this thought process stems from having the realization that it takes a level of trust for some people to be able to reveal some very traumatic details of their lives such as sexual abuse whether be it in a questionnaire or in an interview and the same applies to EDs. Another point of argument that the author would like to include is that there could be a possibility that not all the participants in the studies presenting with ED symptomatology have an awareness that their behaviour points to an ED and this could especially be the case among individuals not in clinical settings.

Now that we have discussed problems associated with establishing the link between sexual abuse and EDs, the author continues the discussion by looking more closely at factors which seem to justify this link more clearly in the following section.

4.2.3 Is there really a link between sexual abuse and eating disorders?

Now that we have gained a clearer picture of the problems related to understanding the link between sexual abuse and EDs, in this section the focus will move to answering the question “Is there really a link between sexual abuse and EDs?” To answer this question, the author of this study suggests that sexual abuse and EDs may be interconnected, as evidenced by shared consequences such as psychological disturbances, distorted self-esteem, and body image issues. According to Ashdown (2022) it is suggested that among those who reported higher levels of psychological stressors such as anxiety and post-traumatic stress, the likelihood of developing EDs is greater. In a study conducted by White (1991:8) it was not only established that a linking factor between these two issues includes a loss of trust as well as a feeling of powerlessness within individuals. Taking these factors into account is key when trying to understand the existing link between sexual abuse and EDs. The reason for this argument is based on a statement made by Waller *et al.* (2015:91) which states that it is important for researchers to have a clear understanding of the “psychological and

practical factors that mediate between the two phenomena" While the existence of psychological overlaps does not justify the aetiology (causative factors) of EDs or the experiences of every individual who has encountered sexual abuse, it does point to the possibility that there is indeed still an existing link between the phenomena among those who find themselves in this space. Waller *et al.* (2015:91) went on to say that the existing relationship between sexual abuse and EDs is not a coincidence. While it is hard to describe why some people who were sexually abused end up battling with EDs and others do not, my take on this is that we all process traumatic experiences differently, meaning that we cannot negate an existing link among these phenomena because the effects of traumatic experiences look different on different individuals.

4.3 Exploring current treatment methods in treating sexual abuse and eating disorders: Literature review

Having discussed the link between sexual abuse and EDs, I will now move on to explore some of the treatment methodologies used to treat individuals presenting with EDs after having experienced sexual abuse. To explore treatment options, the author is aware that because of the complexities of both sexual abuse and EDs, treatment will also need to be holistic and multi-disciplinary in nature. According to Ventegodt *et al.* (2016:1995) it is mentioned that the use of a holistic approach is fundamental as it views an individual as a whole and takes into consideration their physical, emotional, social and economic as well as spiritual needs. Furthermore, while ample research exists on existing treatment methods for sexual abuse or EDs as individual issues, not much exists on the treatment of both these problems collectively. This is a gap that the author will try to bridge in this chapter and in later chapters. In this section the author will be drawing comparisons of current treatment methods across disciplines for both sexual abuse and EDs.

4.3.1 Current treatment trends for sexual abuse and eating disorders

The following table provides a comparison of some of the common treatment methods in the treatment of EDs across disciplines such as psychology, medicine and nutrition *etcetera*.

Table 4.1 – Comparison of multi-disciplinary treatment methods between sexual abuse and eating disorders

Field/Approach	Sexual abuse treatment	ED treatment
Psychological	Cowan et al,(2020:22) mentioned that psycho-dynamic therapy, trauma-focused cognitive-behavioural therapy (TF-CBT), and eye movement desensitization and reprocessing therapy (EMDR) are some of the key therapeutic techniques to treating sexual abuse. According to Randa (2023:3) other treatments for sexual abuse include exposure therapy (ET) and cognitive	Schaefer *et al.* (2022:287) maintained that some key treatment methods in eating disorder pathology are inclusive of Integrative Cognitive-Affective Therapy (ICAT) and Dialectical Behaviour Therapy (DBT). Schaefer *et al.* (2022:287) further mentioned that CPT as well as CBT are considered to be effective methods of treatment among individuals with a history of abuse; however, these might need to be adapted when working with youth and adolescents. In relation to CBT, Kass *et al.* (2013:549) maintain that transdiagnostic

	processing therapy (CPT).	enhanced CBT (CBT-E) is known to have improved ED symptoms in both adults and the youth. According to Kass *et al.* (2013:549) interpersonal therapy (ITP) is another treatment method that may prove effective for EDs, particularly BN and BED. Research has found that family-based therapy (FBT) is effective in the treatment of AN among the youth (Kass et al., 2013:549; Alexander-Mott & Lumden, 2015:150; Gulec *et al.,* 2016:175)
Medical observation	Subramanian and Green (2015:211) stated that treating sexual abuse involves prophylactic medication for the treatment of sexually transmitted infections (STIs) and sexually transmitted diseases (STDs). Furthermore, those who report sexual abuse within a 72-hour window are to be provided with emergency	When eating disorders are diagnosed and treated early, rapid weight loss and malnutrition may be prevented (Alexander-Mott & Lumsden, 2015:136). However, in cases where an individual presents with medical instability it is of paramount importance to conduct a physical examination which consists of the following: • A cardiorespiratory assessment

	contraception and it is advised that a pregnancy test be administered within two weeks (Subramanian & Green, 2015:215). Forensic evidence may need to be collected through the form of a rape kit depending on the time that has passed since the assault has occurred to assist in the potential prosecution of perpetrators (Subramanian & Green, 2015:211; Randa *et al.,* 2023:1-2).	• Neuromuscular assessment • Measurement of postural blood pressure and pulse rate change (Alexander-Mott & Lumsden, 2015:136). Additionally, Alexander-Mott and Lumsden (2015:136) continued to mention that laboratory tests should be conducted to measure "sodium, potassium, chloride, bicarbonate, creatine, BUN, ferritin, folate, B12, zinc and albumin levels". Therefore, treatment involves performing a complete blood count, urinalysis and electrocardiogram (Alexander-Mott & Lumsden, 2015:136). The patient presenting with medical instability should be re-stabilized through "bed rest, intravenous fluid and potassium repletion and normalization of any deficiencies" (Alexander-Mott & Lumsden, 2015:137). Once stabilization has been

		achieved, the process of nutritional repletion/refeeding begins, but this should be done slowly and it needs to be monitored (Alexander-Mott & Lumsden, 2015:137). In severe cases, medical observation of EDs might require hospitalisation and in-patient care or a day treatment facility (Klein *et al.,* 2021:26; Alexander-Mott & Lumsden, 2015:143). Dental care may be important for the treatment of gingivitis and erosion of enamel resulting from poor nutrition, binge-eating and purging (Alexander-Mott & Lumsden, 2015:137-138). In the case where one presents with diabetes, treatment should include the close monitoring of blood sugar levels which is important for the prevention of blindness, renal failure or hypoglycaemia (Alexander-Mott & Lumsden, 2015:138).
Pharmacological Interventions	Anti-depressants (Miles *et al.,* 2024:487) when the individuals are presenting with	Alexander-Mott and Lumsden (2015:115) mentioned that AN may be responsive to treatment with

	psychological problems such as PTSD, depression, anxiety, *etcetera*.	tricyclic antidepressants or lithium carbonate. However, it was also found that the use of pharmacological treatment in EDs is of limited value, but a small number of studies has indicated that the use of cyproheptadine as well as amitriptyline are beneficial in individuals with AN who are hospitalized (Alexander-Mott & Lumsden, 2015:151). Alongside this it was suggested that fluoxetine may also be beneficial in the treatment of EDs (Alexander-Mott & Lumsden, 2015:151; Gulec *et al.,* 2016:175). Furthermore, after an individual has been medically stabilized the use of multi-vitamins such as zinc gluconate, vitamin D and calcium may be necessary, depending on the symptoms a patient is presenting with (Alexander-Mott & Lumsden, 2015:137-138).
Social Work	Social workers empower individuals using trauma-informed	Social workers are likely to make use of individual and family therapy when working

	care which recognizes the strengths and resilience of a person while acknowledging the trauma they have encountered (Patel, 2023:1).	with individuals who have encountered EDs (Linville *et al.,* 2012:217). Support groups for individuals with EDs as well as family support groups are an integral part of treatment (Frieiro *et al.,* 2024:113). Furthermore, Frieiro et al. (2024:121) stated that the development and promotion of socio-educational works are focused on conflict-resolution and family mediation may be necessary to the treatment process. Additionally, as part of the personal development of individuals with EDs, social skills and personal self-management needs to be taught (Frieiro, 2024:121).
Complementary and integrative treatments	Miles *et al.* (2024:487) mentioned that other treatment methods which can be utilised in the treatment of sexual abuse alongside other evidence-based therapies are inclusive of: Art therapy, drama therapy, music therapy,	Zakers and Cimolia (2023:421) state that the complementary approaches that can be applied to eating disorder treatment are inclusive of traditional yoga, music therapy as well as biofeedback and neurofeedback.

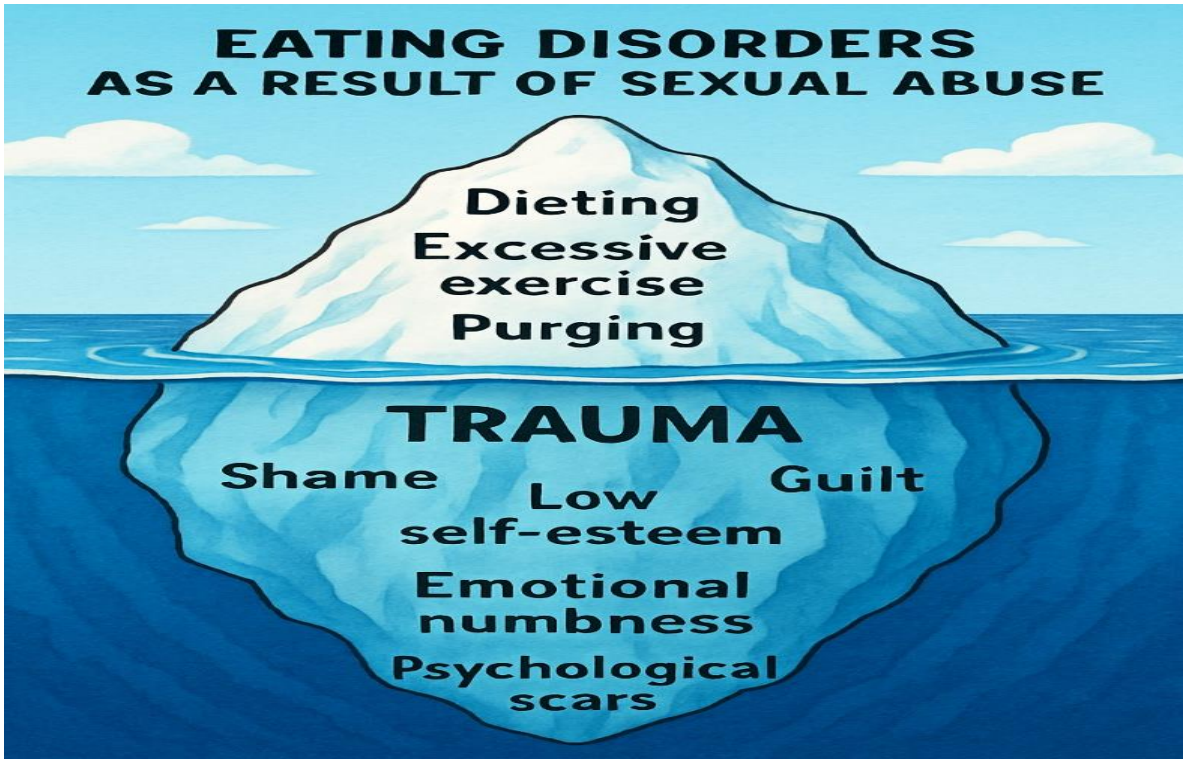
	equine-assisted therapy, meditation and trauma-sensitive yoga.	
Nutrition	The treatment of sexual abuse by a nutritionist can be conducted through trauma-informed nutrition (Gallagher *et al.,* 2025:4; McElrone, 2025:3).	The role of a dietitian in ED treatment typically includes refeeding, meal-planning and providing nutritional education (Yang *et al.,* 2021:16). Heafala *et al.* (2021:731) described the role of a dietitian as one who involves providing person-centred care which includes the assessment, planning treatment as well as nutritional requirements needed for medical stabilization and recovery.

The table above illustrates that treatment for individuals affected by sexual abuse and eating disorders is complex and multi-faceted. It further emphasizes the importance of involving a multi-disciplinary team of professionals when supporting those experiencing either or both conditions. The value of multi-disciplinary collaboration is echoed in the literature, with researchers highlighting its role in addressing the diverse needs associated with such cases (Gallagher et al., 2025:3; Heafala et al., 2021:725; Yang et al., 2021:2). Engaging professionals with varied expertise allows for a more holistic response to the psychological, medical and social dimensions that often accompany both sexual abuse and eating disorders.

In addition, the data presented in the Table reveals notable commonalities between eating disorder (ED) treatment and sexual abuse interventions. This suggests the need for integrated treatment approaches that address both issues concurrently, rather than in isolation. Alexander-Mott and Lumsden (2015:92) support this approach,

stating that while the relevance of sexual abuse in ED treatment requires further investigation, these issues should be addressed in parallel rather than sequentially. They further argue that effective treatment for EDs linked to sexual abuse must recognize the co-existing relationship between the two (Alexander-Mott & Lumsden, 2015:85), with psychological and interpersonal factors often mediating this connection (2015:92). Ventura *et al.* (2023:629) reinforced these findings by identifying a relationship between sexual abuse, psychological maladjustment, and alexithymia - defined as the inability to express or describe one's emotions (*Merriam-Webster, Inc*., 2025) - as significantly influencing the severity of ED pathology. Emotional dysregulation linked to alexithymia has been found to be particularly relevant among trauma-affected individuals. As a result, trauma-informed treatment approaches that focus on improving emotional regulation have demonstrated effectiveness, especially among ED patients with histories of trauma (Ventura *et al.,* 2023:638). Recommended interventions include EMDR, CPT, PE and TF-CBT. As highlighted in the table, adapting these approaches for younger populations may enhance their accessibility and impact. Furthermore, based on the findings presented, the author suggests that trauma-informed care may be particularly beneficial when supporting individuals impacted on by both sexual abuse and eating disorders. The empirical study will help the author gain a further understanding of this.

As someone who currently volunteers at a recovery-oriented organisation called Project Exodus, one of the key insights I have gained is that addictive behaviour often represents only the tip of the iceberg. In the case of eating disorders, the visible symptoms reflect just a small portion of the underlying issues, while the deeper emotional, psychological and relational factors remain hidden beneath the surface. This concept is illustrated by the iceberg model, which will be presented below.



[11]

Figure 4.3 – Eating disorder iceberg (Perplexity AI, 2025)

The author of this study therefore argues that an effective treatment approach goes beyond addressing only the visible symptoms - the tip of the iceberg - and seeks to uncover and work with the deeper underlying issues beneath the surface. While various psychosocial methods, as outlined in Table 4.1, aim to do this, they do not account for a crucial element within the theological framework of this thesis: the role of the Holy Spirit. From a theological perspective, true healing involves more than psychological insight - it includes spiritual transformation made possible through the work of the Holy Spirit.

In John 14:16, Jesus says, “And I will ask the Father, and he will give you another advocate to help you and be with you forever.” John 14:26 (Amplified) further explains:

> But the Helper (Comforter, Advocate, Intercessor—Counsellor, Strengthener, Standby), the Holy Spirit, whom the Father will send in My name [in My place, to represent Me and act on My behalf], He will teach you all things. And He will help you remember everything that I have told you.

[11] Figure 4.1 is an AI generated image that was created on perplexity on 1 August 2025. I prompted perplexity to generate an image of an iceberg model of someone who battles with eating disorders and has been affected by trauma (sexual abuse).

These verses emphasize the Holy Spirit's active role in guiding, strengthening and bringing about inner healing. In a therapeutic setting, this means that the Holy Spirit can access the deeper parts of a person - areas that may be unreachable through human intervention alone - and bring about healing in ways that complement and go beyond conventional treatment methods. The strategy to be developed will place emphasis on the role of the Holy Spirit when counselling youth with eating disorders because of sexual abuse.

One might well ask: what does an effective treatment method require? A key component involves creating a space where individuals feel safe, supported and respected. A consistent principle across disciplines is the cultivation of safe spaces in which individuals can receive the help they need and be met with empathy and non-judgement (Cowan *et al.,* 2020:22; Patel, 2023:1). This kind of therapeutic environment forms the foundation for meaningful engagement and healing. In addition, members of the multi-disciplinary team must maintain professionalism, demonstrating compassion and a non-judgmental attitude towards the individuals they work with (Linville *et al.,* 2012:224). This suggests that one of the key barriers to effective treatment lies in individuals being ill-treated or dismissed during the treatment process. Linville *et al.* (2012:225) affirm this point, noting that participants in their study who felt judged, patronized or criticized experienced the treatment process as disempowering. This is in direct contradiction to the aim of effective treatment, which is to empower individuals and cultivate transformational change.

Participants in the study by Linville *et al.* (2012:225) also identified specific behaviours by treatment providers that contributed to ineffective care, including:

- A lack of clarity or direction in approaching treatment.
- Failure to acknowledge the severity of the individual’s condition.
- Ignoring or minimizing symptoms.
- Asking irrelevant or inappropriate questions.

Beyond relational and professional dynamics, systemic barriers such as the high cost of treatment - whether inpatient or outpatient - can significantly limit access to care. In such contexts, group-based interventions may serve as a viable and impactful alternative. Based on personal experience, group structures have proven to be

powerful tools for healing. Not only do they provide safe environments for exploring various topics, but they also help individuals regain confidence and find their voice. Listening to the experiences of others fosters both learning and a shift in perspective. According to Alexander-Mott and Lumsden (2015:149), group psychotherapy is frequently used in the treatment of eating disorders, both in in-patient and out-patient settings such as day programmes. The benefits of group work include:

- Providing mutual support among group members.
- Offering structured opportunities for interpersonal development.
- Enhancing the overall efficacy of treatment delivery.

An additional advantage is that group structures can be adapted for work with youth. However, for this to be effective, it is essential that facilitators are knowledgeable and well-trained with a solid understanding of the complexities involved in working with young people affected by eating disorders - particularly those with a history of sexual abuse. In the following section, the author presents an empirical study focused on exploring treatment methods. This study aims to deepen understanding of effective treatment approaches for youth and address gaps not fully covered in the current discussion.

4.4. Empirical research

The previous section presented a literature review of current treatment approaches used across different disciplines in addressing eating disorders and sexual abuse. This section now focuses on the empirical part of the study. Hermans and Schoeman (2015:45–46) describe empirical research as a process of gaining knowledge through data, aimed at exploring a topic, describing situations or explaining relationships among variables. Bouchrika (2025) also explains that empirical research is rooted in producing knowledge based on experience. In this study, an empirical investigation was carried out to gather insights from professionals who work with youth affected by eating disorders and past sexual abuse. This section explains the aim of the study, describes the methods used to collect data and presents the main findings.

4.4.1 Study aim

As noted earlier in this chapter, sexual abuse is increasingly recognized as a potential contributing factor in the development of disordered eating behaviours. This empirical study aims to investigate and describe current treatment practices from the perspective of professionals working with the youth. This will strive to fill a gap where not much focus or emphasis has been placed on youth. Through a descriptive-empirical lens, the study seeks to gain insight into therapeutic approaches and challenges in treating youth affected by both eating disorders and sexual trauma.

The insights gathered from this investigation will inform the development of a contextually relevant pastoral counselling strategy. This strategy will serve as a potential framework for practitioners seeking to offer holistic care to youth struggling with eating disorders in the aftermath of sexual abuse.

4.4.2 Research methods

The methodology used in this study is qualitative in nature. Qualitative research focuses on gaining an in-depth understanding of complex human experiences and behaviours (Lim, 2025:199). As Lim (2025:202) explains, one of the key strengths of qualitative research is its holistic approach, as it considers phenomena in their full context rather than in isolation. This is particularly relevant to the current study, which involved semi-structured interviews with professionals from a multidisciplinary team - including psychologists, trauma counsellors, and dietitians - to explore treatment approaches from a broad and integrated perspective.

Semi-structured interviews were chosen to allow for rich, detailed insights into the treatment of eating disorders among young people with a history of sexual abuse. These interviews were guided by a set of open-ended questions. While each participant was asked the same core questions, the interviews remained flexible with questions adapted where necessary and based on the unique experiences and focus areas of each participant. For example, some professionals shared more extensively about trauma counselling, while others contributed deeper insights into their work with eating disorders. All interviews were conducted via Google Meet due to geographical barriers between the author and the participants. Time constraints also posed a

challenge, making it difficult for the author to travel and conduct interviews in person. The use of an online platform allowed for greater flexibility in scheduling and ensured that participants from different locations could still contribute meaningfully to the study. Each session lasted between 90 to 120 minutes, allowing adequate time for in-depth discussion and reflection.

The recruitment process began with the author reaching out to twelve professionals across relevant disciplines. Of these, four responded and expressed willingness to participate. A purposive sampling strategy was employed to specifically target psychologists, trauma counsellors, dietitians and pastoral counsellors who work with youth affected by eating disorders and/or sexual abuse. The study prioritised professionals with significant experience in their respective fields to ensure depth and relevance of insight.

4.4.3 Data-collection

All participants were contacted individually and invited to take part in the study, with informed consent obtained prior to their involvement. Each participant received an official study invitation and informed consent letter outlining the purpose of the study, procedures involved and ethical considerations. The author explained the study in detail and once participants consented, interview appointments were scheduled.

As the interviews were conducted online, all sessions were recorded to allow the author to access and review the data as needed. Participants were assured that the recordings would remain confidential. These recordings are securely stored in a password-protected file accessible only to the author.

To ensure confidentiality, the author avoided using participants' real names. Instead, pseudonyms were assigned, and participants are referred to as "Participant A" through "Participant D." The table below presents key background information about each participant.

Table 4.2: Participant information

Participant name	Job description	Location	Experience

Participant A	Educational Psychologist	Brits: North-West	25 years
Participant B	Clinical Psychologist	Potchefstroom: North-West	20 years
Participant C	Dietician	Brits: North-West	35 years
Participant D	Pastoral Counsellor	Potchefstroom: North-West	35 years

4.4.4 Data analysis

The author of this study employed *thematic analysis* to explore and interpret the core findings. Thematic analysis is a qualitative data analysis method focused on identifying, analysing and reporting patterns or themes within data sets (Braun & Clarke, 2006:79; Naeem *et al*., 2023:2). This approach is particularly valuable because it allows for rich, detailed and complex accounts of data (Braun & Clarke, 2006:78). It is widely used in qualitative research due to its flexibility in identifying themes across a variety of data types (Kiger & Varpio, 2020:846; Ahmed *et al*., 2025:1). Given this flexibility, the author selected thematic analysis as a suitable method for organising and interpreting the data in a coherent and meaningful way.

The data is presented according to the following key themes:

- Sexual abuse as a risk factor for EDs
- Treatment approaches
- Role of the family in treatment
- Multi-disciplinary collaboration
- Role of spirituality in the therapeutic space

The findings from the qualitative interviews are presented in the next section.

4.4.5 Results

In this section, the author presents the findings of the study, taking into consideration the key themes which were identified. She presents the findings based on each individual interview that she had with the participants.

Participant A:

Theme 1: Sexual abuse as a risk factor for EDs

Participant A cited sexual abuse as a potential risk factor for ED development; this is something that this participant backed up with two cases that she had encountered in therapy. In one case a young girl she worked with opened up about not having a desire to grow up, not having a desire to get her period, because getting her period meant that someone could potentially get her pregnant. According to Ross (2009:215) it was described as follows:

> 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.

This young girl displayed a case of not wanting to get into her secondary sexual characteristics over fears of what that would imply. In the words of participant A, the following was shared:

> The statement shows how this person doesn't want to get into that part of her body, yet it was essential to get her to a place where she accepts her body and gains an understanding that she couldn't remain in the place of being a child forever.

A large part of this young girl's experience resonates deeply with me, because it took me back to my 18-year-old self who felt dirty and created a narrative that if I could exercise long enough, starve myself long enough and lose a significant amount of weight then I would successfully reverse my secondary sexual characteristics. I struggled to embrace my femininity and womanhood. According to Ross (2009:214) it is not uncommon for girls with a history of sexual abuse to resort to eating disordered behaviours as an attempt to stop their secondary characteristics. This is a discussion that will be carried further in Chapter 5 of this study.

Theme 2: Treatment approaches

The participant stated that an effective treatment approach is one that is client-centred. From the acknowledgement that experiences will look different from person to person, this participant mentioned fostering a space in therapy where individuals are able to give voice to what they would like to achieve in therapy. This participant mentioned that as a therapist she created an environment where treatment often begins with providing clients with an opportunity to make a list of all the traumatic experiences they had been through. When this list was completed, the individual asked the client how many of the experiences that they had been through they would like to work on. This then resulted in the therapist moving over to the EMDR or brain spotting approach as a key treatment method. She mentioned that when EMDR was used, each session would go on for a period of approximately one hour and thirty minutes.

It was further explained that as part of this treatment, the therapist would investigate the somatic experience of the individual where she would most likely ask the following leading questions:

- “Where do you feel this in the body?”
- “On a scale of 0-10, how was the disturbance scale?”
- “What were the underlying emotions?”

Equally so, this participant pointed out that there were moments within the treatment process especially during brain spotting where the therapist was required to stop speaking, the reason being to allow the individuals to be given space to process their experiences and emotions effectively. The participant mentioned that in this moment it was critical for the therapist to sit and be with the client and this included refraining from taking notes.

The participant said she found this treatment approach to work well in the sense that it was short-term and allowed the client to work on what they wanted to in a short-term period as treatment is costly in South Africa. However, this participant mentioned that in the case of severe ED pathology it might be beneficial to first send the client to a clinic to be further evaluated. When asked whether treatment of EDs because of sexual abuse should be done in parallel or individually, this participant said she

believed it was important to treat the ED first and from that working on the emotional aspects would follow.

Theme 3: Role of the family in treatment

According to participant A, involving the family as part of the therapeutic process is key as such an approach allows for the family to receive the necessary support that they need. This participant mentioned that the family would need to be empowered about being mindful about the language they used when speaking to the individual battling with the ED. It is critical to teach family members to avoid using condescending language, language that pushes the individual towards ED pathology and seems to reward the behaviour. Equally so, family members needed to be taught to move away from using language that shames and causes the individual to feel as if something is wrong with her. The role of involving the family in the therapeutic process is to foster a space where they can get support as a family as the behaviour of the individual not only affects that person individually, but it also has a ripple effect on the family, potentially causing dysfunction within the family system. The therapeutic space can then go on to encourage that as part of a sustainable support structure; family members are encouraged to change their lifestyle together with the child and maybe consider eating the same food as the individual. The author of this study states that a key factor in terms of family support is equipping the family to not be enmeshed in the behaviour and to not be enabling towards the behaviour. A key observation that the author has made over the past two years as a volunteer at a recovery ministry called *Project Exodus* is that often family members do not think they need help, yet healing within a family structure is a two-way street, requiring both the person in recovery or seeking recovery to find their own healing, while supporters such as the immediate family of the individual also need to walk their own individual healing path.

Theme 4: Multidisciplinary collaboration

The participant emphasized that multi-disciplinary collaboration was essential in the treatment of eating disorders. She explained that she worked closely with a team of professionals to ensure that the treatment process was handled with care and that clients had access to all the necessary resources to support their healing and recovery.

For example, she explained that involving an occupational therapist could be beneficial to help the individual be equipped with further and new skills to help facilitate their recovery process, while working with a dietitian provides the benefit of having a companion who will assist with nutrition and weight-related aspects of the recovery process.

Theme 5: Role of spirituality in the therapeutic space

While not much was discussed on spirituality within the therapeutic space, this participant commented that she believed the spiritual aspect that came with this study was of importance, saying that this was a journey that could not be worked out without God. The participant further stated the following regarding spirituality when working through ED recovery:

> It's very important because it gives you a sense of someone who loves you unconditionally, your God who loves you unconditionally.

Participant B

Theme 1: Sexual abuse as a risk factor for EDs

Participant B noted that sexual abuse can be a risk factor in the development of EDs, though she emphasised that this was not universally the case as trauma is processed differently by everyone. She identified self-harm, PTSD and dissociation as factors that often accompany sexual abuse and might contribute to ED pathology. She also pointed out that such issues might not always be disclosed in the initial counselling sessions but emerge later in the therapeutic process.

The participant's observation about self-harm resonates with the argument that, for some survivors of sexual abuse, ED behaviours can function as a form of self-harm (Washburn *et al.,* 2023:1) which will be discussed further in Chapter 5 of this study. This aligns with my own lived experience of resorting to eating-disordered behaviour as part of my desperate attempt to cope with the trauma I faced. I viewed the ED as a form of self-harm, because I was not brave enough to engage in other behaviours such as self-mutilation.

Theme 2: Treatment approaches

Participant B identified CBT and somatic therapy as her primary treatment methods. Her goal was to help clients restore a healthy relationship with both food and their bodies. She stressed the need for a therapeutic space that fosters safety and avoids shaming even in the case of relapse.

She highlighted that young clients often lack the words to describe their experiences, making it necessary for the therapist to “meet them where they are”. She recommended the use of expressive approaches such as art, journaling and dancing which she considered particularly beneficial modes of alternative treatment approaches when working with the youth.

When addressing cases involving both sexual abuse and EDs, Participant B advocated “treating both in parallel rather than separately”. This position aligns with Alexander-Mott and Lumsden’s (2015:92) recommendation for concurrent treatment. She recommended an integrated therapeutic approach to ensure that both issues are addressed simultaneously.

Theme 3: Role of the family in treatment

Participant B emphasised the importance of involving family members in the treatment process. She observed that families often lacked understanding of EDs, and therapists should equip them with knowledge, tools and communication skills that avoid being degrading or triggering. She noted that family structures can sometimes perpetuate ED cycles, particularly when negative comments about weight are made to young people.

Theme 4: Multidisciplinary collaboration

Due to the complexity of EDs, Participant B recommended working with a multi-disciplinary team, where each professional brings unique expertise. She mentioned that the client should be included as an active participant in the team process, fostering transparency, accountability and safety.

Theme 5: Role of spirituality in the therapeutic space

Participant B views healing as a holistic process involving body, soul and spirit. However, she cautioned that spiritual approaches should only be integrated when the client expressed interest, ensuring respect for individual beliefs.

Participant C:

Theme 1: Sexual abuse as a risk factor for EDs

The participant described that she believed sexual abuse to be a risk factor for the development of EDs. However, she highlighted that she was not completely sure what the meaning was that maintained that mentioning that in practice, “it doesn’t always come out that way”. This is a statement the author of this study agrees with in a sense that in as much as sexual abuse may be a risk factor, it is not the only cause for ED development among the youth. Secondly, with under-reporting being such a common factor, it is understandable that not much is known about the extent of sexual abuse as a risk factor for ED pathology. The author holds on to the belief that what is known in research is not sufficient, more especially as she did not come across any South African studies pointing to the linkage between sexual abuse and EDs specifically among youth which in and of itself presents a gap in current literature which needs to be addressed.

Furthermore, participant C highlighted the view that the risk for ED development after past exposure to sexual abuse is often closely linked to factors such as using food in an attempt to regain their control. While others simply make use of the eating disordered behaviour to either attempt to feel invisible due to the violation they experienced from the abuse or to try and reduce further risk for vulnerability by attempting to look unattractive as a protective mechanism.

Theme 2: Treatment approaches

With regards to treatment approaches, participant C emphasized that because of her line of work, treatment was done from a nutritional perspective. What this implies is that the treatment process would generally begin with gathering data on the nutritional information of the individual. It was mentioned that as part of this assessment, some

of the questions asked would be around the individual's relationship with food and their lifestyle. Based on this the dietitian's role would then be to help individuals set goals. During the goal-setting process, the dietitian and client look at things such as *"Do we need to work on weight? Do we need to work on relationship with food?"* This is a very individualised process. According to participant C, part of the treatment process is to help the client get to a place where they need to understand their own ED as this can build greater awareness of some of the reasons for their behaviour. Participant C further mentioned that looking at underlying issues such as trauma, the clients' beliefs and underlying emotions serve as important parts of the therapeutic process. As with any therapeutic space, the participant mentioned giving homework tasks to clients to complete at home, such as having to log food diaries - also in an attempt to foster accountability. As a dietitian the participant mentioned that she sometimes puts together structured and flexible diet plans which clients can use to support their journey.

Alongside this, it was mentioned that an effective therapeutic environment is one where a safe, non-judgemental space is created and one where a relationship of trust exists between the client and dietitian. It was mentioned that it is important to build a relationship of support. A key factor that was mentioned by participant C is that during the treatment process one needs to be mindful of the language used, to ensure that it is language that builds the person up and not breaks them down as this can make or break the treatment process. This took the author back to the words in Ephesians 4:29 to the following effect:

> Do not let any unwholesome talk come out of your mouths, but only what is helpful for building others up according to their needs, that it may benefit those who listen.

When asked about the expected length of treatment, she mentioned that it was hard to put a specific timeframe on how long treatment is expected to take as every individual journey looks different. The participant closed off our discussion on treatment approaches by saying the following words:

> If you change the relationship with yourself and it becomes a loving and nourishing one, that is where true healing lies.

Theme 3: Role of the family in treatment

Working with the family is crucial as very often the family needs to be equipped with the knowledge and skills to help loved ones who are battling EDs. Whether this comes through as teaching family members how to speak with their loved ones battling with an ED as some young people go through processes where the disorder is reinforced by how they are spoken to at home - e.g., a parent telling a young person they need to be thin. Another reason involving the family in treatment can be beneficial is that dysfunctional and counterproductive behaviours can be addressed within safe therapeutic environments, especially when a psychologist or counsellor is involved. It was discussed that involving the family as part of the treatment team may also provide more support of loved ones. Participant C made an example of someone pursuing weight loss and how family disengagement in that process may make it harder to achieve goals.

Theme 4: Multi-disciplinary collaboration

The participant described multi-disciplinary collaboration as a vital and crucial part of the treatment process. According to this participant involving a multi-disciplinary team is extremely important because as a dietician the larger part of the treatment and expertise is nutrition-based, thus pointing to the reality that ED treatment is complex in nature. This statement is supported by Kenny and Lewis (2023:1) who stated that "ED recovery is a complex phenomenon". This complexity comes in as often the ED is rooted in several different problems which could be psychological or medical depending on the severity of the disorder. The Participant put it this way:

> A lot of the treatment has to do with skills development…sometimes there is an element of occupational therapy needed…sometimes they need to see a psychologist…sometimes they need medication.

When asked how important it is for the multidisciplinary team handling an individual case to sit down in collaboration to ensure that treatment was aligned, the participant stated that this was a very important part of the process, but it does not always happen like that. However, as part of her treatment she tries to collaborate often with the team she works with.

Theme 5: Role of spirituality in the therapeutic space

Participant C stated that she believed spirituality does have a place within the treatment process and it is something which should not necessarily be excluded from treatment. The participant further went on to state that the inclusion of spirituality may go on to improve treatment outcomes. This was supported by Abrams (2023) who discussed the view that faith and spirituality may enhance therapeutic outcomes.

Participant D:

Theme 1: Sexual abuse as a risk factor for EDs

Participant D firmly agrees that sexual abuse is a potential risk factor for the development of Eds, especially among girls and women. According to this participant. this risk factor is likely to occur at a higher rate among females as opposed to their male counterparts who are at a lower risk for ED pathology. However, what stood out for the author of this study is that this participant did not completely discount the possibly of EDs developing among males because of trauma exposure such as sexual abuse. To support this link the participant went on to tell a story from a visit to an eating disorder centre in Phoenix, Arizona where he encountered children as young as six admitted to the ED clinic. He described that in this specific clinic, it was found that approximately seventy percent of the patients had a history of sexual trauma. This is a scary statistic but also one that does not necessarily connect to the statistics shown in current research studies. An example of this would be from a study titled *Prevalence of various traumatic events including sexual trauma in a clinical sample of patients with an ED,* which states the following:

“Sixty-seven percent of the patients with an ED reported traumatic life events at the time of assessment, whereby 19% report negative sexual experiences or sexual abuse” (Telléus *et al.,* 2021:1).

Another thing to point out is that while these statistics indicate the possibility of an existing risk factor, not much is known on this topic from a South African perspective. Furthermore, with regards to the statistics found in this specific ED clinic, the author of this study presumes that these are indicative of the entire population of individuals

admitted to the clinic and not only amongst the youth population. This participant further emphasised that while this study strives to look specifically into sexual abuse as a potential risk factor affecting the development of EDs, other traumatic events not mentioned within this thesis also have potential to do the same**.**

Theme 2: Treatment approaches

Participant D described that as a point of departure it is crucial for treatment to occur within a multi-disciplinary perspective that considers healing from a physical, emotional and spiritual viewpoint. The author of this study argues that such an approach is key to helping individuals recover from every aspect. 1 Thessalonians 5:23 says:

> May God himself, the God of peace, sanctify you through and through. May your whole spirit, soul and body be kept blameless at the coming of our Lord Jesus Christ.

The following image (Figure 4.2) provides an example of what is going on within all three of these aspects of the human dimension:

Figure 4.4: Spirit, soul and body diagram (Shaw, 2021)

According to this participant, the recovery process especially in relation to EDs must begin on a physical level as these disorders often carry a physical implication. The participant mentioned that this is the place of the doctor, dietitian or psychiatrist to get

involved. The starting point of treatment would include things such as urine tests, blood tests scans being conducted and medication administered to patients if necessary. The second level of treatment would then be on an emotional level where a counsellor or psychologist would need to get involved to conduct an emotional assessment and observation to see whether any other areas of concern arise which would need to be treated. He described the spiritual component as the area where the pastoral counsellor would need to get involved, taking note that the first responsibility of the pastoral counsellor would be to start with getting the story of the counselee and working with them through their story. In cases where the family needs to get involved as part of the treatment process, it is equally as important to obtain the story from the family members and walk them through their stories as well. As part of the story-telling process, participant D said he suggested that a “directive/non-directive approach” be used as it creates harmony between the amount of guidance and openness given within the pastoral conversation.

What sets the field of pastoral counselling apart is that it puts emphasis on the importance of prayer within the counselling process. In this case treatment would involve praying with counselees through their unresolved trauma. Participant D mentioned that it could be useful to put together a list of all incidences of trauma, rejection and crisis points experienced throughout the counselees’ life which would need to be worked through in the counselling space. This participant also mentioned that where young people and parents are in a counselling session together, the role of facilitating a space where forgiveness occurs may be necessary on both sides.

When asked about the length of treatment, the participant stated that the length of treatment was dependent on how advanced the problem presented was. An interesting story with regards to treatment was one he observed on a visit to an ED clinic where after a certain period of time and when one had reached a certain point of readiness in their recovery, the patients get taken out to eat at a restaurant. However, this process does not take place abruptly; instead, it requires deliberate and thorough planning whereby menus are discussed in advance and only then do the patients have an opportunity to decide what they will order when they get to the restaurant. This is especially important to ensure that the process is not overwhelming and/or triggering for individuals.

Theme 3: Role of the family in treatment

The family was described by participants as a foundational factor in the treatment of eating disorders. According to Participant D, family therapy was an important component of a pastoral approach, since sometimes the family is part of the problem. I agree with this from personal experience: my home environment often reinforced my disordered eating. The language used around me encouraged behaviours that felt necessary to be “acceptable enough” or “beautiful enough”, and these message - together with other interrelated addictive behaviours - exacerbated my distress. At the same time, family members can also feel powerless and hurt when they do not know how to respond. I witnessed my mother’s frustration when I insisted that an apple constituted a full meal or when I avoided mirrors because I believed I was not thin enough. She repeatedly said that “apples are not a meal”, prepared full meals for me, and tried to persuade me to eat - reactions that came from concern, but which also reflected the complex, often conflicted role families play in both maintaining and attempting to alleviate disordered eating.

Theme 4: Multi-disciplinary collaboration

Throughout our conversation participant D referred to the important role of multi-disciplinary collaboration in counselling as stated earlier. This participant stands in agreement with what the other participants in this study already mentioned by stating that it is essential for the multidisciplinary team working with an individual battling with EDs to consult with each other as part of the treatment process.

Theme 5: Role of spirituality in the therapeutic space

As a pastoral counsellor one can boldly state the role of spirituality as being key within the therapeutic space. In conversation with Participant (?) this was proven to be highly accurate. The participant referred to the statistic that approximately 80% of South Africans are of the Christian faith (Cabrita & Erlank, 2018:309). Another study suggested that approximately 89% of the South African population has indicated that they had been raised in Christian households, while only approximately 87% continue to live out their faith (Schoeman, 2017:3). When faced with traumatic experiences a lot of these individuals get to a point where they struggle with God. It was mentioned

that a lot of these individuals find themselves in a position where they tend to ask questions such as: “Where was God?” Why did He allow that? This participant said that when working with such individuals “If you don’t accommodate spirituality then you can’t help them.” It was further discussed that spirituality serves as the real and ultimate solution to effective therapy. Not discounting the role of the other disciplines, the participant noted that while all the other disciplines were helpful, the role of the Holy Spirit in bringing about inner healing was incomparable.

Even as a pastoral counsellor it was fundamental how this participant also mentioned showing respect to people of other religions. Hearing this reminded the author of this study how our goals as pastoral counsellors are not to chase those of different viewpoints away, but instead ours is to the best of our ability to embrace those who walk into the therapeutic space. In scripture Jesus gave the invitation to just “come”, and Matthew 11:28 reads *“Come to me, all you who are weary and burdened, and I will give you rest.”*

4.5 Conclusions

This chapter concluded the question “what is going on?” This was achieved by studying the links between sexual abuse and eating disorders, in an attempt to connect the data shared in chapters two and three. As part of the core discussion in this chapter, it was found that a link between sexual abuse and EDs exists in the sense that the abuse provides a probable risk to the potential of developing ED pathology. Getting to this point also came with an understanding that not every individual who was sexually abused will develop an ED, taking into consideration that every individual is different.

With regards to treatment, it was found that treating EDs which occur because of sexual abuse are complex and multi-faceted. As a result of this complexity, it was pointed out that this treatment requires multi-disciplinary collaboration. This could involve working with psychologists, medical practitioners, social workers and making use of pharmaceutical interventions to treat underlying health problems which could arise. Alongside this it was discussed that other contemporary measures such as the use of art therapy, music therapy *etcetera* could be used to facilitate the therapeutic process. Equally so, the use of integrative treatment methods, family-based therapies

and other forms of group work were said to be effective treatment methods when working particularly with individuals batting with ED pathology after sexual abuse exposure. This was also informed by the results of the semi-structured interviews.

This chapter concluded with an empirical research section which investigated the current treatment practices from the perspective of multi-disciplinary professionals working with youth. Participants consisted of psychologists, a dietician and pastoral counsellor. While the fields are vastly different, each of these professionals agreed on the following factors:

- Sexual abuse is a risk factor for the development of ED pathology among the youth.
- Treatment is complex and multifaceted.
- Multi-disciplinary collaboration is foundational.
- The role of the family in the treatment process is crucial.
- Spirituality is an important factor in treatment; however, it should be applied with boundaries and respect of all individuals.

CHAPTER 5: INTERPRETIVE TASK – MULTIDISCIPLINARY PERSPECTIVES OF EATING DISORDERS OCCURING AS A RESULT OF SEXUAL ABUSE

5.1 Introduction

Chapters two to four of this thesis comprehensively focused on Osmer's first task of practical theological interpretation which focuses on answering the question "what is going on?" In this chapter the focus shifts from examining the "what?" to answering the question "why?" The interpretative task of Osmer's (2008:4) methodology seeks to answer the question, viz "Why is it going on?" In the attempt to answer this question, the author of this study will be making use of theories from multidisciplinary disciplines to try and gather diverse perspectives on the reasons eating disorders can occur after sexual abuse exposure.

Firstly, the discussion contained in this chapter will look at the bio-psychosocial factors which are likely to play a role in the development of EDs. This discussion will begin

with contextualising the definition of bio-psychosocial factors. This will be followed by discussing the biological factors at play in the development of EDs because of sexual abuse. The discussion on biology takes into consideration the role of genetic predisposition and the impact that both trauma and EDs have on the brain which informs ED development as well as sustaining the behaviour. This will be followed by discussing psychological determinants which play a role in ED development among those with a history of past sexual abuse, and this will be followed by a discussion of social factors.

Secondly, factors such as the need for control will be discussed. Thirdly, the discussion will focus on the need for identity as another factor influencing ED development after having a history of sexual abuse. This will be followed by a discussion focused on the attempt to control one's sexuality as a reason for ED development. Finally, this chapter will conclude with a discussion about spiritual perspectives where the focus will be placed on discussing sin and brokenness in relation to 1) sexual abuse and 2) eating disorders.

5.2 Bio-psychosocial factors

In this section the author of this study will be discussing the bio-psychosocial factors which play a role in eating disordered related behaviours likely to occur because of sexual abuse among the youth. However, before delving into these factors, it is first important to contextualize the word bio-psychosocial. According to the *Merriam-Webster Online Dictionary* (2025), the word *bio-psychosocial* is defined as "something relating to or concerned with the biological, psychological, and social aspects of something, especially in contrast to the strictly biomedical aspects of disease."

Roberts (2023:368) mentioned that the bio-psychosocial model was first proposed in an article by George Engel in 1977 and explained that this model was considered useful with regards to "organizing and communicating information about the psychosocial determinants of health". The author views this as a particularly important approach to consider when trying to gain a broadened perspective on eating disorder aetiology especially since she often comes across the question "Why do some people struggle and others not?" There is no easy way to answer such a question, but the bio-psychosocial model is a standout as it allows for one to explore a topic from multiple

different angles. Research continuously mentions that EDs are influenced by biological, psychological and socio-cultural factors (Yilmaz *et al*., 2015:131; Marciello *et al.,* 2020:78; Krauss *et al.,* 2023:1141). According to Connors and Morse (1991:1) in their paper *Sexual abuse and eating disorders: A review* it was stated that "sexual abuse is best considered a risk factor in a bio-psychosocial etiological model of eating disorders." Therefore, in this section focus will be placed on discussing the biological, psychological and social factors that play a role in EDs.

5.2.1 Biological factors

This first section will discuss the biological factors that play a role in ED pathology in relation to the role of genetic predisposition and the impact that both trauma exposure and EDs have on the brain.

- **Genetic predisposition**

It is a reality that sometimes our behaviour is influenced by genetic factors. This statement is supported by Baker (2007:837) who maintains that "human behaviour is subject to genetic variations." Baker (2007:837) further states that the way individuals inhibit intellectual, personalities and mental health differences is largely attributable to genetic predisposition. The same principle can be applied in relation to EDs. This is supported by Monteleone *et al.* (2019:301) who discussed in their study that the interactions between both genetic predispositions and environmental factors have a potential role in the development of EDs. According to a study conducted by Berrettini (2004:20) which looked into considerations of both family and twin studies, it was found that eating disorder rates were relatively increased among family structures where female relatives presented with AN and BN. To compare with this, the findings of the twin study showed that EDs are moderately inheritable, carrying a 46 to 72 percent heritability rate for behaviours associated with binge eating, purging as well as restrictive food intakes, while on the other hand behaviours related to body dissatisfaction and other eating and weight concerns constitute about 32 to 72 percent (Berrettini, 2004:20). Similarly, Michael *et al.* (2020:1496) support this notion by also making estimates based on a twin study which showed that it is estimated that AN is approximately 48 to 74% heritable, while BN proves to be 55-62% heritable and the estimates for BED range from 39-45% and having first-degree relatives diagnosed

with these disorders improve the risk among individuals. In their study Yilmaz *et al.* (2015:133) mention that there is an existing genetic correlation between AN and BN which may be attributable to the high crossover rates between these disorders.

With this in mind, among those who are more genetically predisposed to eating disorders the risk is higher for them to potentially develop some sort of ED pathology as a direct result of trauma exposure, such as that related to sexual abuse. However, this is not to say this will happen to everyone who may have experienced sexual abuse as our individual capacity to process and cope with trauma differs. In the study conducted by Michael *et al.* (2020:1499) it was mentioned that the participants perceived that their own individual experiences and genetics are predictors of their own eating disorders. The limitation is that the study itself did not make mention of experiences of individuals so one cannot state with certainty whether sexual abuse played a role as a key contributing factor among any of these participants. However, according to Konopka (2015:315), abuse of a sexual nature has differing effects on individuals because of the genetic vulnerabilities that each one carries.

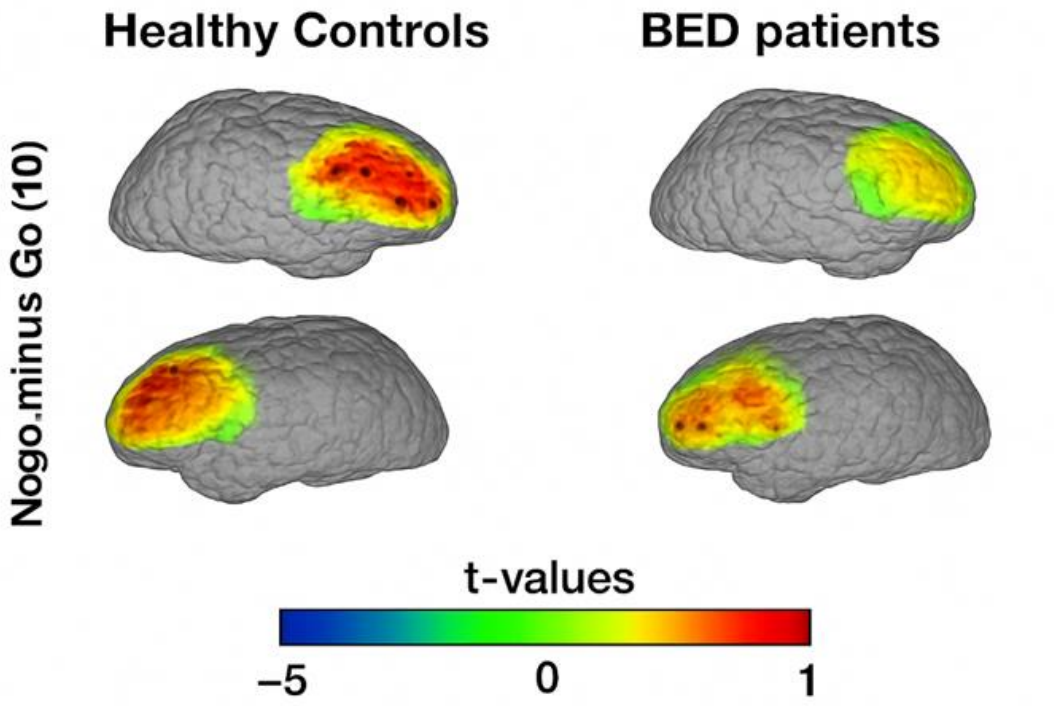
5.2.1.2 The impact of trauma on the brain

Both exposure to trauma and the development and sustained use of eating disordered related behaviours have an impact on the brain of an individual. To support this statement, Konopka (2015:315) says the following: “Clearly, childhood sexual abuse significantly changes it’s victims’ brain and alters its function, cognition, and emotion.” Monteleone *et al.* (2019:301) further explain that childhood trauma affects brain areas involved in reward, taste and body image perception, all of which play an important role in eating disorder psychopathology. Equally so, Guo and Xiong (2024:2) mention a similar concept in relation to BED and BN maintaining that these disorders also pose a negative effect on brain regions responsible for appetite control, food craving, rewarding, processing as well as impulsivity. However, this alteration is not only limited to BED and BN, EDs which in their entirety carry the potential of bringing about alterations in the brain as shown in an fMRI (van Beers *et al.,* 2025:3). Alongside these identified effects it is vital to mention that one of the key areas affected by trauma are related to parts of the brain responsible for emotional regulation. One such study is that of Behar *et al.* (2016:152) which describe that exposure to psychological trauma especially during the early development of the right hemisphere could have a severe

impact on this region of the brain. Behar *et al.* (2016:152) mention that the ventral-medial prefrontal cortex, which is located within the right hemisphere is the area responsible for emotional and stress regulation. Therefore, it goes without saying that damage to this area of the brain potentially puts individuals at risk of developing struggles with emotional and stress regulation.

The author argues that since the prefrontal cortex does not fully develop until the mid-20s, damage to this region places young people at risk of emotional dysregulation and destructive coping behaviours following traumatic experiences such as abuse. According to the paper *Maturation of the Adult Brain,* the prefrontal cortex governs executive functions, and disruption of this area increases engagement in risky behaviours such as unprotected sex, impaired driving and substance use (Arian *et al.,* 2013:453). Based on this, the author maintains that eating disorders (EDs) should be understood within the same framework, as they share addiction-like patterns of reinforcement seen in substance use disorders. While some studies (e.g., Behar *et al*., 2016) emphasize the role of trauma in altering prefrontal cortex functioning, research has also shown that EDs themselves affect this brain region (Uher *et al.,* 2004:1238; Scharner & Stengel, 2019:29; Viet *et al.,* 2021:2). The figure below illustrates this point, showing differences in prefrontal inhibitory response and impulsivity between healthy individuals and those diagnosed with binge-eating disorder (BED). Viet *et al.* (2021:7) suggest that individuals with BED demonstrate greater difficulties inhibiting impulsivity compared to their healthy counterparts. This aligns with my personal experience of trauma and addictive behaviours, including EDs. In moments of overwhelming pain, my primary drive was toward instant relief and gratification rather than prioritising long-term wellbeing. For me, that feeling of instant relief came through as part of my rigorous exercise regime. As Arian *et al.* (2013:453) note, one key function of the prefrontal cortex is to support impulse control and the ability to delay gratification.

Figure 5.1: Comparison between prefrontal inhibitory response and impulsivity in healthy individuals and BED patients



Source: Viet *et al.* (2021:7).

Alongside the prefrontal cortex, another brain region involved in emotional regulation is the cingulate cortex (Rolls, 2019:3001; Beers *et al.,* 2025:3). Beers *et al.* (2025:3) explained that alterations in this region can impair self-control, increasing the risk of obsessive or restrictive eating, binge eating and purging behaviours. Although this study highlights the role of loss of control in maintaining healthy eating patterns, the author is also left to consider a paradox. Self-control, in some cases, might itself serve as a motivating factor in such behaviours. This line of thought stems from my own journey, which provides a personal illustration of the research findings. I came to view my sense of self-control as misdirected toward an unhealthy lifestyle. I adhered rigidly to my exercise regime, meticulously counted calories, and avoided foods I deemed unhealthy - no matter the cost. My family often praised me for my self-control; yet I would argue that my behaviour did not embody self-control in its truest sense.

In the paper *Real-life self-control conflicts in anorexia nervosa: An ecological momentary assessment investigation*, the authors mentioned that “Individuals with AN are often thought to show heightened self-control and increased ability to inhibit desires” (Fürtjes *et al.,* 2022:1). While this speaks about self-control in relation to

maintaining the ED behaviour, the author argues that when it comes to treatment and recovery it is sometimes hard to invest the same level of self-control. It is during these moments that the sense of impaired self-control becomes most apparent. Eriksson *et al.* (2023:2) distinguished between two types of control, namely under-control and over-control, defining them as follows:

> Under-control is characterized by impulsiveness, spontaneity, fluctuating emotions, and expressing these emotions even when socially inappropriate. Over-control, on the other hand, can lead to overly organized behaviour, as well as an ability to delay gratification and refrain from pleasure.

It is the view of the author, that self-control manifested in this manner becomes pathological and potentially carries a sense of anxiety and/or depression along with it. However, Eriksson *et al.* (2023:1) stated that the extent of the association between self-control levels and psychiatric disorders such as anxiety and depression are unknown. Building on this perspective, the author is of the conviction that the inability to stop the behaviour when one reaches a point where they want freedom is another potential indicator of impaired self-control. This psychological struggle finds a parallel in a spiritual sense in the words of the Apostle Paul in Romans 7:15: “I do not understand what I do. For what I want to do I do not do, but what I hate I do.”

Furthermore, most studies examining the impact of childhood trauma confirm that it affects the hypothalamic-pituitary-adrenal (HPA) axis, the main component of the stress response system, which has also been implicated in eating disorder pathology (Marciello *et al.,* 2020:77; Cascino & Monteleone, 2024:1). Consequently, it has been shown that eating disorders such as AN are associated with increased cortisol levels. Monteleone *et al.* (2019:301) made an important distinction, noting that these alterations may have particularly severe consequences for individuals with genetic vulnerabilities to psychiatric conditions such as eating disorders. Additionally, research has highlighted several key brain areas affected by both trauma exposure and eating disorder pathology that have not been discussed in this study, such as the orbitofrontal cortex, hippocampus, thalamus, striatum, amygdala, sensory cortices and many more (Monteleone *et al.,* 2019:301). While much of this discussion has focused on the impact of brain alterations, it is also important to recognize that the brain has the capacity to heal and recover. This is due to the process of neuroplasticity which has to do with the brain’s incredible capacity to “modify its structure and function in

response to environmental and experience change" (Zotey *et al.,* 2023:1). Having this knowledge provides hope that with persistence and dedication to treatment, recovery and healing are possible.

The following section deals with the psychological factors at play in the development of EDs after sexual abuse exposure.

5.2.2 Psychological factors

Both sexual abuse and EDs are associated with a range of psychological factors. Chapter 3 of this study already discussed the various co-morbid factors linked to EDs. Among these are depression and anxiety (Berrettini, 2004:21), which Li *et al.* (2019:12) note are also common psychological consequences of sexual abuse. Post-traumatic stress disorder (PTSD) is particularly regarded as a significant mediating factor in the relationship between sexual abuse and EDs (Behar *et al.,* 2016:153; Convertino *et al.* 2022:1087; Vanzhula *et al.,* 2019:1; van Beers *et al.,* 2025:2). Convertino *et al.* (2022:1087) argue that this connection arises because individuals who have experienced abuse are at a heightened risk of developing PTSD. Supporting this, van Beers *et al.* (2025:2) found that the prevalence of PTSD among those with EDs is approximately twice as high as in the general population. Furthermore, Vanzhula *et al.* (2019:2) observed that individuals diagnosed with AN and BN are not only more likely to exhibit PTSD symptoms, but that higher levels of PTSD are linked to increased body dissatisfaction. Vanzhula *et al.* (2019:2) further noted that ED behaviours such as binge eating, purging and restrictive eating may function as coping mechanisms aimed at escaping or avoiding distressing memories, thoughts and emotions associated with PTSD. The problem with this, though, becomes that using an ED to cope with a traumatic event such as sexual abuse is not healthy and can be regarded as a maladaptive coping strategy. Similarly, van Beers *et al.* (2025:2) suggest that ED symptoms may manifest as attempts to manage intrusive PTSD experiences, including nightmares and flashbacks.

Therefore, it becomes evident that among individuals battling EDs following experiences of abuse, disordered eating may function not only as a coping mechanism but also as a means of emotional regulation. Brustiengh *et al.* (2019:510) mention that

individuals with a history of childhood trauma exhibit a greater risk of emotional dysregulation. According to Brustiengh *et al.* (2019:510):

> … disorganized eating behaviours can be configured as attempts to deal with negative emotions. Some evidence has shown that emotional dysregulation can follow traumatic events and become the link between them and eating disorders, resulting in anger, dissociative experiences, impulsiveness and compulsiveness.

While most studies identify emotional abuse as a strong predictor of emotional dysregulation (Vajda &, Láng, 2013:386; Racine & Wildes, 2016:1; Barone *et al.,* 2024:1), Burns *et al.* (2012:37) argue that, because sexual abuse rarely occurs in isolation, the overlap between emotional and sexual abuse may account for the shared symptoms observed between EDs and CSA. While still on the topic of emotional dysregulation, it is important to point out that Ross (2009:215) mentions the concept of "suicide by starvation" which he cites as a common motive of AN, stating this process is one of attempting to gain control over the uncontrollable by attempting to manage one's existence. Based on this argument by Ross, it can therefore be argued that for some the ED may function as a form of self-harm. Hodge (2021:47) also agrees with the notion that an ED after abuse exposure may be viewed as a form of self-harming behaviour of which self-harm is psychologically known as a mental health problem in its own right.

Furthermore, the author argues that we should not discount shame from this discussion. Living in a society where mental health problems are often met with shame (Rüsch *et al.,* 2014:178) and where sexual abuse and EDs are stigmatized, brings a lot of shame to individuals. Hodge (2021:108) described several stories of women who mentioned that they battled with feelings of worthlessness which were regulated by shame. Hodge (2021:108) further maintained that for a lot of these women: "An eating disorder was understood as a process of transformation of this emotion through the physical body. Their shame became contained through disordered eating practices and thus made safe." Based on this it can then be argued that shame perpetuates the continuous cycle of ED related behaviours. A cycle which I am way too familiar with as my story involved constantly feeling ashamed about who I was, my behaviours, my experiences and in the attempt to try and ease that feeling and numb my emotions it

just seemed easier to over-exercise, starve myself and at times even overeat. Shame told me that something was wrong with me that needed to be fixed.

Having explored the psychological mechanisms that link sexual abuse to the onset and maintenance of eating disorders, the following section will discuss the social factors at play in maintaining EDs among those with a history of sexual abuse.

5.2.3 Social factors

With an increase in social platforms and many young people getting exposure to digital spaces at a young age, the author believes that we cannot discuss social factors without taking into consideration the proliferating rate of social media and social spaces which influence young people today. Rosenbaum *et al.* (2023:3) mentioned that social media use may influence the internalization of socio-cultural attitudes that encourage negative body image by means of comparison, self-objectification, and self-surveillance, all of which increase the risk of developing EDs. A similar notion is stated by Harrison and Cantor (2006:41) who mentioned that media influences disordered eating habits based on values, norms and aesthetic standards embraced by modern society. Although media such as TV and magazines can play a role in sending messages to young people about what is considered as societal standards of beauty, this is not where it ends. I remember at the height of my eating disorder leaning into online communities that supported my ED patterns of behaviour. The messages shared on these platforms can often play a key role in encouraging and reinforcing destructive behavioural patterns. This notion is supported by Borzekowski *et al.* (2010:1526), who stated that pro-eating disorder websites – largely known as pro-ana or pro-mia websites – are online communities where individuals can find a host of materials to help support both the progression and maintenance of EDs. Borzekowski *et al.* (2010:1526) further stated that the content found on these websites is often "conveyed through text, images, audio, or video and it encourages knowledge, attitudes, and behaviours to achieve terribly low weight." This then takes the author to social learning theory developed by Albert Bandura, which suggests that behaviour is learnt through the observation of others (Kretchmar, 2024). In this regard, young people who have experienced sexual abuse may reach a point of vulnerability, prompting them to seek other coping mechanisms. In my own story, looking for love

and validation in external social spaces during a time of trauma led me to pro-ana websites, where I not only observed the content but also imitated the behaviours. With every kilogram of weight I lost, my behaviour was constantly reinforced. I thought I had found peers who understood me, but I failed to recognize that the messages on those sites were rooted in negative peer influence, brokenness and mutual self-harm.

While there is limited research directly linking eating disorders among sexually abused youth to social learning theory, the author asserts that sexual abuse - as discussed multiple times throughout this study - is often met with deep-seated shame, leaving individuals feeling isolated. Disclosure within family structures can sometimes result in dysfunction and not being believed, further intensifying this sense of isolation. For many, such isolation can lead to not being heard which could result to one reaching out to external sources and potentially self-destructive behaviours, not only as a coping mechanism but also to attempt to belong and be heard. I, for one, could not speak about my traumatic past with my family, and I internalized negative perceptions about my body based on the trauma I experienced. Combined with the messages I was receiving from my family regarding my body I concluded that I could control my exercise regime and eating habits as a way to regain a sense of agency and self-worth.

5.3 The need for control

Sexual abuse often leads individuals to experience a profound sense of loss of control. This is supported by Patterson *et al.* (2023:1873), who found that among participants with histories of sexual abuse, many described not only losing control during the abuse itself but also in other areas of their lives. The experience of being unable to disclose the abuse or receive adequate support further exacerbated these feelings, leaving many with the belief that something was inherently wrong with them and reinforcing their overall sense of powerlessness and loss of control (Patterson *et al.,* 2023:1874). As a result, in their study Patterson *et al.* (2023;1879-1880) described different scenarios experienced by the participants in their study where others resorted to drinking and hypersexuality in the attempt to not only cope with the abuse, but to try and regain a sense of control. Within the context of this study, individuals are prone to resorting to EDs as part of their desperate attempt to regain control (Talago, 2024).

This image was painted out by Hodge (2021:209) who through an analysis of an image drawn by a girl battling an ED after being raped, suggested that one of the core messages of this image point to this girl trying to "regain some kind of control over her life, through her body, by starvation." Hodge (2021:209) mentioned that this girl said the following about her experience: "None of that matters (the rape) if I've lost my weight." This statement indicates not only the need to regain control, but a sense of avoidance to the trauma she has encountered. According to Patterson *et al.* (2023:1878), avoidance can often be used as a form of control and as tactic to attempt to cope with the overwhelming emotions that come with abuse.

However, the author argues that this is a rather paradoxical way to attempt to regain control. Once again drawing from my own experiences, I am aware of how the use of an ED to be in control became the opposite of what I expected it to be. I lost complete control of my sense of self, but equally so my behaviour quickly became unmanageable. I was powerless and, in that powerlessness, lost my voice. In fact, Barbarich-Marsteller *et al.* (2015:4) describe the control associated with EDs as a false sense of control, further asserting that individuals with Anorexia Nervosa (AN) often

> behave similarly to those with substance use disorders by narrowing their behavioural repertoire so that weight loss, food restriction, and excessive exercise interfere with other areas of functioning in much the same way that substance abuse does (Barbarich-Marsteller *et al.,* 2015:1).

This also aligns well with the following statement by Olsen Husebø (2007:7) which mentions that:

> Individuals with AN exhibit extreme self-control and denial of bodily compulsion, those suffering from Bulimia Nervosa exhibits ambivalence and alternation between being in control (dieting) and losing control (binge eating and purging) while individuals with BED simply lose control. To lose control over both emotions and behaviour is depicted as the core aspect in this eating disorder.

The paradox of EDs can also be understood through the cycle of addiction which asserts that loss of control, unmanageability, obsession, compulsion, and acting out as central features (Project Exodus, 2020:17). This cycle is similarly evident in the maintenance of EDs, which can be difficult to break until the underlying patterns are interrupted. Krauss *et al.* (2023:1142) describe how individuals exhibiting eating disorder symptoms may repeatedly lose control over their eating behaviour, despite a

desire to manage it. Guo and Xiong (2024:1) similarly identify persistent loss of control over eating behaviours. Thus, the use of EDs as a coping mechanism after sexual abuse illustrates a cycle in which attempts to assert control paradoxically reinforce powerlessness.

5.4 The need for identity

The concept of identity has been broadly defined across literature. Croce *et al.* (2024:2) define identity as a conscious awareness of oneself that encompasses a sense of self-sameness across time and situations, as well as a sense of uniqueness that distinguishes one from others. Similarly, Guenther *et al.* (2020) describe identity as an integration of an individual's "traits; attitudes; self-knowledge; cognitive structures; past, present, and future self-representations; social roles; relationships and group affiliations." Collectively, these characteristics not only define who a person is and how they perceive themselves and the world around them, but also influence their behaviours, judgements, and decisions (Guenther *et al.,* 2020). In contrast, the Biblical perspective describes identity as an understanding of oneself in relation to God, others, and the world (Bible Hub, 2025). From this viewpoint, identity is closely associated with one's sense of self, purpose, and belonging, which are rooted in the divine image and calling (Bible Hub, 2025). Louw (2012:61) expands on this view, suggesting that identity "entails more than individual characteristics and self-understanding"; it represents a revelation of moral values and is interconnected with integrity.

However, traumatic experiences such as sexual abuse pose a significant threat to an individual's sense of identity. Muldoon *et al.* (2024:1759) support this, stating:

> Being a survivor of child sexual abuse can therefore be seen as a stigmatized identity by the person themselves and a mark of shame that is experienced as something to be hidden.

This is also supported by Vartanian *et al.* (2018:232) who mentioned that experiencing adverse events especially early in life can bring about a disruption in normal identity development which increases vulnerability to socio-cultural risk factors such as "internalization of societal beauty standards and appearance-based social comparisons." The author therefore views sexual trauma and the development of

eating disorders as an attack on one's identity. Such experiences often give rise to profound confusion and disconnection from the self, leaving individuals uncertain about who they are and diminishing their sense of being. From a personal standpoint, there was a time when I limited my sense of identity to worldly standards of beauty. When trauma entered my life, I experienced a deep sense of betrayal both by my body and toward my body which profoundly affected how I perceived myself and my body image.

Research indicates that many young people between the ages of 10 and 14 are known to have a negative body image (Mchiza, 2014:185). While this often correlates with eating disorder-related behaviours, experiences of sexual abuse have also been found to significantly impact one's body image (Groth *et al.,* 2020:444). Talago (2024) reaffirms this by stating that:

> Sometimes sexual abuse can lead survivors to view themselves as damaged or flawed. They may mistakenly believe the abuse was their fault and carry misplaced guilt and shame about the experience. This can lead to a negative or distorted body image and is common among people with eating disorders.

Therefore, it can be argued that eating disorders may develop because of a disrupted sense of identity, in which disturbances of self-perception and body image contribute to maladaptive coping mechanisms. This is particularly common among the youth, for whom identity formation represents a critical stage of development. Pfeifer and Berkman (2019:2) acknowledge that adolescence is a crucial period for the development of one's sense of self and identity. Similarly, Wurdeman (2015:6) refers to Erikson's stages of development theory, which posits that adolescents often experience challenges during the stage of identity versus role confusion.

According to Verschueren *et al.* (2021:2), individuals who experience identity confusion are more likely to present with traits such as low self-esteem and emotional internalization, which may make them vulnerable to maladaptive coping behaviours, especially among young people who struggle to regulate their emotions effectively. In their study, *Eating disorder symptomatology and identity formation in adolescence: A cross-lagged longitudinal approach*, Verschueren *et al.* (2018:1) found that identity confusion increases vulnerability to body dissatisfaction and the development of BN symptoms. The author believes that identity confusion may also play a key role in the development of other eating disorders such as AN and BED. This belief stems from

personal experience: not knowing who I was kept me trapped in destructive cycles of behaviour that momentarily numbed the pain I was feeling. The unfortunate truth, however, is that in my attempts to fix myself by becoming thinner and more beautiful, I fell deeper into the pit of a lost identity, slowly losing parts of myself until I no longer recognised who I was. Hope was only restored when I finally embraced two truths:

(1) I was created in the image of God (Genesis 1:27)

(2) I have been fearfully and wonderfully made (Psalm 139:14)

These truths not only restored my sense of identity but also reaffirmed that true healing begins with understanding who I am in Christ.

5.5 The attempt to control sexuality

The trauma that comes with sexual abuse is often so great that it affects how individuals relate to and/or perceive their sexuality (Roller *et al.,* 2009:50). Meydan and Godbout (2023:2) put it as follows, “Childhood sexual abuse has been associated with a variety of sexual difficulties.” While some are more inclined to hypersexuality after traumatic sexual experiences (Slavin *et al.,* 2020:2029), others are more likely to avoid exploring their sexuality (O’Callaghan *et al.,* 2019:1046) and want to separate themselves from this aspect of their lives. This is supported by Roller *et al.* (2009:50), who noted that among women, the most common response after sexual abuse is the likelihood to avoid intimate relationships due to fear and distrust of men. Not only that, but others experience a total disgust of sex and sexuality after being subjected to traumatic experiences (White, 1991:12; Fink, 1995:2; Badour, 2013:155). Fink (1995:2) mentions that this sense of disgust towards one’s sexuality can pave the way for the development of EDs. Hodge (2021:15) agrees with this statement by mentioning that there is an existing correlation between the development of ED pathology amongst women who are struggling to cope with past sexual abuse.

For some young people who develop EDs following sexual abuse, one of the ways in which they attempt to cope is by trying to suppress or halt the development of their secondary sexual characteristics (Ross, 2009:214). It was also mentioned that one of the reasons individuals attempt to stave off these secondary sexual characteristics is rooted in a desire to appear prepubertal; making them less attractive to perpetrators

or, on the other end of the spectrum, to gain a sense of “invisibility” to potential perpetrators (Ross, 2009:214; Patterson *et al.,* 2023:1878; Talago, 2024). An example of this was already discussed in Chapter 4, where a young girl expressed no desire to grow up or even get to the point of getting her period over perceived fears of sexuality and pregnancy. Reflecting on this, I became aware that I too used to drastically reduce my calorie intake and over-exercise, hoping it would reverse the development of my secondary sexual characteristics, as I viewed the feminine parts of myself as deeply traumatic. This is supported by Ross (2009:215) who maintains that menstruation can indeed be a traumatic trigger among individuals affected by sexual abuse, more especially rape. Kearney-Cooke and Striegel-Moore (1994:306) explain that, amongst survivors of sexual abuse, the avoidance of secondary sexual characteristics such as menstruation “may be used in the service of denial, by producing a shutdown of impulses and other physiological reminders of a painful and shame-bound sexual past.”

Another factor to consider is that sexual abuse creates a sense of sexuality as something that is dirty (O’Callaghan *et al.,* 2019:1057). Therefore, in this regard individuals will tend to engage in behaviours which are meant to rid themselves of this dirt. As a result, research states that for many battling with EDs after sexual abuse, one of the core fundamental aims of this behaviour is to attempt to purify themselves and gain a sense of cleanliness (Hodge, 2021:186). This behaviour was mostly observed among those who demonstrated with purging behaviours (Hodge, 2021:186). However, this makes me wonder if other controversial behaviours such as ON, as discussed in Chapter 3, do not carry a similar effect as it was discussed that this behaviour is concerned with the purification of the body. Ross (2009:217) had to say the following:

> 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…

While Ross’s quote describes this sense of purification in relation to one form of sexual abuse, it is equally important to recognize that sexual abuse takes many forms, and feelings of “dirt” are not limited to those who have experienced penetrative encounters. The author contends that such feelings can accompany any form of sexual violation,

regardless of whether it was penetrative or whether the individual's body physically responded to the act.

5.6 Spiritual perspectives

Answering the question "why is it going on" will not be fully complete without a consideration of spiritual perspectives at play. As part of this discussion, the author will first contextualise the notion of sin and brokenness. This will then be followed by discussions of sin and brokenness from the perspectives of both sexual abuse and EDs.

5.6.1 Sin and brokenness

Sin and brokenness are unfortunately a reality of the world we live in. The notion of sin is defined as transgression of the Law, falling short of the mark and failure to do the good we know we should do (Little, 1987:61). This definition is not only supported by the *Merriam-Webster Dictionary* (2025) which also states that the concept of sin relates to a "transgression of the law of God" or "an often-serious shortcoming" but simply put it relates to committing an offence. Furthermore, van Laar-Jochemsen (2025:139) defines sin as "a break in the human relationship with God." This then leads to viewing sin as anything that stands in the way between God and humanity. Rooted in human rebellion and disobedience, sin is the doorway to the brokenness we face as humanity. This statement is reiterated by van Laar-Jochemsen (2025:139) who stated that not only do we face brokenness because of sin, but because of the relational nature attached to sin this brokenness extends to others, ourselves and the world pointing out that it affects the entire essence of our being. Bargár (2021:232) supports this by explaining that brokenness is a consequence of the disrupted relationship between humanity and God.

Now one may ask how this is relevant to answering the question, "Why is going on" or even more so to the issue of sexual abuse and eating disorders? This is going to be covered in the next two sections where sin in relation to sexual abuse is discussed, followed by a discussion of sin from an ED perspective.

5.6.1.1 Sin and brokenness in relation to sexual abuse

Individuals who encounter sexual trauma tend to go through a whirlwind of emotions which include feeling completely consumed by guilt, shame and blame towards themselves for their experiences (Wong, 2021:16; Choruby-Whiteley & Morrow, 2021:302). But we do know that all these feelings of guilt, shame and blame towards oneself are often misdirected as the victims are not to blame for their experiences. So how does sin fit in when discussing sexual abuse if the victim is not to blame? Well, the Bible is no stranger to discussing issues related to sexual abuse (Graybill, 2022; Wong, 2021:2). This is evidenced through stories such as that of Dinah (Genesis 34); Tamar (2 Samuel 13) and the concubine who was raped and murdered in Judges 19 (Graybill, 2022). From the Biblical text it can be pointed out that acts related to sexual violence are condemned and dishonouring to God. This is also seen in Deuteronomy 22:25-27 which reads as follows:

> But if out in the country a man happens to meet a young woman pledged to be married and rapes her, only the man who has done this shall die. Do nothing to the woman; she has committed no sin deserving death**.** This case is like that of someone who attacks and murders a neighbour, for the man found the young woman out in the country, and through the betrothed woman screamed, there was no one to rescue her.

From this portion of Scripture, it is evident that the sin of sexual abuse is not towards the victim as he/she has been sinned against and not to be blamed for their experiences (Deming *et al.,* 2013:473; Mofokeng, 2022:81). According to Figueroa and Tombs (2020:69), sexual abuse is often regarded as a sin committed by the perpetrator but the criminal element of it is often ignored. A similar notion was asserted by Jones (2016:238) who also mentioned that sexual abuse had in the past been regarded a sin, but in recent times it has become recognized as a crime. The author, however, argues that the crime cannot be separated from the sin, claiming that the two are inseparable. In as much as sexual abuse is a criminal activity, it is equally rooted in sinfulness. Wong (2021:15) pointed out the following:

> Sexual abuse perpetrators heinously offense and possess the bodies of the victims, this presumption is banished from sexual abuse victims because what they experienced and learned is that their bodies no longer belong to them.

Wong (2021) not only paints an image of a victim of sexual abuse being humiliated and sinned against, but also highlights the victim's loss of autonomy and control. This loss carves a pathway to deep-seated brokenness, often leaving the victim searching for ways to cope with the crime they endured. These coping mechanisms tend to be maladaptive in nature (Fitzsimmons & Bardone-Cone, 2010:689; Jimenez-Padilla, 2025:3). For me, personally, trauma pushed me into a place where the void in my heart longed to be filled, and in my desperate attempt to fill it, I found myself trapped in what felt like the valley of the shadow of death. I became stuck in a never-ending cycle of addictive disorder which included falling prey to ED related behaviours. In Matthew 18:6, the Bible states that:

> If anyone causes one of these little ones those who believe in me to stumble, it would be better for them to have a large millstone hung around their neck and to be drowned in the depths of the sea.

The following section will go on to deal the notion of sin and brokenness in relation to EDs in greater depth.

5.6.2.2 Sin and brokenness in relation to EDs

Attempting to discuss EDs from a spiritual perspective is not as black and white. The basis of this statement stems from the reality that the Bible does not necessarily address EDs directly. Due to the limited research that exists on this topic, a large part of this section will be based on opinion and personal conviction related to the journey that I have walked thus far. Therefore, to boldly say that eating disorders are a sin would not be entirely accurate; however, the author is convinced that an element of sin is present in these disorders. Why would I say this? The Bible tells us in Exodus 20:3, "You shall have no other gods before me." For a moment in my journey, my worship towards God became disorderly, as my focus was first and foremost on my body—what I ate, how much I ate, what I weighed, and how much weight I lost. My patterns of eating and how I looked quickly became a god to me. My worship was focused on myself and my appearance rather than keeping my eyes completely fixed on God. Yes, the brokenness of trauma pushed me to this point, but remaining fixated in this state of powerlessness was largely rooted in freedom of choice. The eating disorder kept my devotion away from God, and quite frankly informed my view of God

to one that was flawed. As a result of both sexual trauma and EDs, the image of God I created was one where I saw God as angry and judgemental as opposed to loving and caring. These flawed perspectives of God kept the behaviour going and I could not necessarily break free until I realised the truth of who God really is and learned to develop restored God images.

Secondly Romans 12:2 reads:

> Do not conform to the patterns of this world but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is – his good, pleasing and perfect will.

I could boldly say that conformity to the images that I saw across media platforms informed my decision to try and fix myself through resorting to eating disordered cycles of behaviour. Brokenness taught me that true beauty was based on the standards of this world instead of viewing beauty from the standard of my creator who said in Genesis 1:27 that I was created in His image and that I was fearfully and wonderfully made (Psalm 139:14). I viewed beauty from a misinformed sense of perfection which did more harm than good, as opposed to seeing myself in the way that God sees me.

Thirdly, the ED cycle became a stronghold for me as it held me captive and I lost all sense of control. According to Bible Hub (2025), the concept *stronghold* is representative of all mental and/or spiritual barriers that oppose the knowledge of God. This is supported by Coleman (2025) who said that strongholds could present themselves as something physical, mental or emotional. Through the powerlessness and loss of control I faced throughout my struggle with ED, not only did I become entangled in the behaviour, but false beliefs, ideologies and sinful patterns were prevalent (Bible Hub, 2025) throughout the journey. In 2 Corinthians 10:4-5 Paul says the following:

> The weapons we fight with are not the weapons of the world. On the contrary, they have divine power to demolish strongholds. We demolish arguments and every pretension that sets itself up against the knowledge of God, and we take captive every thought to make it obedient to Christ.

Coleman (2025) further states that strongholds are metaphorically described as the things which stand in the way of our relationship with God, but these things also blind us from seeing ourselves in the way that God created us to be. Furthermore, the author argues that strongholds in a metaphorical sense are there to try and steal, kill and destroy from us as John 10:10 mentions that “The thief comes only to steal, kill and destroy.” This, in essence is what brokenness came to achieve, but the restoration that comes through Christ carries with it the promise of life, as in the ending of John 10:10, the words of Jesus in that portion of scripture then become “I have come that they may have life and have it to the full.”

5.7 Conclusions

This chapter answered Osmer’s second question about practical theological interpretation, which is: “why is it going on?” This was achieved by discussing interpretive aspects from multi-disciplinary fields regarding the development of EDs because of sexual abuse. As part of this discussion, it was found that bio-psychosocial factors play an integral part in the development of EDs after exposure to sexual abuse. Research shows that some individuals are more genetically predisposed to EDs than others. The impact of trauma on the brain also plays a role in the development of EDs among some individuals. Secondly, psychological mediators such as PTSD also tend to increase the likelihood of ED development. Alongside this, psychological factors such as the impact of emotional dysregulation, maladaptive coping mechanisms, shame, “suicide by starvation” and self-harm also serve as possible predeterminants of ED pathology amongst those with a history of sexual abuse. Thirdly, social influences such as online ED communities may have an impact on both the development and the maintenance of EDs. Dysfunction within family structures as well as isolation was also identified as potential predeterminants or pathways which may influence the development of EDs after sexual abuse.

This chapter also deal with the view that sexual abuse often leaves victims feeling a sense of loss of control. This then results in those with EDs engaging in these behaviours as part of their attempts to regain a sense of control. Yet it was found that this is rather paradoxical as those with EDs exhibit a further sense of loss of control as their behaviour only leads to powerlessness which sustains the behaviour.

Furthermore, engaging in ED related behaviours in the attempt to regain identity was identified as a factor rooted in identity confusion as Erickson's theory maintains that identity development is a key factor in adolescence.

Another factor which was discussed is based on the need to control one's sexuality. Sexual abuse was discussed to cause feelings of disgust towards one's sexuality, which ultimately results in the ED serving as mechanism to not only suppress this sexuality, but also to attempt to starve one's secondary sexual characteristics. Finally, spiritual perspectives were discussed in relation to ED development after abuse occurring because of sin and brokenness. The following chapter will move on to examining Osmer's third task of practical theological interpretation through the form of a hermeneutical interpretation.

CHAPTER 6: NORMATIVE TASK – EXPLORING SCRIPTURAL PERSPECTIVES

6.1 Introduction

The previous chapter answered the second task of Osmer's model. In this chapter, the third task of Osmer's (2008:4) methodology is addressed, with a specific focus being on answering the question, "What ought to be going on?" The focus of this chapter is on Scriptural perspectives, and the methodology used throughout is a hermeneutical interpretation.

In this chapter, the focus is on contextualising the concept of hermeneutics, after which a hermeneutical interpretation of three pericopes follows. For each pericope studied, both the historical and cultural context are discussed, followed by an exploration of the literary context. The observation section takes the form of a lexical analysis and word study, which is then followed by an application.

The first pericope of discussion is Genesis 1:26–27, where the focus is on navigating God's original design concerning identity and sexuality. This is followed by an analysis of 1 Corinthians 6:19–20, where the discussion centres on the body as the Temple of the Holy Spirit. Finally, Psalm 34 is examined, with specific attention to Psalm 34:18, where the focus relates to the notion of God being close to the broken-hearted.

6.2 Contextualizing hermeneutics

The entire essence of this chapter is grounded in a spiritual foundation through the process of hermeneutical interpretation. This approach helps to affirm the theological nature of this study. It is important to note that Scripture is regarded as authoritative in this context, in line with 2 Timothy 3:16–17, which reads: “All Scripture is God-breathed and is useful for teaching, rebuking, correcting and training in righteousness, so that the servant of God may be thoroughly equipped for every good work.”

Before engaging further with theological interpretation, it is essential to define hermeneutics and to consider the processes that accompany it. The term *hermeneutics* is defined as the art, study, or science of interpretation (Clines, 1982:65; Zowada, 2018; *Merriam-Webster*, 2025; George, 2020). According to George (2020), hermeneutics presents itself across various disciplines such as law, medicine, human and social sciences, humanities, and theology - fields that all require interpretive approaches to discern meaning. These approaches aim to uncover “the meaning of human intentions, beliefs, and actions, or the meaning of human experience as it is preserved in the arts and literature, historical testimony, and other artifacts” (George, 2020).

From a theological perspective, hermeneutics may therefore be understood as the process and principle of interpreting the Word of God (Zowada, 2018). Perry (2022) explains that this process carries particular significance because it enables one to interpret meaning within communication, especially across different cultural contexts. This reinforces the idea that one of the main purposes of biblical hermeneutics is to gain an understanding of what Scripture intended to communicate to its original audience, and how that same message remains relevant and applicable in our present-day context (Zowada, 2018). However, while interpretation forms the foundation of what hermeneutics entails, Porter and Malcom (2013:31) argue that the concept is not limited only to interpretation but should rather be understood from a broader perspective. According to these authors, hermeneutics is not merely about interpreting Scripture from a practical sense - it is also about what it means to be an interpreter, considering several underlying factors such as:

> What are the assumptions, felicitous conditions, activities, prior commitments and human components, among other things, that enter, and even govern, any act of human understanding, whether its object be language, culture, the physical world, even texts and much else.

The author agrees with Porter and Malcom (2013) that hermeneutics involves more than interpreting Scripture; it also considers how our assumptions, experiences, and cultural contexts shape the way we understand God's Word. This perspective is particularly important in this study, as it seeks to bridge the gap between real-life human experiences of trauma and theological understanding. Within this context, Scripture provides a balance between the meaning of an ancient text and the realities of the human condition in the present day. Furthermore, the role of the Holy Spirit in hermeneutical interpretation cannot be overlooked. While reflection on lived experience can shape understanding, it is ultimately the Holy Spirit who guides the interpreter in discerning the meaning of Scripture within a certain context at a given time. This guidance enables sensitivity, discernment, and obedience to God's Word, ensuring that interpretation remains faithful to the original message while also being applicable to contemporary contexts - particularly in addressing complex issues such as sexual abuse and eating disorders. Harris (2015) highlights this when stating that:

> The role of the Holy Spirit in the interpretation of Scripture is to guide us to the truth contained within it. The Spirit assists us in interpretation by guiding us to truth, convincing us that it is true, and helping us understand and appropriate truth as our own truth and word of life.

John 16:13 echoes this truth, saying:

> But when he, the Spirit of truth, comes, he will guide you into all the truth. He will not speak on his own; he will speak only what he hears, and he will tell you what is yet to come.

Having considered the foundational role of the Holy Spirit in guiding interpretation, it is now necessary to look at the practical process of Biblical hermeneutics. According to Zowada (2018), this process involves four essential steps, which are outlined below:

Step 1: Historical and cultural context: Understanding the book in relation to aspects such as authorship, audience, purpose, and themes.

Step 2: Literary context: Analysing Scripture in relation to its genre, structure, and overall flow.

Step 3: Observation: Paying attention to the details by asking questions such as “What?”, “When?”, “How?”, “Where?”, and “Why?”, and then recording those observations.

Step 4: Application: Applying the principles learned from the passage into real-life situations in the present.

The rest of this chapter seeks to follow these four steps of theological interpretation to make sense of how we can understand concepts related to sexual abuse, eating disorders, sin and brokenness, and identity within our current context. The next section will therefore focus on humanity as created in the image of God.

6.3 Navigating Gods design of sexuality and identity

In this section a hermeneutical interpretation based on Genesis 1 is conducted. The focal verse to be focussed on throughout this discussion is Genesis 1:26-27. To conduct a thorough hermeneutical interpretation, the four steps identified by Zowada (2018) will be used as a point of departure.

6.3.1 Historical and cultural context

Genesis, as stated in its opening line, “In the beginning…,” is known as the book of beginnings and forms part of the Pentateuch (Longman III & Dillard, 2006:38; Hays & Duvall, 2014:67; Hill & Walton, 2023:46). According to Hays and Duvall (2014:57), the Pentateuch refers to the first five books of the Bible, and it derives from the following two Greek words:

(1) *Pente* – Meaning “Five”
(2) *Teuchos* – Refers to “scroll” or “book”

Therefore, when combined the word *pentateuchos* refers to a “five-scroll” or “five-book” collection or to “a book consisting of five volumes” (Rossouw, 2019:106). The books which form part of the Pentateuch are known as the Torah in the Hebrew Bible which translates into “teaching” or “instruction” (Hays & Duvall, 2014:57; Rossouw, 2019:106). Therefore, it has been added that these first five books contain divine

instruction and teaching (Hays & Duvall, 2014:57; Rossouw, 2019:106; Hill & Walton, 2023:32) and are also fondly known as “the Books of the Law” (Hays & Duvall, 2014:58).

Another factor of importance relates to the fact that the Pentateuch is concerned with the Mosaic covenant (Hays & Duvall, 2014:57). However, the authorship of Genesis is not attributed to Moses (Longman III & Dillard, 2006:41). Instead, research indicates that Genesis does not have a known author (Hamilton, 2012:9; Hill & Walton, 2023:46). Due to this, Hamilton (2012:9) mentions that Genesis can be regarded as an anonymous book. However, conservative scholars still debate the notion of Mosaic authorship (Longman III & Dillard, 2006:41). There are, however, several existing theories to consider which help to theorize the possibility of the authorship of Genesis.

Firstly, Longman III and Dillard (2006:41) mention that the Torah in a strict sense is anonymous, as none of the books explicitly point to the authorship of Moses as the sole author, but there are references to his writing activity as seen through commands God gave him to write certain laws and historical events. Secondly, another argument which arose regarding the authorship of Genesis is based on what is known as the documentary hypothesis (Hamilton, 2012:9). This hypothesis argues that the authorship of Genesis is based on four sources, known as the Jehovist (J); Elohist (E); Deuteronomic (D) and Priestly (P) sources (Hamilton, 2012:9; Longman & Dillard, 2006:43). However, Hamilton (2012:9) states that the anonymity evident in several Old Testament (OT) books serves as an invitation for readers to focus on the theological message conveyed in Scripture, rather than on the identity of the author. Hamilton (2012:10) concludes his discussion on authorship by saying that there are two possibilities regarding the origin of Genesis:

- Genesis 1-50 is theorized to having possibly existed as tablets which Moses later arranged in chronological order and went on to add the material about Joseph. This approach would make Moses the compiler as opposed to the author.
- The composition of Genesis may have occurred during the time of the exodus, making it an appropriate composition to read to the tribes of Israel before they departed for Sinai. In this case, the author would most likely have been the individual appointed to lead them to Sinai - namely, Moses.

The book of Genesis is known to be a starting point of the story of covenant history between God and His people Israel (Hill & Walton, 2023:45; Rossouw, 2019:106). The story of Genesis was informed by three key ideas where God created and all He created was good, but the moment sin entered the world disobedience separated the people from God. In the attempt to restore this, God instituted a covenantal promise with Abraham. Therefore, the four major themes of Genesis as identified by Hill and Walton (2023:45) are as follows:

- The covenant and the election
- Focus on one God
- Disorder as humanity choose their own way
- Cosmic and human identity

From a cultural context, it is mentioned that Genesis, as all OT literature, is informed by an Ancient Near Eastern (ANE) background (Longman III & Dillard, 2006:51). However, Genesis is aided by comparable literature originating from places such as Mesopotamia, Canaan, and Egypt (Longman III & Dillard, 2006:51). An example of this is seen in the creation account which is known to contain parallels with Babylonian and Ugaritic texts, such as the *Enuma Elish* and the flood story containing parallels with the *Gilgamesh Epic* (Longman III & Dillard, 2006:52). However, despite these existing parallels the Bible remains a divinely inspired book as mentioned earlier in this chapter.

6.3.2 Literary context

The book of Genesis is regarded to contain a variety of genres ranging from narrative, genealogy, battle report, poetic testament *et cetera* (Longman III & Dillard, 2006:54). However, Longman III and Dillard (2006:54) state that within the context of the canon, Genesis “contains a unity of narrative plot that takes the reader from the creation of the world to the sojourn in Egypt.” The book is written using an eleven account (*toledoth)* formula (Hill & Walton, 2023:45; Longman III & Dillard, 2006:54; Rossouw, 2019:106). From a literary perspective, Genesis can be described as “theological history” based on the content of chapter 1 (Longman III & Dillard, 2006:54).

The structural outline of Genesis, according to Hays and Duvall (2011:71-72), looks as follows:

A. Creation of the world, people, and the Garden (1:1-2:25)
B. Paradise lost: Sin, death, and separation from God (3:1-11:32)
    - Sin 1: Adam and Eve eat the forbidden fruit and are banished from the garden (3:1-24)
    - Sin 2: Cain kills his brother, Abel, and is driven away (4:1-26)
    - Sin 3: (and then some): Worldly wickedness brings on the flood (5:1-9:29)
    - Sin 4: The Tower of Babel results in scattering the people (10:1-11:32)
C. God's response to human sin: Deliverance through the Abrahamic covenant (12:1-50:26)
    - Abraham: The promise and the obedience of faith (12:1-23:20)
    - Isaac: Continuing the patriarchal promise (24:1-25:18)
    - Jacob: Struggle and the beginning of the twelve tribes of Israel (25:19-36:43)
    - Joseph: Faithfulness and God's sovereign deliverance (37:1-50:26)

6.3.3 Observation

The words of particular importance in this pericope are "created", "image", and "likeness". The Hebrew word for "created" (bārā' – בָּרָא) refers to the act of shaping or bringing something into existence (Bible Hub, 2025). According to Rossouw (2019:110), this term denotes the "acts of God in doing or calling into existence something new or marvellous." The creative act of God can also be observed in the word "make" (ʿāśāh – עָשָׂה) found in Genesis 1:26, which conveys the idea of doing or producing (Bible Hub, 2025). The terms bārā' and ʿāśāh (עשה) are sometimes used interchangeably, as both emphasize the object being created (Iowa Bible & Archaeology, 2023). According to Hughes (2004:36), Genesis 1:27 can be viewed as the first poetic instance due to it's four stresses and the repetition of the verb bārā'.

In the context of Genesis 1:26–27, the object of creation is humanity - the Hebrew "adam" (אָדָם) - which represents humankind as a whole (Bible Hub, 2025). Throughout Genesis 1, Israel's God is depicted as the sole Creator who brings all things into being through His spoken word (Longman III, 2013:508). This not only highlights the authority of God, but Longman III (2013:508) mentioned that it highlights to Israelites that their God is not only responsible for everything, but that He is the only one worthy of their worship.

This brings us to the next key term, viz. “image”. In this verse, humankind (adam – אָדָם) is created (ʿāśāh) in the image of God. The words used to describe the concepts “image” and “likeness” are tselem (צֶלֶם) and demût (דְּמוּת) respectively. Longman III (2013:1106) mentions that the word “image” usually refers to a statue, typically of a God, while “likeness” refers to something that has a similar physical appearance. Similarly, Rossouw (2019:110) stated the following:

- ***“Image”*** suggests reproduction in form and substance, physical or spiritual. Humans are made “in the image of God”; “possessing divine qualities indestructible and inalienable, which no animal possessed.”
- ***“Likeness”*** gives the idea of resemblance and outward similarity. Humans are made “after the likeness of God”; his character is potentially divine, capable of approaching, or receding from, the “likeness” of God.

While these definitions show the existing differences between the words *image* and *likeness*, the Bible hub (2025) lexicon pointed out that:

- *Tselem* refers to an “illusion; resemblance; hence a representative figure; especially an idol - image, vain shew”
- *Dmuwth* refers to “resemblance, concretely, model, shape, adverbially, like – fashion, like (-ness, as), manner, similitude.

Based on this, it becomes evident that while these words contain parallels such as “resemblance”, there are differences which can also be noted. It has been said that these words are often used interchangeably within an OT context and further mentioned that the word “image” points to humanity having a uniqueness or distinctiveness that sets them apart from other creatures (Erickson, 2013:458; Rossouw, 2019:110). This is supported by Longman III (2013:1105) who said that being created in the image of God indicates that human beings have a unique status over animals because they have a special similarity with God. Human beings are called into a relational communion with God where they can both communicate with and respond to His Word (Rossouw, 2019:110). The other word commonly used to describe the image of God is *imago Dei* (Hughes, 2004:37). According to Simango (2012:638-639) the following three views regarding the *imago Dei* have been suggested:

- Some consider the image of God to consist of certain characteristics within the very nature of humankind, which may be psychological or physical or spiritual. This view is known as the “substantive view” of the image of God.
- Others regard the image of God not as something inherently or intrinsically present in a human being, but as the experiencing of a relationship between human beings and God or between two or more humans. This view is called the “relational view” of the image of God.
- Some consider the image of God as a function that humans perform. This view is called the “functional view” of the image of God.

However, Erickson (2013:457) notes that the substantive, relational and functional views are not entirely satisfying; instead, individuals should seek to understand the image of God by inquiring directly into Scripture. The following section will apply this pericope considering the study’s focus on eating disorders, sexual abuse and the impact of sin and brokenness.

6.3.4 Application

An understanding of who humankind is, begins with knowing that we are made in the image of God (Guzik, 2025). This statement resonates deeply with the author, as one of the core convictions held is that humanity cannot truly understand who we are without first understanding who God is. Scripture reveals that human beings are called to be image-bearers of God (Hughes, 2004:37). Yet, this raises the question - what does it truly mean to have been made in God’s image? As discussed above, humanity’s creation in the image of God signifies that humans are distinct from all other created beings, sharing a unique correspondence with the Creator (Guzik, 2025). This image-bearing nature encompasses moral, intellectual and spiritual capacities (Hughes, 2004:37; Guzik, 2025). Furthermore, Hughes (2004:37–38) explains that to bear God’s image entails the capacity to hear and respond to the Word of God, to exercise dominion over creation (Gen. 1:26, 28), and to exist in filial relationship - or sonship - with God (Gen. 5:3). Guzik (2025) notes at least three key aspects of humanity’s creation in the image of God:

- Personality: Human beings possess knowledge, feeling and will - qualities that distinguish us from all animals and plants.

- Morality: Human beings can make moral judgments and possess a conscience.
- Spirituality: Humanity is made for communion with God; it is on the level of spirit that we communicate with God.

Based on this understanding, it becomes evident that once the image of God within humanity had been tainted by sin and brokenness (Gen. 3), the moral and spiritual integrity of humankind became corrupted. While human beings retained a sense of morality, we became immoral. The thesis topic itself highlights one of the gravest expressions of this moral corruption - sexual abuse. Such perpetration can rightly be described as an evil act rooted in immorality. The behaviour, in and of itself, taints the image of God in humanity. Schmutzer (2008) provides a compelling theological and psychological description of how sexual abuse damages the divine image in humanity:

- Sexual abuse fractures the unity of personhood. It is an act that “un-creates”, thus dismembering its victims and leaving them with deep feelings of helplessness, loss, vulnerability, shame, humiliation and degradation (Schmutzer, 2008:793).
- Sexual abuse impairs sexual expression. Whereas God’s original design in Genesis 1:28 was for sexual union to serve for bonding and reproduction, abuse distorts this purpose, often leading victims toward hypersexualized behaviours or distorted understandings of love (Schmutzer, 2008:794–795).
- Sexual abuse distorts delegated authority. Research indicates that approximately 80% of victims are abused by family members, and 19% by trusted adults—associating authority with terror and betrayal (Schmutzer, 2008:796–797).
- Sexual abuse disfigures “facial identity”. It robs individuals of the uniqueness and dignity tied to their sexual and personal identity (Schmutzer, 2008:797–798).
- Sexual abuse isolates the “self” from community. Created for relationship with God and others, victims often experience seclusion, shame, and alienation that crush their sense of belonging (Schmutzer, 2008:800).
- Sexual abuse destroys family relationships. Incest - the most common form of sexual abuse - wrenches families apart and disregards God’s created boundaries, collapsing relational structures (Schmutzer, 2008:802–803).

- Sexual abuse mars connecting metaphors for God. Biblical images of God as Father, Shepherd or Protector are often corrupted in the minds of victims, making trust and intimacy with God profoundly difficult (Schmutzer, 2008:804).

This multi-dimensional description of how sexual abuse damages the image of God, reveals the devastating effects of sin and brokenness. The author further observes that this distortion of the divine image involves a loss of self, resulting in an identity crisis and a painful search for meaning and belonging. As discussed above, hypersexuality may emerge as one form of “acting out,” while eating disorders - also identified as a risk factor for survivors of sexual abuse - represent another manifestation of this internal struggle. Although eating disorders are not explicitly mentioned in Scripture, they nonetheless threaten the image of God within humanity, as they are rooted in a fractured sense of identity and worth. Yet, there is hope: Hughes (2004:38) reminds that the restoration of the divine image is found in Christ, “the image of the invisible God, the firstborn of all creation” (Col. 1:15). In Christ, the true Image-bearer, the broken image within humanity can be renewed and redeemed. The next section will consider the body as the temple of the Holy Spirit.

6.4 The body as the temple of the Holy Spirit

This section of the study explores the concept of the body as the temple of the Holy Spirit, with reference to 1 Corinthians 6:19–20, which states:

> Do you not know that your bodies are temples of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore, honour God with your bodies.

In the discussion that follows, the author examines this passage with specific attention to its historical and cultural context, literary context and lexical analysis (observation) through a word study. The section concludes with a practical application of the verse within the context of this study, focusing on eating disorders among the youth who have experienced sexual abuse.

6.4.1 Historical and cultural context

The book of 1 Corinthians was written specifically to the church in the city of Corinth. The Corinthian church was identified as a problem church (Van der Walt, 2009:103; Hays & Duvall, 2014:1515). In fact, it is believed that Corinth represented Paul's most challenging congregation (Hays & Duvall, 2014:1517). According to Van der Walt (2009:103), one of the main problems in Corinth stemmed from the believers' inability to distinguish themselves from their non-Christian counterparts. This was evident in their persistence in holding on to flawed belief systems, as well as their arrogance and immaturity (Hays & Duvall, 2014:1519). Hays and Duvall (2014:1519) further note that the Corinthians struggled with issues related to spirituality, where rivalry and pride emerged among those who believed that they had attained higher levels of spiritual maturity. In addition, the city of Corinth was plagued by idolatry, particularly the worship of Aphrodite, known as the "goddess of love," and her temple priestesses (Van der Walt, 2009:104). However, Carson and Moo (2009:1158) suggest that the traditional description of "one thousand temple prostitutes" may be an exaggeration, intended to emphasize the severity of Corinth's moral crisis. This aligns with Hays and Duvall (2014:1517), who describe Corinth as being notoriously known for its sexual immorality.

Van der Walt (2009:104) also identifies additional issues addressed in the letter, including sexual immorality, marriage, food sacrificed to idols, and the observance of the Lord's Supper. Within the specific context of 1 Corinthians 6:12–20, Paul directly confronts the problem of sexual immorality, urging believers to recognize their bodies as temples of the Holy Spirit and to honour God through their conduct. A key historical factor to note is that the city of Corinth was destroyed by the Romans in 146 BC and rebuilt by Julius Caesar in 44 BC. During this period, many of the original citizens were killed or sold into slavery (Carson & Moo, 2009:1157; Van der Walt, 2009:103). The newly rebuilt Corinth was populated by a diverse mix of people, including freedmen from Rome, Jews and Greeks. Carson and Moo (2009:1158) further observe that "from Asia and Egypt came many mystery cults". contributing to the city's religious pluralism and aristocracy of wealth.

According to Van der Walt (2009:103), while Athens was regarded as the cultural capital of the ancient world, Corinth, being more affluent and cosmopolitan, became the political capital of southern Greece. The city's reputation for moral corruption was

so severe that the term “to Corinthianise” became synonymous with fornication, and the phrase “Corinthian girl” was used as a euphemism for a prostitute. The Apostle Paul founded the church in Corinth during his second missionary journey, as recorded in Acts 18:1–18 (Carson & Moo, 2009:1159; Hays & Duvall, 2014:1517). However, he is believed to have written the letter during his third missionary journey, around AD 54, while in Ephesus (Hays & Duvall, 2014:1517). Although Paul’s authorship has occasionally been contested, Carson and Moo (2009:1156) affirm that most scholars uphold Pauline authorship. The letter also mentions Sosthenes (Hays & Duvall, 2014:1517), who is identified in Acts 18:17 as a synagogue leader in Corinth and an associate of Paul (Bible Hub Topical Encyclopaedia, 2025).

6.4.2 Literary context

As already noted above, 1 Corinthians is an epistle or letter (Carson & Moo, 2009:1156; van der Walt, 2009:103). Corinthians is known as one of Paul’s main letters (van der Walt, 2009:95). According to Hays and Duvall (2014:1515), the letter to the Corinthians is a letter about the church which is “raw and unedited” in nature. Hays and Duvall (2014:1519) suggested the following structural breakdown of 1 Corinthians:

- Greeting and thanksgiving (1:1-9)
- Paul responds to reports about the church (1:10-6:20)
- Paul responds to the letter from the Corinthians (7:1-16:4)
- Concluding matters (16:5-24)

From this outline, it is evident that Paul followed the conventional structure used in ancient letter writing. Typically, such letters began with an introduction of the author (1 Corinthians 1:1), identification of the recipients (1 Corinthians 1:2), a blessing (1 Corinthians 1:3), and concluded with personal greetings and expressions of goodwill (Van der Walt, 2009:93). Regarding the structure of 1 Corinthians 6, Guzik (2025) offers the following literary outline, which divides the chapter into two major thematic units.

A. Instruction regarding lawsuits among Christians

I. Paul denounces their recourse to the pagan law courts in disputes among Christians (1)

II. Why Christians are fully capable of judging their own matters, and it is wrong to go to heathen law courts to settle the disputes (2-6)

III. Paul rebukes the man who had been wrong: Why not accept the wrong? (7)

IV. Paul rebukes the man who had done wrong: Do you realize how serious your sin is? (8-11)

B. Instruction regarding sexual purity

I. A principle for sexual purity among Christians: What is permitted is not our only guide for behaviour (12)

II. A principle for sexual purity among Christians: Appetites for food and sex are not the same (13-14).

III. A principle for sexual purity among Christians: Our bodies are part of the body of Christ and so should never be joined to a prostitute (15-17).

IV. A command for sexual purity among Christians (18)

V. A principle and a command for sexual purity among Christians (19-20)

6.4.3 Observation

The following table is a lexical analysis of 1 Corinthians 6:19

Table 6.1: Word study of 1 Corinthians 6:19 (Biblehub, 2025)

NASB	Greek	Transliteration	Strong's	Definition	Origin
Or	ἢ	ē	2228	Or, than	a prim. conjunction used disjunctively or cptv.
do you not know			3609a	To have seen or perceived, hence, to know	perf. of eidon

that your body	σῶμα	sōma	4983	A body	of uncertain origin
is a temple	ναὸς	naos	3485	A temple	probably akin to naió (to inhabit)
of the Holy	ἁγίου	agiou	40	Sacred, holy	from a prim. root
Spirit	πνεύματος	pneumatos	4151	Wind, spirit	from pneó
who is in you, whom	οὗ	ou	3739	Usually rel. who, which, that also demonstrates words such as this, that	a prim. pronoun
you have	ἔχετε	echete	2192	To have, hold	a prim. verb
from God,	θεοῦ	theou	2316	God, a god	of uncertain origin
and that you are not your own.	ἑαυτῶν	eautōn	1438	Of himself, herself, itself	from a prim. pronoun he (him, her) and gen. (dat. or acc.) of autos

The word *sōma* (σῶμα, G4983) is widely used in the New Testament and often refers to the human body. Gundry (2025) notes that in this context, *sōma* encompasses more than the mere physical aspect; it refers to the whole person and the relationship with God. The description of the human body as a temple is a particularly powerful metaphor. In its original meaning, a temple is defined as “a building for religious practice” (*Merriam-Webster* 2025). Simply put, a temple is a space associated with worship. In 1 Corinthians 6:19, however, the body as a temple signifies a sacred space

dedicated to God, which must be kept pure from all forms of immorality (Guzik, 2025). Gundry (2025) further emphasizes that this understanding highlights both ethical and spiritual responsibility.

The words “who is in you” emphasize that the Holy Spirit dwells within believers. This concept is affirmed throughout Scripture. For example, Romans 8:9 states:

> You, however, are not in the realm of the flesh but are in the realm of the Spirit, if indeed the Spirit of God lives in you. And if anyone does not have the Spirit of Christ, they do not belong to Christ.

This agrees with Paul’s statement, “you are not your own” (heautōn), which points to the reality that the believer belongs to Christ. As Scripture declares, “You shall be my sons and daughters, says the Lord Almighty” (2 Corinthians 6:18; Joel 2:28). Therefore, the believer’s body is not autonomous property but a consecrated vessel - belonging fully to God and indwelt by His Spirit.

6.4.4 Application

Living in a culture where it is easy to declare, “It’s my body; I can do with it as I please,” 1 Corinthians 6:19-20 powerfully challenges this prevailing notion by affirming that we are not our own. We belong to Christ, and the Holy Spirit dwells within us. This pericope, therefore, calls believers to live spiritually transformed lives that are reflected in the way we treat our bodies - lives that express worship to God through physical stewardship. There is a cost to everything, a concept that echoes throughout this thesis. Being violated in the body through experiences such as sexual abuse brings deep pain and destruction. Likewise, mishandling the body through disordered eating behaviours carries its own cost - manifesting in emotional suffering, spiritual disconnection and physical illness. In 1 Corinthians 6:20, the Apostle Paul reminds believers that “you were bought at a price”, reinforcing the idea that redemption involves cost. Through His death on the cross, Jesus paid the ultimate price for our sins.

As I worked through this Scripture, I realised that throughout my journey with an eating disorder, I rarely considered the cost associated with such behaviour. I seldom reflected on whether the way I was treating my body honoured God. Yet 1 Corinthians 10:31 teaches that “So whether you eat or drink or whatever you do, do it all for the

glory of God." The same principle that underlies 1 Corinthians 6:20 applies here: believers are called to glorify God in all that they do. The very essence of our being is that our lives - including the way we care for our bodies - should be an act of worship to God. Although 1 Corinthians 6 primarily addresses sexual immorality, its underlying theological principle extends beyond that context. It applies equally to anyone struggling with bodily stewardship, including those battling with eating disorders. The call remains the same: to honour and glorify God with our bodies, recognising them as sacred spaces indwelt by His Spirit.

6.5 God is close to the broken-hearted

This section of the study looks at the Psalms. Hill and Walton (2023:297) mention that the Psalms are one of the best-loved and most-used books within the Old Testament. Another known factor about this series of books, is that they are best known for providing comfort and encouragement for the reader in times of disappointment; equally so, they provide the reader with wisdom and words to praise the Lord (Hays & Duvall, 2014:529).

Psalm 34:1-22 is the pericope of focus. The focal verse which to be discussed in this section is Psalm 34:18, which reads: "The Lord is close to the broken-hearted and saves those who are crushed in spirit."

6.5.1 Historical and cultural context

Longman and Dillard (2006:237) explain that the name Psalms derives from the Septuagint (Psalmos) and was transmitted through the Vulgate. These authors further mention the Hebrew term *mizmor,* which comes from the verbal root *zāmar,* meaning "to sing" or "to pluck," thereby emphasizing the Psalms' inherent connection to music. According to Hays and Duvall (2014:531), the Greek word used for *psalms* refers to songs sung with instrumental accompaniment. The Hebrew title for the book, *Tehillim*, means "praises," although most of the Psalms are more accurately described as *Tephilloth,* meaning "prayers" (Longman & Dillard, 2006:237–238; NIV Study Bible, 2011; Hays & Duvall, 2014:531). It is suggested that the grouping of the 150 psalms

into five different books serves as an intended parallel to the five books of the Pentateuch as found in the Torah (Hays & Duvall, 2014:531).

Defining the historical context of the Psalms, however, presents a challenge, as the book is a collection rather than a unified composition, and most psalms are historically nonspecific (Longman & Dillard, 2006:239). Nevertheless, Longman and Dillard (2006:239) note that Psalm 90 dates to the time of Moses, while others, such as Psalm 126, originate from the post-exilic period indicating a compositional span of nearly a thousand years. This is supported by Hill and Walton (2023:299), who mention that the psalms were written and composed over a timeframe of a thousand years by several individuals. Additionally, Hill and Walton (2023:299) added that the evidence of all five books of the Psalms was composed over a significant period, was found in the Dead Sea Scrolls.

The NIV Study Bible (2011) similarly suggests that the Psalms were written between the time of Moses and the Babylonian exile, roughly between 1440 BC and 538 BC. This is supported by Hays and Duvall (2014:534), who state that some of the psalms point directly to the Babylonian exile (for example, Psalm 137:1). Based on this evidence, it can therefore be concluded that the final compilation of the Psalter likely occurred after the exile, or possibly during the time of Ezra and Nehemiah, which dates between 450 and 400 BC (Hays & Duvall, 2014:534). The Psalms were composed for and addressed to the nation of Israel (NIV Study Bible, 2011; Longman & Dillard, 2006:239). In the context of Psalm 34, the heading “Of David. When he pretended to be insane before Abimelek, who drove him away, and he left” - clearly references the events recorded in 1 Samuel 21:10–22:1. During this period, David was a fugitive from Saul and sought refuge in the Philistine city of Gath, where he found no safety. He then escaped to the cave of Adullam, which is believed to be the setting where this psalm was composed (Guzik, 2025).

With regards to authorship, it is known that the psalms have multiple authors. Author information is usually reflected within the psalm title which often provide context into the psalm (Longman & Dillard, 2006:241-242; Hays & Duvall, 2014: 536). The authors of the psalms are inclusive of the following individuals: David, Asaph, the Sons of Korah, Solomon, Heman, Ethan, Moses and other unknown authors (NIV Study Bible, 2011). According to Hays and Duvall (2014) the authorship of the psalms is structured as follows:

Table 6.2: Authorship of the psalms

Author	Psalms attributed to specific authors
David	David wrote 73 Psalms (Longman III & Dillard, 2006:242) which are concentrated in Books 1 and 2, but also scattered throughout books 3, 4 and 5.
The sons of Korah	Wrote Psalm 42-49; 84-88
Asaph	Psalm 50, 73-83
Solomon	Psalm 72 and 127
Heman	Psalm 88
Ethan	Psalm 89
Moses	Psalm 90

Based on this table, and the title of Psalm 34, this psalm was authored by David. However, Hill and Walton (2023:297) note that some scholars argue that the titles of the Psalms do not necessarily indicate authorship. For instance, Psalm 72 appears to be a blessing upon Solomon by David, rather than a psalm written by Solomon himself.

Regarding themes, Hays and Duvall (2014:543) note that the two main emphases within the Psalms are lament and praise, whereby lament usually ends in praise. The Psalms were also shaped by the broader ANE cultural context, particularly among Israel and neighbouring regions, such as Philistia, where music played a central role (Hays & Duvall, 2014:543). Similarly, music continues to hold cultural significance in contemporary society.

Hill and Walton (2023:296) expanded on the themes by identifying five central theological ideas portrayed throughout the Psalms:

- Recognition of the kingship and sovereignty of God.
- The conduct and destiny of the righteous and the wicked.
- God's comfort and defence in times of crisis.

- The importance of praise in all its variations.
- The role of nature and creation in reflecting divine glory.

Furthermore, Hill and Walton (2023:296) observe that the Psalms portray God as one who delights in rewarding the righteous and punishing the wicked, while simultaneously remaining present with those in crisis or suffering. This depiction not only underscores the message of Psalm 34 but also aligns with the central focus of this study, which considers the Psalms' relevance to healing and support in contexts of sexual abuse and eating disorders.

6.5.2 Literary context

The Book of Psalms forms part of the wisdom and poetic literature. Longman III and Dillard (2006:246) describe the book as an anthology. Due to their poetic nature, the Psalter is described as being "impassioned, vivid and concrete; rich in images, simile and metaphor" (NIV Study Bible, 2011). As already mentioned earlier, the book contains 150 chapters or compositions which are representative of seven different genres. Within these seven genres, praise, lament and thanksgiving are the three most frequently occurring genres in the book, while there is also an occurrence of "the psalms of confidence", "psalms of remembrance", "wisdom psalms" and "psalms of Kingship" (Longman III & Dillard, 2006:250). Psalm 34 is classified as an acrostic or alphabetic Psalm which implies that the first word of each verse, begins with a different letter of the Hebrew alphabet (Hays & Duvall, 2014:557; Davis, 2019:35). For example, in Psalm 34 the first verse begins with the Hebrew letter *aleph,* and the second with *bet* (Hays & Duvall, 2014:557). Hays and Duvall (2014:558) further note that although the purpose of this alphabetic structure remains uncertain, it may have been intended either to facilitate memorization or to serve an aesthetic function.

A suggested outline for the Book of Psalms as proposed by Hill and Walton (2023:296) is as follows:

I. Introduction (1-2)
II. David's conflict with Saul (3-41)
III. David's kingship (42-72)
IV. The Assyrian crisis (73-89)

V. Introspection about the destruction of the temple and the exile (90-106)

VI. Praise and reflection on the return and the new era (107-145)

VII. Concluding praise (146-150)

According to Guzik (2025) a proposed literary structure for Psalm 34 looks as follows:

A. Calling God's people to praise

I. A life overflowing with praise (1-2)

II. The testimony of the delivered one (3-7)

III. An invitation to share the joyful testimony (8-10)

B. Teaching the people of God

I. Living in the fear of the Lord (11-14)

II. Living under the watchful eye of God (15-16)

III. God, the helper of the humble (17-18)

IV. God's care for His righteous ones (19-22)

6.5.3 Observation

The focal verse which will be observed in this section is Psalm 34:18. The verse reads as follows in the New American Standard Version (NASB): "The Lord is near to the broken-hearted and saves those who are crushed in spirit." A lexical breakdown is presented in the table below:

Table 6.3: Psalm 34 Word Study (Biblehub, 2025)

NASB	Hebrew	Transliteration	Strong's	Definition	Origin
The Lord	יְהוָה	Yahweh	3068	The name of the God of Israel	From the word hava
is near	קָרֹוב	Karovv	7138	near	From the word garab
to the brokenhearted	לְנִשְׁבְּרֵי־	Lenishberei	7665	To break, break in pieces	A prim. Root *(Shabar)*
and saves	יוֹשִׁיעַ׃	yō·wō·ši·a‘	3467	To deliver	A prim. Root *(Yasha)*
those who are crushed	דַּכְּאֵי־	Dakkeei	1793	Contrite	From the word daka
in spirt	רֽוּחַ	Ruach	7307	Breathe, wind, spirit	From an unused word

According to Martin (2024), God is known by numerous names - approximately one thousand - which each reveals different aspects of His character and nature. However, *Yahweh* stands apart as His unique, personal name. The term appears about 6,800 times in the Old Testament, except in the books of Esther, Ecclesiastes and Song of Songs, where it does not occur (Martin, 2024). Similarly, the Blue Letter Bible (2025) estimates that Yahweh appears around 6,519 times, with its first occurrence found in Genesis 2:4. Although the name appears early in the biblical narrative, God formally

revealed the name Yahweh in Exodus 3, where He declared to Moses, “I AM WHO I AM” (Exod. 3:14). The phrase “I AM” is regarded as synonymous with Yahweh, expressing God’s self-existence and eternal nature (Martin, 2024). In the Septuagint (LXX), Yahweh is translated as *Kyrios*, meaning “Lord” or “Master,” and at times as *Despotes*, a title that emphasizes divine sovereignty and absolute authority (Blue Letter Bible, 2025). In Jewish tradition, the name Yahweh is held in deep reverence and considered too sacred to pronounce aloud; therefore, readers substitute it with Adonai (“Lord”) when reading the Hebrew Scriptures (Martin, 2024). Similarly, the Hebrew word qarov (קָרוֹב, Strong’s H7138) derives from the verb *qarab*, meaning “to come near” or “to approach,” and it belongs to a semantic field associated with nearness and relational proximity (Online Hebrew Dictionary, 2025). The verb *qarab* occurs approximately 279 times in the Old Testament, while its adjectival form *qarov* appears around 78 times in passages such as Genesis 19:20, Genesis 45:10, and Isaiah 50:8 (Blue Letter Bible, 2025; Bible Study Tools, 2025). According to Bible Hub Strong’s Concordance (2025), qarov conveys the idea of being “near,” “close,” or “at hand,” yet its meaning extends beyond spatial proximity to include relational and covenantal dimensions. It may describe neighbours (Exod. 32:27), relatives (Lev. 21:2), or kinsmen (Lev. 25:25), thus emphasizing both physical closeness and relational intimacy.

The Hebrew verb *šāḇar* (שָׁבַר, Strong’s H7665) further enriches this verse’s meaning. Appearing approximately 151 times in the Hebrew Bible (Bible Study Tools Lexicon, 2024; Blue Letter Bible, 2025), *šāḇar* generally means “to break” or “to break in pieces” (Bible Hub Strong’s, 2025). It occurs in several verb stems, including *Qal* (“to break, crush, or quench”), Niphal (“to be broken or crushed”), Piel (“to shatter”), *Hiphil* (“to cause to break out or bring to the truth”), and *Hophal* (“to be broken or shattered”). According to Bible Hub’s Cambridge Bible commentary (2025), it is stated that the broken in heart and the crushed in spirit refers to those who have been crushed down by both sorrow and suffering, in whom, it is suggested that affliction has given birth to fruit, and “all self-asserting pride has been subdued and replaced by true contrition and humility.”

Together, the terms studied in this section reveal a profound theological image of who God is in the context of Psalm 34:18 where we encounter a God who is eternal

“Yahweh”, a God who is near *“Qarob”* to those who are broken and hurting “*šāḇar”* offering hope and restoration to the wounded.

6.5.4 Application

Psalm 34 offers profound insight into the nature and character of God. Within this psalm, several images of God emerge: He is portrayed as deliverer (Ps. 34:4), good (Ps. 34:8), provider (Ps. 34:9–10), teacher and parent (Ps. 34:11), attentive (Ps. 34:15), just (Ps. 34:16), near (Ps. 34:18), and protector (Ps. 34:20). However, traumatic and painful experiences often distort one’s perception of God. This has also been true in my own journey. In seasons of suffering, God at times seemed distant rather than near, inattentive rather than attentive, and unjust rather than just. Having experienced deep hurt from male figures, I struggled to relate to the image of God as Father.

Yet Psalm 34 presents a counter-image - a portrayal of God who is not only loving and good but also close to the broken-hearted and one who saves those who are crushed in spirit (Ps. 34:18). This psalm reveals a God who remains constant and present in times of distress, whether the pain stems from the trauma of sexual abuse or from other struggles such as eating disorders. A common question among survivors of abuse is: “Where was God?” Psalm 34 responds to this by affirming that God is near, attentive, and actively involved in the healing and restoration of the wounded.

As Davis (2019) notes, the hope presented in Psalm 34 lies in the assurance that God is attentive to the cries of the righteous, hears them, delivers them and condemns their enemies. God can redeem that which is broken. One of the most meaningful analogies for this redemption is that of the potter, who gathers broken pieces of clay and forms them into something new and beautiful. Verse 22 reinforces this hope: “The Lord will rescue his servants; no one who takes refuge in God will be condemned.” This verse holds profound relevance when addressing topics such as sexual abuse and eating disorders, as it reminds believers that in Christ they are declared “not guilty.” The invitation is to respond with trust, keeping our eyes fixed on Jesus, the author and perfecter of our faith (Heb. 12:1–4).

This promise aligns with Psalm 34:5, which assures believers “that those who look to the Lord will be radiant and never put to shame”. The Psalm extends an invitation to

come to the Father, to turn away from destructive behaviours, and to pursue what is good and pleasing in the eyes of the Lord. In doing so, one inherits blessing and peace. In my own journey, true freedom only came when I surrendered my desire to control my life—when I recognised that I was not the god of my own existence, but that my life belonged fully to God. Healing began when I laid everything down before God—the over-exercising, the over-eating and the starving of myself. Only in surrender did I begin to experience the restoration and peace promised in Psalm 34.

6.6 Conclusions

In this chapter, the third task of Osmer's model was addressed, with the aim of answering the question, "What ought to be going on?" A hermeneutical interpretation was applied to three key pericopes to gain a scriptural perspective on issues relating to identity, sexuality, the body as the temple of the Holy Spirit, and the nearness of God in the midst of brokenness. The hermeneutical interpretation followed a four-step process, as proposed by Zodwana, which considered the following:

- Historical and cultural context
- Literary context
- Observation
- Application

This four-step process was applied to each pericope analysed in this chapter. The first pericope examined was Genesis 1:26-27, which centres on God's design for human identity and sexuality, as well as the effects of sin and brokenness in distorting these aspects of human life. The analysis highlighted that human identity is firmly grounded in knowing oneself in Christ and understanding that all human beings are created in the image of God.

The second pericope, 1 Corinthians 6:19-20, emphasizes that the body is the temple of the Holy Spirit. The discussion underscored that the Holy Spirit dwells within believers and that God calls them to glorify and honour God through bodily stewardship. By living in this way, a believer's life becomes an expression of worship to God.

The final pericope analysed was Psalm 34, with particular attention to verse 18, which states that God is close to the broken-hearted. This passage highlights the nature of God as an ever-present help in times of trouble, demonstrating that He is near to those who are hurting and broken, walking with them moment by moment even when circumstances do not make sense.

CHAPTER 7: PRAGMATIC INTERPRETATION OF EATING DISORDERS AMONG SEXUALLY ABUSED INDIVIDUALS

7.1 Introduction

The previous chapter explored Osmer's third task of practical theological interpretation, which addressed the question, "What ought to be going on?" This was done by examining Scriptural perspectives that could theologically connect Scripture to real-life experiences in addressing eating disorders among individuals with a history of sexual abuse. In this chapter, the final question of Osmer's (2008:4) methodology "How do we respond?" is addressed. This section of the study seeks to explore a pastoral counselling strategy that can be applied in the treatment of eating disorders among youth who have experienced sexual abuse.

In this chapter the discussion begins with discussing several pastoral guidelines and provides suggestions on how these guidelines can be applied and implemented within the pastoral counselling setting.

Secondly, a pastoral strategy for counselling youth with EDs because of sexual abuse is discussed. As part of this discussion a proposed pastoral strategy and framework are discussed, followed by an implementation of the pastoral strategy in practice which explores how pastoral counselling sessions can be conducted using the proposed strategy and framework.

Finally, this chapter closes off with an epilogue and final thoughts where the author brings her own personal narrative and reflections of her journey to a close.

7.2 Application of pastoral principles[12]

The following proposed pastoral principles serve as essential guiding principles which pastoral counsellors should adhere to in the counselling of youth with eating disorders after sexual abuse. This section not only introduces a set of principles but deals with how each of these should be implemented within the pastoral counselling setting.

7.2.1 Multi-disciplinary collaboration

Within a pastoral counselling setting, a multi-disciplinary approach is fundamental and serves as a key point of departure in practice (cf. 4.3 and 4.4.4). Individuals presenting with eating disorders and trauma histories related to sexual abuse often face complex challenges (cf. 2.2 and 3.2), which a multi-disciplinary team is best positioned to address holistically.

In this context, pastoral counsellors collaborate with medical practitioners, psychologists, psychiatrists, and dieticians (cf. 4.3.1), each contributing expertise that ensures that care encompasses emotional, spiritual and physical dimensions. This approach supports restoration across spirit, soul and body (cf. 4.4.4).

A multi-disciplinary framework also allows counsellors to work within their scope of practice, safeguarding both their integrity and the well-being of the counselee. From the moment an individual enters the pastoral counselling space, counsellors should be knowledgeable about eating disorder symptoms—such as extreme food restrictions, bingeing or purging (cf. 3.2.1–3.2.3) as well as signs of sexual abuse and any comorbid conditions. Such awareness enables timeous and appropriate referrals to other professionals when necessary.

Practical examples include:

- Conducting thorough intake assessments and involving the multi-disciplinary team from the outset.

[12] This section of the study was based on the CPSC (2025) document titled: *Ethical values and standards of the Association of Christian Religious Practicioners (ACRP).* This document served as a guiding principle.

- Holding regular follow-up meetings to ensure coordinated and effective treatment.
- Promptly referring individuals with severe symptoms or psychological distress to the appropriate professionals, including primary care facilities when required.

Maintaining open communication and fostering collaboration among multi-disciplinary team members ensures treatment alignment and progress across all areas of the programme (cf. 4.4.5).

7.2.2 Maintaining ethical standards

Upholding ethical standards is fundamental in all counselling spaces, ensuring that counsellors maintain integrity, competence, responsibility and respect. Confidentiality is a core aspect of ethical practice. Counsellors must safeguard information shared during sessions, except when the counselee intends to harm themselves or others, or in cases of under-age sexual abuse. Pastoral counsellors should be familiar with relevant legislation (cf. 2.2.2). Even when collaborating with multi-disciplinary teams, transparency is essential to maintain trust and accountability (cf. 4.4.5). Implementation requires maintaining clear communication with the counselee throughout the counselling process. In exceptional circumstances, or when referral is necessary, information may need to be shared with other professionals of the multidisciplinary team to serve the counselee's best interests.

Practical examples

- Begin sessions by explaining the concept of *confidentiality* and obtaining informed consent from the counselee.
- Keep accurate session notes and ensure they are securely stored.
- Clarify how disclosures of abuse or self-harm are handled within the counselling space.

7.2.3 The use of spiritual disciplines within the pastoral counselling setting

Due to the theological paradigm of pastoral counselling, spiritual disciplines are a key component of the counselling process. Pastoral counsellors are called to maintain sensitivity and discernment to the Holy Spirit, engaging sessions from a Spirit-led posture. Guidance is therefore grounded not in human strength but in the truth of God's Word, allowing the Spirit to comfort, guide, and strengthen the counselee for inner healing (cf. 4.3.1 and 4.4.5).

Prayer and Scripture are central to this approach but only in the case where counselees have consented to it, as not everyone who steps into pastoral counselling will be Christian. Prayer helps the counsellor enter the session with humility and sensitivity, while Scripture directs the counselee toward Christ. Spirit-led discernment guides what to say, when to speak, or when to remain silent. Counsellors are also called to embody the image of Christ, creating safe spaces for vulnerability and authenticity, as modelled by Jesus in the Garden of Gethsemane.

Practical examples

- Begin sessions with prayer if the counselee is comfortable with it or guided reflection to invite Spirit-led discernment.
- Make use of Scripture relevant to healing, identity, or courage, inviting discussion.
- Encourage journaling or reflective prayer exercises between sessions and even after sessions.

The stories of the Samaritan woman (John 4) and the woman caught in adultery (John 8) illustrate a pastoral model rooted in truth and grace. Counsellors are called upon to meet individuals where they are, acknowledge their pain and story and gently guide them toward Christ. For non-Christian counselees, respect for their beliefs is essential, providing care without imposing or denying faith perspectives (cf. 4.4.5).

7.2.4 Integrating a client-centred approach

The pastoral counselling process needs to remain client-centred, recognising that everyone carries a unique story with complex layers. Factors contributing to eating

disorders after sexual abuse vary, including genetic predisposition, bio-psychosocial influences (cf. 5.2), and needs such as control (cf. 5.3 and 5.5) or identity (cf. 5.4). Pastoral counsellors should be able to adapt strategies to everyone's context and capacity. For example, during my own therapeutic journey, I initially expressed myself through writing before developing the ability to verbalise my emotions, and my therapist honoured this process. Similarly, contemporary methods such as art, music, and journaling can facilitate counselling for youth with EDs after sexual abuse (cf. 4.3.1 and 4.4.5).

Practical examples:

- Cultivate an adaptable space where counselees may express themselves in a way that allows them to voice their thoughts and emotions. This could be through various art forms such as writing, drawing and music for those unable to verbalise what they are feeling.
- Set achievable and collaborative goals which the counselee can work towards achieving each week (e.g., practising one healthy habit per week).
- Adapt each session to fit the needs of the individual because what works for one person may not necessarily work for the other.

The aim is not a one-size-fits-all model but a journey toward healing that honours individuality and God's transformative work in the counselee's life.

7.2.5 Displaying priestly listening

Listening serves as an integral part of the pastoral counselling process. It involves the capacity to hear beyond what the counselee is verbally expressing. At times, what the counselee articulates may represent only a fraction of what he/she is truly communicating; beneath their words, there may be deeper meanings. Their body language may reveal further insights, and their behavioural patterns may, for instance, indicate that something more than the eating disorder itself is at play. As the tip of the iceberg model suggests, what is visible to the human eye often represents only a small portion of the underlying issues (cf. 4.3.1). Through priestly listening and discernment, however, the pastoral counsellor can perceive more than what is outwardly presented.

Practical examples:

- Use reflective listening techniques to validate and clarify counselee emotions based on what they are sharing.
- Take note of non-verbal cues such as posture, facial expressions or hesitation to uncover unspoken distress.
- Invite the counselee to explore deeper emotions gradually, ensuring a safe and non-judgmental environment.

With the ability to listen well comes the opportunity to open meaningful dialogue and enter into conversation in which the pastoral counsellor may ask questions and provide space for young people to share their stories. This process should be approached with great sensitivity, empathy, and compassion. Doing so not only fosters a supportive relationship but also strengthens trust within the pastoral counselling process. Over time, this enables the counselee to open up more freely and display courage and vulnerability to tell their truth without fear of judgement.

7.2.6 Make space for providing support to the family

Eating disorders affect not only the individual but also family members, who may feel uncertain about how to provide support. Lack of knowledge can inadvertently cause further harm. The pastoral counselling space can therefore educate and empower families regarding EDs, the implications of sexual abuse, and trauma-related challenges (cf. 4.4.5).

Family sessions should provide a safe space for members to express emotions related to the young person's struggles. This promotes individual and relational healing while fostering family unity. Through guidance, families develop a clearer understanding of how to support the young person effectively.

Practical examples:

- Facilitate individual or joint family sessions for the safe expression of feelings and experiences.

- Role-play difficult situations, such as what to expect during mealtimes. This will help to teach family members some supportive strategies to display towards a loved one without creating any conflict or shame.
- Equip and empower families with knowledge of the relationship between EDs and sexual abuse and with these teach them on triggers and warning signs which may arise.
- Encourage families to attend sessions with multi-disciplinary professionals to help them gain an understanding of the individual from a holistic background such as:
    - **Emotional support:** Learning to recognize and validate the young person's feelings.
    - **Practical support:** Providing support and guidance to loved ones during mealtimes or in the midst other challenging situations such as facing the emotions which are associated with trauma exposure (sexual abuse).
    - **Communication strategies:** Learning what to say or avoid saying to an individual battling with EDs after sexual abuse.
    - **Awareness of triggers:** Understanding potential triggers which could arise for the young person and how to assist during this time but equally developing an awareness of one's own triggers in the process.
    - **Coping strategies:** Learning effective and healthy coping mechanism during times of distress.

By equipping families in this manner, pastoral counsellors foster individual and relational healing, creating a supportive environment that reinforces the young person's recovery across emotional, social and spiritual spheres.

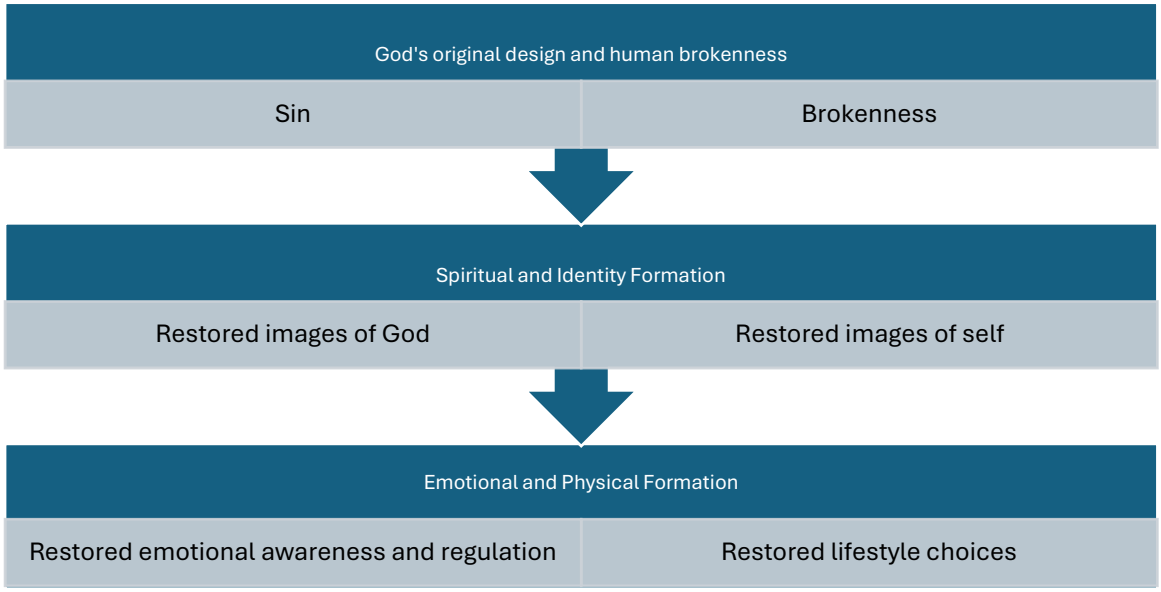
7.3 Pastoral strategy for counselling youth with EDs as a result of sexual abuse

Now that the pastoral principles have been established, the following section explores a pastoral strategy for counselling youth with eating disorders after sexual abuse. This section presents a visual representation of a pastoral strategy that may be considered

when working with youth who struggle with eating disorders because of sexual abuse. This is followed by a framework illustrating how the pastoral strategy can be applied within a pastoral counselling context.

7.3.1 Proposed pastoral strategy and framework[13]

Figure 7.1: Visual representation of a pastoral counselling strategy for youth with eating disorders after sexual abuse



The following visual representation is structured around three interconnected spheres that symbolise the pastoral process of inner healing and restoration. These three areas of focus include:

1. God's original design and human brokenness,
2. Spiritual and identity formation, and
3. Emotional and physical formation.

The first layer represents God's original design for human sexuality and identity (cf. 6.3). Within the context of God's design, the reality is that humanity was originally created to live in perfect harmony with God, themselves and others, however because of the fall, sin and brokenness took precedence and that in many ways continues to

[13] While this is largely the author's contribution to the study base, two key resources which influenced the nature of this strategy are: Dallas Willard's book titled*: Renovation of the heart: putting on the character of Christ* and J.C.Ryles book titled: *Holiness: Its nature, hindrances, difficulties and roots.*

create distortion in the created order (cf. 5.6; 6.3.3 and 6.3.4). In the context of this study when one is sexually abused that is a sin that was committed against them which ultimately brings about brokenness in a way that this brokenness not only results in acting out through resorting to ED related behaviours, but the other factors which associate with this brokenness are inclusive of feelings of shame, depression, anxiety, loss of control, loss of identity *et cetera* (cf. 4.3.1; 5.3, 5.4 and 6.3.4).

As part of the foundational application of this first layer the pastoral counsellor is not only aware of this narrative, but creates a safe, non-judgemental space where the individual is pointed towards the truth of God's word. Often sexual abuse comes with a sense of blame where the victims fault themselves for the abuse experience (cf. 2.3.2.2). Part of the goal in counselling is to help them recognize that they have been violated and sinned against and they are not to blame for the experience. The ED is therefore a manifestation of the brokenness they experienced. To put this first layer into practice, it would involve cultivating a space where shame can be broken by allowing the individual to tell their story up to a point where they feel comfortable. During this cultivate a space where the counsellor can show the counselee that even in the midst of human brokenness and sin, God continues to remain faithful and constant in who He is. Working on establishing this understanding first can help the individual to have an open-minded approach to the rest of the counselling experience especially leading to sessions which go deeper into exploring spirituality.

The second layer then goes on to explore spiritual and identity formation. Exposure to traumatic experiences such as sexual abuse tend to lead to feeling a disconnection from God and from oneself (cf. 2.10). Therefore, within this second layer, the purpose is to go back to what it means to be created in the image and likeness of God and to develop a restored sense of the nature of who God truly is (cf. 6.3). As part of this process, the pastoral counsellor can engage Scripture to help the counselee see what the Bible says about God and equally to see what the Bible says about the believer's identity in Christ. As part of this process, helping the counselees to name what they think about God and themselves is important as this will not only allow them to voice their thoughts and feelings, but this will also create an opportunity to help the counselee to reframe some of the negative connotations they may have attached to both God and themselves.

Finally, the third layer explores the aspects of emotional and physical formation which places emphasis on the emotional and lifestyle choices which are often accompanied with EDs because of sexual abuse. Often those who have been exposed to sexual abuse struggle with emotional dysregulation (cf. 4.3.1 and 5.2.2) which may also occur because of biological reasons caused by the ED once it alters certain parts of the brain (cf. 5.2.1). The main goal to achieve within this aspect is to help the counselee to develop a sense of restored emotional health and physical health in terms of encouraging the counselee to make healthier lifestyle choices.

Taking these three layers into consideration, the fundamental aim is that treatment will look at the individual as whole, taking into perspective that there is healing which needs to occur within the spirit, soul and bodily dimensions of the individual (cf. 4.4.5).

The following schematic framework also gives an idea of what this process could potentially look like:

Table 7.1: Key treatment pillars in a pastoral counselling treatment framework

Pillar of recovery	Description	Pastoral application
Spiritual formation	This process involves fostering growth in an individual's relationship with God through prayer, Scripture, and spiritual disciplines.	Involves the counselee in getting to a point where their relationships with God and their image of who God is are re-established and restored.
Identity formation	Developing a sense of restored self- identity and re-defining the image that one has of themselves. The process includes learning to see oneself through the lens of Christ as a beloved child of God as opposed to seeing oneself as a	Helping the counselee to develop a self-image that is based on biblical truth and seeing oneself as someone created in the image of God. This process involves helping the counselee develop a

	product of trauma or societal expectations.	restored sense of the images that they have of themselves and getting to a point where they can have a healthy idea of who they are and who they are created to be.
Emotional formation	Emotional formation is concerned with helping individuals develop a restored sense of emotional awareness, emotional regulation and a sense of resilience through the Spirit's work.	Addressing emotions related to feelings of guilt, shame and fear caused by both trauma and ED development through taking hold of Biblical truths.
Physical formation	A core part of this is focused on taking care of the body as the temple of the Holy Spirit (cf. 6.4).	Encourages recovery that honours physical health by treating oneself and one's body well.

All these pillars are rooted in dependence on the Holy Spirit. While pastoral counsellors provide guidance and practical support, true transformation is ultimately the work of the Holy Spirit. The young people are then invited to continually trust in God's restorative work throughout the counselling process, fostering wholeness and holistic healing across all areas of their lives.

The next section investigates some practical approaches which can then be adopted within each counselling session when working with youth who battle with EDs after sexual abuse.

7.3.2 Implementation of the pastoral strategy in practice

In this section the author explores how pastoral counselling sessions can be conducted for youth with EDs after sexual abuse. The key concept to take note of is

that when working with young people, it is important to try and develop dynamic sessions which are engaging and create margin to meet the individual where they are, whether this be through creative outlets or other ways in which the counselee can express themselves.

Another factor to note is that each session will run for about 60 minutes. At first, sessions are conducted weekly and then, after the individual has made sufficient progress throughout the counselling process, sessions can begin to move to bi-weekly and even up to once a month. The session examples given in this section explore what sessions could look like, especially within the context of the pillars which were presented in the visual representation and schematic framework presented in this chapter.

Session 1: Initial intake

Purpose: The purpose of the first session is to introduce the counselee to the pastoral counselling process while creating an environment of safety and acceptance for the counselee. During this first session it is necessary for intake and informed consent forms to be completed before the commencement of the pastoral counselling process. These ensure that counselees are well informed about the counsellor's scope of practice and ethical procedures such as multi-disciplinary procedures which occur as part of the counselling process *et cetera.*

Building a relationship of trust is a key part of this initial session where the counsellor discusses concepts such as confidentiality, affirming to the counselees that the counselling space is a safe environment for them where they are encouraged to feel comfortable and clarifying the role of the counsellor. Doing this helps to lay a foundation of trust and respect between the counsellor and counselee which is essential for the journey that will be undertaken together.

Opening: Upon meeting a counselee, greet him/her warmly and welcome them into the session. Open the counselling session with a prayer to invite the Holy Spirit into the counselling space from the very beginning.

At this point it is also important to be mindful that not every counselee who walks into the pastoral counselling space will be from a Christian background, so it is important to elicit respect (cf. 4.4.5) and not force one's beliefs on the counselee.

Conversation starter: To help the counselee ease into the counselling session, begin the session with a conversation starter as a form of “small talk”. This will not only create a space where the counselee learns to open up but it could also indicate to them that the counsellor is interested to know more about them. An example of this would be to ask two or three open-ended questions about the counselee which are focused on getting to know them more, for example:

- What is your dream holiday destination?
- What is your favourite activity to do?
- What is your all-time favourite movie and why?

For this session it is encouraged that both the counsellor and counselee participate in it. This will also help the counselee learn a little bit more about the counsellor and could help the counselee to learn to feel comfortable with the counsellor, not as a person who is there to interrogate them, but as someone who will be journeying with the counselee. Another form of small talk that is not so obvious as an icebreaker, is to be attentive to how the counselee is dressed. If he/she maybe wears a jacket with a national emblem, say for instance for chess, the counsellor can ask them about their chess journey. The counsellor can simply also ask about their family and where they grew up, went to school, *et cetera*. The goal of small talk is to set the counselee at ease and to build trust.

Discussion: At this point, the counsellor must formally introduce him-/herself to the counselee and ensure that they understand what was in the intake and informed consent forms and once again reminding them of the counsellor’s role in maintaining confidentiality. This can also be used as a time to answer any other questions the counselee may have about the initial counselling process.

After this, the counsellor invites the counselee(s) to share their story and with that to maybe name one thing he/she is looking to achieve through the counselling process. It could be as simple as: “healing” or “wholeness” – doing this will allow the counsellor to approach the counselling process with a goal-oriented outlook. In the process of the counselee sharing his/her story, the counselee should only share what he/she is comfortable with sharing at that moment. Respect this time by creating a balance

between just listening and pausing for a moment to ask any leading questions which might arise, such as:

- Tell me more about what happened to you?
- How did that experience make you feel?

As the counselee speaks, the counsellor is encouraged to make notes which can be used for their reference. These notes play a role as part of the initial assessment process. Pay attention to the symptoms the counselee showing, pay attention to their tone of voice and their body language while showing compassion and empathy throughout this process. Listening well without any judgement or blaming the victim (cf. 7.2.5) is a fundamental part of this process, especially because sometimes young people have already experienced a sense of blame from those around them or from external sources that put the blame on victims of sexual abuse or experiencing people labelling them over the fact that they struggle with EDs. In this session, already identify the effect of sin and brokenness in relation to the individual's experience of sexual abuse and how that contributed to the development of EDs. As part of this conversation begin to explore perspectives with the counselee, such as asking questions like:

- Do you think you are to blame for your experiences? If yes, if you could rate the level of blame on a scale of 1-5 what would it be?
- How do you relate with the feeling of shame?
- What is your view of sexuality now and what is your view of a God given identity currently?

The questions asked can be adapted to be made age-specific and relevant to the individual experiences faced by counselees.

Assessment: Based on what has been discussed and shared as part of the initial discussion, the pastoral counsellor not only assesses the counselee by looking into what is really going on with him/her, but the assessment gives the counsellor the opportunity to recognise patterns which might be existent. In the case where a young person opens up about struggling with an ED or potentially looks like they might have struggles, the counsellor has the responsibility to refer him/her to a team of multi-

disciplinary professionals with immediate effect unless the counselee has stepped into counselling already walking with a team of other professionals.

An essential part of this assessment process involves helping the counselee develop a clear understanding of the symptoms associated with eating disorders, as well as an awareness of what constitutes sexual abuse. It also includes recognising the behaviours and mental health struggles that may arise because of their experiences. At the same time, this process invites the counsellor to gently take the counselee “by the hand” and begin walking with them on a gracious journey toward healing.

This initial assessment process also gives the counsellor an idea of what he/she is working with, which then informs them what the treatment is going to look like for the individual, taking into consideration that from this point onwards, treatment will differ from person to person (cf. 4.4.5 and 7.2.4).

Goals: When the assessment process is complete, the counsellor and counselee can then work towards establishing goals. As part of the process the counselee may be given an opportunity to start working on vision:

- What is the counselee looking to work on as part of the counselling process?
- What vision do they have of becoming the best versions of themselves?
- What do they want to achieve?

Homework suggestion: Give homework that builds on the goals which have been identified. The suggested homework activity would be to encourage the counselee to begin working on a personal development plan which they can write to describe the following components:

- The vision they have for themselves
- Identify what it will take to help them reach that vision
- Identify factors which could stand in the way of reaching the vision
- What does it take to challenge those factors which are stumbling blocks to reaching that vision

Closing the session: Before officially closing the session, thank the counselee for his/her courage to share their story. Ask them whether they are comfortable to close the session, and once they have indicated the affirmative, close the session with prayer.

Session 2: Spiritual formation

Purpose: The purpose of this session is to help the counselee to develop a sense of growth in his/her relationship with God through the practice of spiritual disciplines, but the counsellor should first ascertain where an individual is with God and approach such a session with caution as not every counselee will be religious. The intention here is to help the counselee work towards healing their views of God. The foundational Scripture that can be used for this process, is Psalm 34 (cf. 6.5.4).

Opening: As with the previous session, welcome the counselee again, open with prayer to invite the Holy Spirit and ask for His guidance throughout the duration of the counselling process.

Conversation starter: In this session, conduct a conversation which focuses on exploring the emotional well-being of the counselee. An approach which could be taken is to ask the counselee to share whether their emotion was in the form of an emoji based on the past week, and what emoji would they choose and why?

Discussion: Begin the counselling session by conducting a brief follow up of the previous session. Begin by asking them what were some of the key takeaways from the previous session and how they are feeling about moving into this week's session? This allows the counselee to express how he/she is feeling, especially because in the early days of beginning counselling their emotions are often accompanied by feelings of uncertainty and anxiety.

Before moving onto the agenda for the week, follow up with the counselee to find out if they have been able to go and see any member/s of the multi-disciplinary team of whom they were referred to and ask them how their experience was.

Follow this up by asking the counselee whether he/she has anything specific they would like to discuss or bring to the session. If there is anything specific, then work

with the counselee on that specific topic or answer any questions they might have and if possible, depending on what was brought forward and make space for the planned topic focus of the day. Including this is extremely important as it highlights the fact that counselling sessions are not always going to be as black and white or focused specifically on the day's plans, but there is always room for adaptability.

However, assuming that in this case the session allows for the counselee's plan to go ahead as scheduled, then the discussion point will be based on spiritual formation as it concerns the counselee's relationship with God. As part of this discussion, it is suggested that the counsellor begins a discussion with an activity where they begin the session by brainstorming the different attributes or images of who they think God is. Based on this, the counsellor facilitates a conversation with the counselee which explores some of the following topic areas:

- How would you describe your relationship with God before being exposed to trauma and before struggling with an ED?
- Based on what we brainstormed, what do you think influences how you view God now?
- What is the first thing that comes to mind when hearing that God is with and near you, even during what feels like a difficult situation for you?

After the counselee answers these questions, the counsellor may then move onto the reading of Psalm 34 and the rest of the discussion can be focussed on discussing what may have stood out for the counselee in the reading of this scripture. An example of this would be to ask the counselee some leading questions such as:

- When reading Psalm 34 what were some of the attributes of God which stood out to you?
- How do you now reconcile with the idea of "God being close to the broken-hearted"? (cf. 6.5).

Homework suggestion: A suggested homework activity is to let the counselee take time to draw a table about some of the flawed beliefs they have about God vs what the truth is about what the Bible says about God. An example is as follows:

Current belief about God	**The truth of who God really is …**	**Bible verse example**
God is distant	God is near	Psalm 34:18: "**The Lord is close to the** broken-hearted…"
God is unloving	God is love	John 3:16: "For **God so loved** the world that He gave His only Son…"

The counsellor must continually encourage the counselee to continue reading and meditating on Psalm 34 on their own during the week.

Close the session: Before closing the session, ask the counselee to check in again with an emotion and close off with prayer.

Session 3: Identity formation

Purpose: In this session the goal is to help the counselee develop a restored sense of self-identity and learning to view oneself in the manner that Christ sees them.

Opening the session: After prayer, take approximately five to ten minutes to follow up with the counselee based on the previous session. Have a conversation to check in how the counselee's week went and if they were able to read Psalm 34 again and what are some of the realizations, they have gained from that.

Conversation starter: Due to the session's focus being on identity formation, the opening conversation can be within that theme. As a result, the counsellor can pose the following question to the counselee:

- What is your favourite thing about yourself and why?

Give the counselee the opportunity to have fun while answering this question. The counsellor may also participate in this to create an environment where he/she may learn that counsellors themselves are also human and not limited by their occupation. This activity will help to set the tone for the counselling session.

Discussion: In this session, the counsellor is encouraged to read Genesis 1:26-27 with the counselee as a fundamental point of departure to the session. After reading this Scripture, take a moment to pause and reflect. Then ask the following questions:

- What stands out to you the most from this Scripture?
- What does it mean to you to be created in the image of God (cf. 6.3.3 and 6.3.4)?
- When you think about the journey you are currently walking in, how easy or difficult is it for you to still acknowledge that you are created in the image of God?

As part of this discussion, explore together with the counselee what images they have of themselves. Have a conversation around how trauma experiences and struggles with EDs often distort this image of God (cf. 6.3.3 and 6.3.4), and the role of the Holy Spirit in bringing inner healing can help bring total freedom and restoration.

With this discussion teach the counselee about speaking life and truth over oneself and do an activity together where the counselee identifies the lies he/she believes in about themselves and replace the lie with a truth as well as include a declaration, an example of this activity is as follows:

Flawed belief	**Truth**
I am unworthy because of the sexual abuse that happened to me	I am worthy because God says I am worthy – He created me in His image, and nothing can separate me from God.
I am unloved because I was abused and nobody was there to protect me, God did not protect me.	I am loved because I am a child of God – God did not leave me even in that moment of abuse – He continued to remain close even during my brokenness

Encourage the counselee to take these truth statements and treat them as declarations to speak about themselves. The key with declarations is that they will be

kept brief and linked to the pain and freedom found in God, so that the counselee is able to remember them.

Homework suggestion: The counsellor may give the counselee a task to either find or draw an image of something that they believe most represents who they are (e.g., a picture of a lion may serve as a symbol of strength and resilience). Encourage the counselee to put this image up somewhere they can see it easily.

Encourage the counselee to identify three things they would like to declare to themselves and say them out loud every morning. This could even include doing something as practical as writing the declarations down and putting them somewhere the counselee can see them every day (e.g. on a wall in the counselee's room).

Close the session: This session can be closed off by asking the counselee to share one key insight they learnt from the session. To bring in a sense of enthusiasm within the counselling environment, ask the counselee to close the session with prayer if they are comfortable with it.

Session 4: Emotional formation

Purpose: The purpose of this session is to help counselees develop an awareness of their emotions and learn effective emotional regulation skills and resilience.

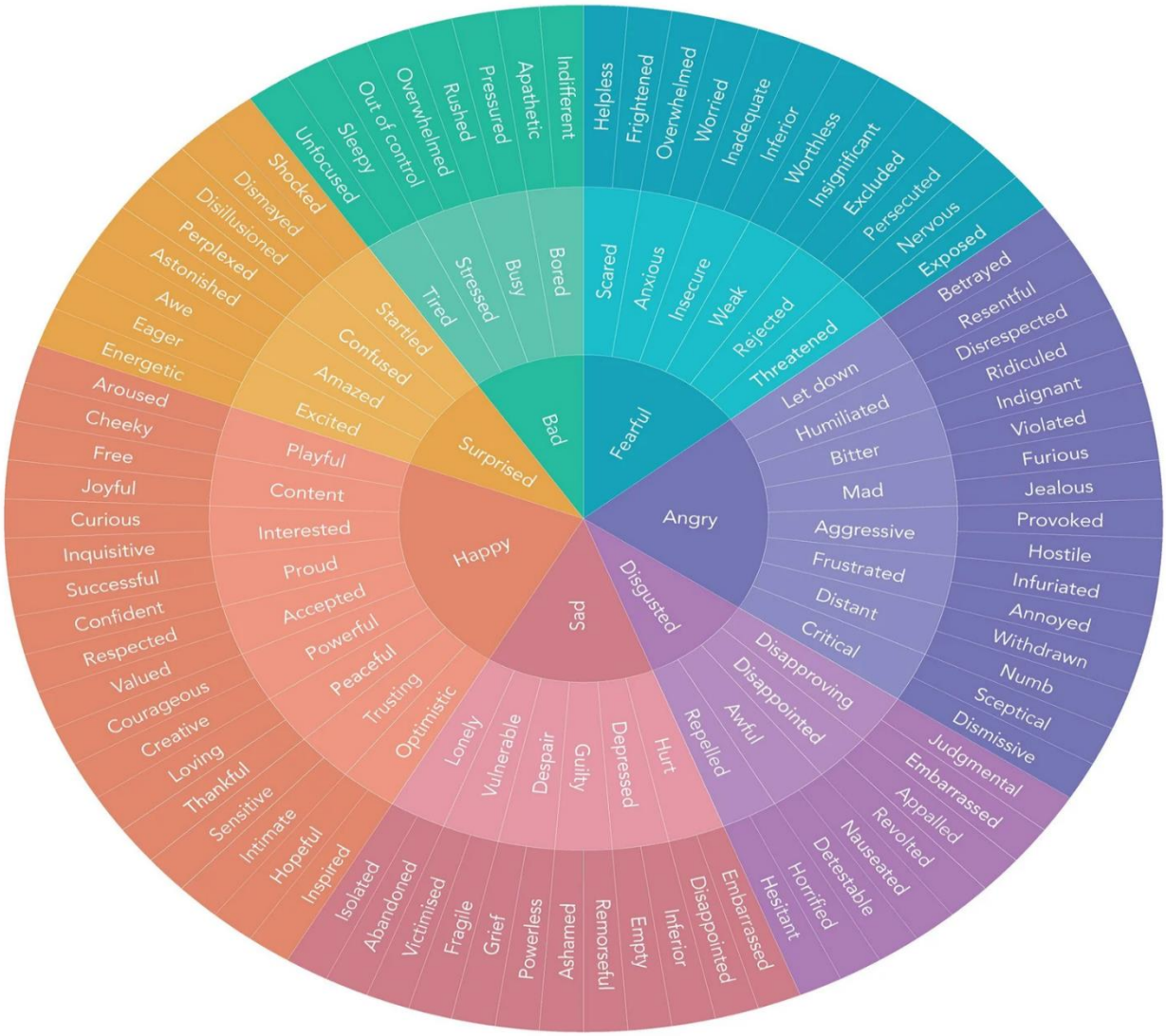
Opening the session: This session can begin with a reflection of the previous sessions and asking the counselee what his/her expectation of this session is and what he/she is trusting God for in this session.

Affirm to the counselee for any signs of progress they may have been displaying up to this point before continuing to open with prayer and begin the discussion on emotional formation.

Conversation starter: Due to the session's focus being on navigating emotional formation, it is only fitting for the session to begin with an emotional check-in on how the counselee is feeling at the moment, but for the counselee to be introduced to the

feelings-wheel as a source of reference throughout the counselling sessions and in moments when they are struggling to name or identify their emotions. The counsellor can then resort to ask the following question: “If you were to choose three main emotions which you are feeling right now, what would they be.”

Figure 7.2: Feelings Wheel



Source: Calm, 2025. https://www.calm.com/blog/the-feelings-wheel

Discussion: Sexual abuse experiences often leave victims with feelings of numbness and sometimes individuals resort to disordered eating behaviours as part of a desperate attempt not to feel anything or the feel in control of something. Victims of sexual abuse feel as if they lost control, and eating disorders gave their control back in a weird way. Furthermore, often emotional dysregulation is a key role player in ED development after sexual abuse (cf. 5.2.2). The focus of this discussion is to help the counselee to identify and name their emotions. By using the feelings-wheel, the counselee identifies three main emotions they felt during the abuse, and the counsellor can ask some leading questions, such as:

- You mentioned feeling angry, sad and lonely… what triggered you to feel this way?

- Do you think there is anything wrong with the feelings you are experiencing?

Teach the counselee that his/her emotions are not wrong under the circumstances, and that human beings are created to be able to feel. For Scriptural references, the counsellor must reflect on pericopes, such as that of Jesus in the garden which show the reader how even the Son of God experienced all sorts of emotions at some point in His life. Another scriptural reference on Jesus showing emotions is in John 11. Ask the counselee that after learning that Jesus "wept", "was in anguish", experienced "anxiety" *et cetera*… what are their perspectives on God's view on emotions?

Also have a discussion on exploring alternative techniques to regulate their painful emotions. As part of this exercise, the counsellor can teach the counselee mindfulness techniques to apply amid painful emotions, such as breathing exercises or journalling as healthy coping mechanisms. A core aspect of this section is to teach the counselee emotional intelligence so that they know how to effectively manage their emotions.

Homework suggestion: For homework it is suggested that the counselee has access to an emotions wheel which they can use to journal any of the emotions that they experience to help the counselee recognize patterns in terms of emotions and how they to deal with these emotions. An activity like this not only helps with self-awareness, but it also helps to build resilience and a restored sense of emotional regulation.

Close the session: To close this session, asks the counselee if he/she would be willing to release the emotions he/she is experiencing to God. If the answer is "yes", the counselee and counsellor can both spend a moment in prayer to pray for a release and surrender of hard emotions, trusting God for a restored sense of peace and freedom in Christ.

Session 5: Physical formation

Purpose: The purpose of this session is to encourage Christ-centred physical stewardship of the body. This is informed by the Scripture reference 1 Corinthians 6:19-20 (cf. 6.4).

Opening the session: Open this session by reviewing how sessions and appointments with multi-disciplinary team members have been going. Then invite the counselee to open the session up with prayer.

Conversation starter: Ask the counselee: When you hear the question: “What makes you feel alive, what is the first thought that comes to mind?”

Discussion: Taking care of the body is not just a responsibility, but as people are created in the image of God and it is important to take note that the believer is called into a place of honouring God in everything he/she does. Taking that into consideration, the counsellor may then start the pastoral counselling session by asking the counselee the following question:

- What does it mean to you to honour God with your body?
- In what ways would you say you exemplify honouring God with your body and in what ways are you still falling short?
- How can you begin to learn to treat your body with the respect and care it deserves?

Remind the counselee that their body remains the Temple of the Holy Spirit (cf. 6.4) and regardless of the trauma that was perpetrated against them or even their current ED struggle, it does not change the fact that the body is the Temple of the Holy Spirit. Furthermore, have a discussion on the importance of implementing self-care and routine as a key part of treating the body as a temple of the Holy Spirit. Explore ways in which the counselee may implement self-care in a manner that is healthy and sustainable while still rooted in maintaining accountability. For example, suggest that the individual should keep a journal where he/she logs the food they eat during the day, the amount of exercise they engage in, *et cetera.*

Homework suggestion: For homework the young person should be given an exercise that allows them to express gratitude for their body, by naming parts of their body and expressing a sense of gratitude (e.g., Lord, I thank you for ears that hear and for eyes that can see).

Close the session: Close this session by asking the counselee what form of self-care they can practice and implement into the week ahead. This session can also end with a discussion of holding a family counselling session, so that the family can also be

equipped with tools on how to walk with the individual presenting with EDs after sexual abuse and learn ways in which they can best be supportive to this individual.

7.4 Epilogue and final thoughts

Throughout this study, I have shared reflections on my own personal journey and how traumatic sexual experiences have influenced my view of myself, God and the world around me. These experiences paved a path of pain and brokenness that ultimately manifested in eating disorder–related behaviours.

A big part of my story is one of a girl who was exposed to traumas that were unbearable to face and as a result, I turned to disordered eating to cope with the pain of my experiences. I was utterly convinced that if I could somehow fix myself, then everything would be in order. My understanding of sexuality was distorted, my sense of identity was fragmented and my view of God was flawed. Because of my acting out, I saw God as distant and judgemental and I struggled to accept that He could truly love me.

Only recently has my view of God begun to change. I came to realize that God has always been near—constant, loving, and present—even amid pain and brokenness. Through the support of those closest to me, I was finally able to face the mountain that stood in front of me. Therapy played an important role in this process, pointing me toward hope and showing me that healing was possible.

Wholeness became a reality when I understood that this was not a journey I could walk alone. I learned that surrender was not a once-off act, but a daily posture of the heart. The question *“Do you want to get well?”* became one I had to wrestle with until I finally realized that all I needed to do was to give God my *“yes”.* By taking hold of what I had learned in counselling, embracing forgiveness and trusting the ministry of the Holy Spirit in my life, I began to experience what true healing and freedom in Christ really mean.

Today, my story is one of redemption—a story that testifies to the possibility of freedom, restoration and healing in Christ.

7.5 Conclusions

In this chapter, Osmer's final question of practical theological interpretation which is "How do we respond" was answered. The discussion began with a proposal of guidelines which should be adhered to when conducting pastoral counselling sessions. These guidelines are inclusive of factors such as:

- Multi-disciplinary collaboration
- Maintaining ethical standards
- Effective use of spiritual disciplines in pastoral counselling
- Integrating a client-centred approach
- Displaying priestly listening
- Providing support to families of loved ones affected by EDs because of sexual abuse

This was followed by a discussion which focused on proposing a pastoral strategy and framework which can be used and applied within the pastoral counselling sessions. Based on the proposed visualisation, the chapter provided practical session ideas of what a pastoral counselling process can look like from the first intake to working on various aspects of healing which include spiritual formation, identity formation, emotional formation and physical formation. The chapter then concludes with an epilogue and final thoughts where the author provides the reader with a final glance of the journey she walked from brokenness into freedom and healing, discussing that recovery from EDs after sexual abuse is possible and attainable.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS.

8.1 Introduction

In this final chapter of the study the author compiles chapter by chapter conclusions followed by a discussion of some of the identified limitations and recommendations discovered throughout the study.

8.2 Chapter 1: Introduction

The first chapter served as an introduction to the nature of this study. In this chapter the topic of the study “Pastoral counselling for youth with eating disorders as a result of sexual abuse” was introduced. The chapter began with the clarification of four key concepts that would be commonly used throughout the study which included words such as “eating disorders”, “youth”, “sexual abuse”, and “pastoral counselling.” This was followed by a brief overview of the research topic. Using a preliminary literature review which included utilizing key sources such as books, journal articles and eBooks, the researcher conducted an overview of both sexual abuse and EDs and this was followed by a brief overview which looked at the link between sexual abuse and eating disorders. As part of this literature study, it was discussed that there is a lack of

pastoral counselling studies which examine the link sexual abuse and EDs, a gap which this study will seek to fill. While acknowledging this gap in existing literature, it was hypothesized in this chapter that past sexual abuse experiences pose a risk factor to the possible development of EDs. This is in line with the CTA which states that there is a link between sexual abuse and EDs pathology amongst South African youth. Due to the theological nature of this study, Biblical perspectives on sexual abuse and EDs were briefly introduced.

This was followed up by identifying a suitable problem statement for the study. The problem which was identified relates to the high treatment costs associated with treatment, which results in treatment being inaccessible to many individuals. Alongside this, the researcher identified some treatment methods likely to be used within the therapeutic space with the hopes to back these up at a later stage with more extensive research and with the aim to take what has been learned to develop a pastoral counselling model aimed at facilitating healing of body, mind and soul. To design the pastoral model, the researcher mentioned that she would need to explore the existing link between sexual abuse and EDs.

The chapter went on to discuss the research question and further questions. The identified question is: “What does a pastoral counselling model designed for youth with EDs look like?” Alongside this research question, four other research arose which will inform how content is arranged throughout the thesis chapters and these were designed in alignment with Osmer’s (2008) practical theological interpretation which serves as the foundational method which this study will undertake.

This was followed by an identification of research aims and objectives. Chapter 1 mentions that the study aim is to design a pastoral counselling model for youth struggling with EDs because of sexual abuse. The objectives are outlined in accordance with the further questions of this study.

The epistemology of the study was also discussed, and the author mentioned that this study would be written in accordance with a practical theological paradigm with the field of pastoral counselling as the foundational point of departure. As mentioned already in this section, the research method used in this study was Osmer’s (2008:4) practical theological model and this was identified as a well-suited method as it allows

out that an interdisciplinary approach to be used. Chapter 1 introduced that the four key questions which will be explored in this study are:

- What is going on?
- Why is it going on?
- What ought to be going on?
- How might we respond?

These questions helped guide the discussion points throughout the chapters of this study.

Lastly, this chapter dealt with the ethical considerations to be considered when conducting the empirical research phase of the study. In this chapter the researcher introduces to the reader that the empirical research of this study involves working with a diverse group of multi-disciplinary professionals based in South Africa. The chapter also introduced to the reader the reality that the empirical research in this study would take the form of semi-structured interviews. Other factors such as the approximate population size, sampling criteria, participant recruitment criteria, informed consent etc. were discussed as part of the introductory chapter.

8.3 Chapter 2: Descriptive-empirical study of sexual abuse in South Africa

The second chapter of this study, titled “Descriptive Analysis of Sexual Abuse within a South African Context”, corresponds with the first task of Osmer’s (2008) practical theological interpretation, which seeks to answer the question, “What is going on?” This chapter aimed to explore the reality of sexual abuse in South Africa by contextualising the phenomenon within legal, societal and theological frameworks. The chapter began by defining and contextualising the concept of sexual abuse, acknowledging that definitions vary across disciplines and national contexts due to differing legal frameworks. The discussion then turned to an analysis of key South African laws addressing sexual abuse, including:

The Domestic Violence Act (116 of 1998): This Act recognises the impact of sexual abuse on the overall health and well-being of victims, while identifying multiple forms

of abuse - physical, emotional, verbal, and psychological - that often accompany sexual violence. Although the Act strives to provide “maximum protection” to victims, this goal was critiqued as idealistic considering South Africa’s high levels of violent crime.

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (32 of 2007): This law is significant for its gender-neutral definition of sexual abuse, acknowledging that both men and women can be victims or perpetrators. Despite its intentions to support victims through reporting and trial processes, it was found that many victims still experience humiliation by law enforcement, leading to perceptions that the justice system protects perpetrators rather than victims.

The Children’s Act (28 of 2005): While primarily designed to protect minors from sexual exploitation and to affirm that children cannot legally consent to sexual acts, its inclusion in this study was recognised as somewhat limited, given the focus on youth rather than children. However, it was noted that many young people may have histories of childhood sexual abuse.

The Criminal Law Forensic Procedures Amendment Act: This Act established DNA databases for the prosecution of sexual crimes (Knoetze & Crouse, 2016:40). Limitations included delays in processing rape kits, loss of forensic evidence, and incomplete DNA databases - all of which undermine effective prosecution.

The chapter further analysed the effectiveness of sexual abuse legislation, revealing that judicial processes are often influenced by rape myths and stereotypes, perpetuating discrimination against victims. Despite these shortcomings, the study acknowledged the potential of law to promote transformation when applied with fairness and dignity. The discussion then explored rape myths in South Africa, highlighting how these misconceptions - rooted in patriarchal belief systems (Spies, 2016:391)—continue to shape societal attitudes and judicial outcomes. The “real rape” narrative was identified as a limiting construct that oversimplifies the complexity of sexual abuse. It was noted that social media platforms often amplify victim-blaming content, which tends to gain greater public support than victim-affirming messages (Stubbs-Richardson *et al*., 2018:90). The study argued that addressing these myths requires guiding individuals toward the truth found in Jesus Christ, who restores dignity and identity to the broken.

The chapter also discussed the portrayal of South Africa as the “rape capital of the world,” a label associated with alarming prevalence rates suggesting that a person is raped approximately every seven to thirty-five seconds (Naidoo, 2013:210; Woodbridge & Joubert, 2018:107). The validity of this claim was, however, questioned due to data inconsistencies. Sexual abuse was defined as a human rights violation, as it infringes on victims’ freedom of movement, bodily integrity, and autonomy. It was shown that sexual abuse occurs across multiple contexts - including schools, churches, homes, and public spaces - and that its effects are both physical and psychological. Furthermore, sexual abuse was framed as a public health issue, contributing to heightened risks of HIV/AIDS, unwanted pregnancies, and mental health conditions. The economic cost of sexual abuse in South Africa was estimated between R28.6 billion and R42.4 billion, underscoring its societal burden. The study further linked sexual abuse to the Sustainable Development Goals (SDGs) - specifically those focused on eradicating poverty, promoting health and well-being, and achieving gender equality.

Finally, the impact of sexual abuse on victims was discussed in detail, highlighting its association with depression, anxiety, PTSD and suicidal ideation. The chapter concluded with a brief examination of sexual abuse within church contexts, noting an increase in abuse cases linked to controversial church movements. However, a key limitation identified was the lack of exploration into the church’s proactive role in addressing sexual abuse - a gap that warrants further theological and pastoral inquiry

8.4 Chapter 3: Descriptive-empirical study on eating disorders in South Africa

Chapter three continues the descriptive-empirical task of Osmer’s (2008) practical theological interpretation. In this chapter, the question, “What is going on?” is explored in relation to EDs. Throughout the discussion, the author integrates reflections from her personal journey, providing both academic and experiential insight into the phenomenon. The chapter begins by contextualising the concept of eating disorders, defining them as disturbances in eating behaviours and identifying them as among the deadliest of all mental disorders. Eating disorders are described as complex, multifaceted, and often rooted in psychological, emotional, and sociocultural factors.

The most recognised EDs are AN, BN and BED and they were discussed in depth, alongside more controversial conditions not yet formally recognised in diagnostic manuals, such as orthorexia nervosa (ON) and bigorexia nervosa (muscle dysmorphia).

After contextualising the topic, the author provided a descriptive analysis of each disorder, beginning with AN. AN was identified as carrying the highest mortality rate among all eating disorders, with women affected by AN being approximately twelve times more likely to die than those without the disorder. It was also found that the onset of AN typically occurs during adolescence. The study compared diagnostic criteria from both the DSM-5 and ICD-11, noting that AN is characterised by restrictive eating, significantly low body weight, and subcategories that vary across diagnostic frameworks. The section concluded by identifying both physical (amenorrhea, bradycardia, osteoporosis) and psychological (depression, PTSD, OCD, and suicidal ideation) comorbidities associated with AN.

The next section addressed BN, defined as a disorder characterised by binge eating and compensatory behaviours aimed at weight control. Research suggests that approximately 30% of individuals with AN may transition into BN. The age of onset for BN is typically around 18 years. The study highlighted that BN could affect both males and females and is classified into four severity levels, ranging from mild to extreme. Physical comorbidities include diabetes, ruptured oesophagus, and colon damage, while psychological comorbidities commonly include MDD, anxiety, and BPD.

Following this, BED was discussed. BED involves recurrent episodes of excessive overeating accompanied by feelings of loss of control. The ICD-11 suggests that BED often emerges during adolescence or young adulthood. Like BN, BED has four severity levels, determined by the frequency of binge episodes. Physical effects include obesity, asthma, and arthritis, while psychological comorbidities commonly include depression and anxiety. The discussion also drew comparisons between EDs and addictive behaviours such as substance use disorders, noting shared characteristics such as repetitive engagement, loss of control, persistence despite negative consequences, and the development of tolerance (Chamberlain *et al*., 2015:841–842).

The chapter then turned to the more controversial disorders not yet recognised in the DSM-5. The first of these, ON, is characterised by an obsessive focus on healthy eating. Research indicates that ON shares several behavioural similarities with AN. The author proposed a possible diagnostic criterion for ON that could guide future inclusion in diagnostic manuals. The second, bigorexia nervosa, also known as muscle dysmorphia, is defined by a compulsive preoccupation with gaining muscularity and a distorted self-perception of being too small or weak. Unlike most EDs, bigorexia appears to be more prevalent among males than females.

The next section examined eating disorders within the South African context, positioning them as a public health crisis. This is due to both their physical and psychological consequences, as well as their strong association with increased suicide risk. Young people with EDs were found to be twelve times more likely to die than their peers without these disorders. Contributing factors to the under-diagnosis of EDs include stigma, under-reporting, high treatment costs and limited access to specialised care. The author also explored the relationship between eating disorders and the SDGs. Specifically, SDG 3 (health and well-being) was found to be highly relevant, as EDs pose a serious threat to physical and mental health. Furthermore, SDG 5 (gender equality) was discussed, with the argument that EDs must be addressed through a gender-inclusive lens, recognising that although prevalence rates are higher among females, males also experience these disorders and should not be excluded from discourse or treatment initiatives.

The prevalence of EDs in South Africa was also examined. Data from Tygerberg Hospital in Cape Town indicated that 40.1% of patients were diagnosed with BN, 33% with EDNOS and 26.5% with AN. However, this data was limited to cases recorded between the 1990s and 2014 and may not align fully with DSM-5 diagnostic criteria. The author incorporated a personal reflection on the impact of eating disorders, particularly on self-esteem and identity. Drawing from her own experience, she described how negative self-talk, the desire for control and self-critical thought patterns perpetuated disordered eating behaviours. This reflection supported the broader argument that eating disorders significantly threaten an individual's sense of self and personal worth.

Finally, the chapter addressed eating disorders within the context of the church. It was observed that EDs are seldom discussed in faith communities despite their growing

prevalence. The author argued that the church has a vital pastoral role to play in creating safe, shame-free environments where difficult and taboo topics can be discussed openly. In such spaces, individuals can encounter healing, hope, restoration, and freedom through compassionate community and spiritual formation.

8.5 Chapter 4: Descriptive-empirical study on the link between sexual abuse and eating disorders

Chapter 4 constituted the final component of Osmer's (2008) first task of practical theological interpretation. The purpose of this chapter was to address the question, "What is going on?", with a specific focus on exploring what can be learned from a descriptive-empirical perspective regarding current treatment approaches for youth with EDs because of sexual abuse. The discussion commenced by examining the link between sexual abuse and the development of eating disorders. This formed the foundation for supporting the CTA of this study, which proposed that there is an existing relationship between sexual abuse and the possible development of EDs among South African youth. It was noted that scholarly inquiry into this linkage has existed for decades, with the first analytical study conducted as early as 1902 and the first empirical study in 1985. Despite this long-standing research interest, the chapter revealed that no definitive conclusions have yet been reached on the exact nature of this relationship.

Regarding prevalence, the literature indicates that approximately 30% of individuals diagnosed with EDs report a history of sexual abuse. However, these figures do not provide a complete picture, as prevalence rates differ significantly across studies due to variations in methodology, assessment tools, and diagnostic criteria. Research further suggests that sexual abuse is more strongly associated with BN and BED than with restrictive AN. A limitation identified in this discussion was the lack of youth-specific prevalence data within the South African context, which constrains the study's aim of developing youth-focused insights. The challenge of establishing a clear causal link between sexual abuse and EDs was explored. It was concluded that this link is complex and difficult to define due to methodological inconsistencies and differing definitions of both sexual abuse and EDs. Nonetheless, several psychological parallels were identified, including emotional disturbances, distorted self-esteem, and body

image issues. It was noted that individuals reporting higher levels of psychological distress, such as anxiety or post-traumatic stress, appear to have an increased likelihood of developing disordered eating behaviours. Consequently, the chapter concluded that while trauma responses differ among individuals, sexual abuse can be regarded as a significant risk factor for the development of eating disorders.

The chapter also explored current treatment approaches addressing both sexual abuse and EDs. It emphasized that due to the multifaceted nature of these conditions, treatment must be holistic and multidisciplinary. The discussion reviewed treatment models from psychology, medicine, pharmacology, social work, nutrition, and complementary or integrative practices. A key insight that emerged was the importance of treating both the trauma and the eating disorder concurrently, rather than in isolation. The chapter highlighted the value of trauma-informed care, recommending interventions such as EMDR, CPT, PE, and TF-CBT. Establishing a therapeutic environment that fosters safety, trust, and respect was identified as a cornerstone of effective treatment.

The empirical component of the chapter consisted of semi-structured interviews with four professionals representing different disciplines within a multidisciplinary team. Thematic analysis of these interviews yielded the following key themes:

- Sexual abuse serves as a potential risk factor for the development of EDs.
- Treatment must be client-centred, acknowledging that each individual's recovery journey and trauma processing are unique.
- Family involvement and empowerment form a vital part of the healing process.
- Multidisciplinary collaboration is essential due to the complexity of the conditions involved.
- Spirituality has a place within professional practice, if it is approached with sensitivity and respect for individual differences.

8.6 Chapter 5: Interpretive task – Multidisciplinary perspectives of eating disorders occurring as a result of sexual abuse

Chapter 5 focuses on answering Osmer's (2008) second question of practical theological interpretation, namely, "Why is this going on?" The chapter emphasises theories from multidisciplinary perspectives to gain diverse insights into the reasons why EDs are likely to develop following sexual abuse. The discussion begins by examining the bio-psychosocial factors that contribute to the onset of eating disorders after sexual abuse. Biologically, determinants are linked to genetic predispositions, suggesting that human behaviour may be influenced by genetic variations. Research indicates that the likelihood of developing an ED increases in families where relatives have presented with either AN or BN. The heritability rate for AN is estimated between 48% and 74%, for BN between 55% and 62%, and for BED between 39% and 45%. Another biological aspect discussed is the impact of sexual abuse and EDs on brain function. Brain structures associated with reward, taste, and body image perception - key components in ED pathology - are likely to be affected. Additionally, areas involved in impulse control and emotional regulation, including the prefrontal and cingulate cortices, are often impacted.

Psychological factors that predispose individuals to developing EDs after sexual abuse exposure extend beyond anxiety and depression. PTSD has been identified as a significant mediating factor between sexual abuse and EDs, with prevalence rates of PTSD found to be twice as high among those with EDs. Other influential psychological factors include emotional dysregulation, experiences of "suicide by starvation," and profound feelings of shame - all of which contribute to ED vulnerability among survivors of sexual abuse. From a social perspective, media influence plays a critical role in shaping attitudes toward body image, thereby affecting the risk of ED development. Traditional media such as television and magazines, along with online platforms, transmit societal messages about body ideals. Notably, online pro-eating disorder communities reinforce and support ED-related behaviours. Social isolation further exacerbates vulnerability, often leading individuals to engage in harmful or self-destructive behaviours as coping mechanisms.

The chapter also highlights the need for control as a central theme. Survivors of sexual abuse frequently experience a profound sense of powerlessness, leading some to use ED behaviours as an attempt to regain control - though ironically, this perpetuates a recurring cycle of control and loss. Closely related is the need for identity. Sexual abuse poses a deep threat to one's sense of self, resulting in the use of ED behaviours as compensatory efforts to reclaim or redefine identity. Similarly, EDs may emerge as a means of controlling one's sexuality following trauma, with survivors sometimes engaging in restrictive behaviours to suppress secondary sexual characteristics or to attain a sense of purification. Finally, the chapter explores spiritual perspectives on ED development following sexual abuse. Within this framework, the concepts of sin and brokenness are regarded as essential to understanding both the act of abuse and its aftermath. Sexual abuse disrupts the wholeness of human life, leading to brokenness that may manifest through destructive behavioural responses—such as those associated with EDs.

8.7 Chapter 6: Normative analysis of eating disorders and sexual abuse

This chapter addressed the third question of Osmer's (2008) methodology, namely, "What ought to be going on?" The central focus of this chapter was to explore normative perspectives that are important in the pastoral counselling of youth who struggle with eating disorders (EDs) because of sexual abuse. The methodological approach employed was hermeneutical interpretation.

The chapter began by contextualising the concept of hermeneutics, defining it as the art, study or science of interpretation - a concept that extends across various disciplines such as law, medicine, the humanities and theology. From a theological standpoint, hermeneutics was described as the process of interpreting God's Word. The approach followed was that of Zowada (2018), which employs a four-step interpretative process consisting of the:

- Historical and cultural context
- Literary context
- Observation

- Application

This four-step process was applied in the analysis of three pericopes. The first pericope analysed was Genesis 1:26–27, which focuses on God's design concerning identity and sexuality. This discussion revealed that human beings are created in the image of God (*imago Dei*), yet the effects of sin and brokenness distort this divine image. Sexual abuse was discussed as a profound violation that not only harms those who experience it but also distorts God's image by conveying false messages about the nature of true sexuality. Consequently, survivors may act out in self-damaging ways as they attempt to regain a sense of identity and worth.

The second pericope examined was 1 Corinthians 6:19–20, which emphasises that the body is the temple of the Holy Spirit. This passage highlights that believers are called to honour God through the way they treat their bodies, recognising that the mistreatment of the body carries spiritual and emotional consequences. It was also underscored that believers do not belong to themselves, and therefore all actions should reflect a life of worship and bring glory to God.

The final pericope studied was Psalm 34, with a special focus on verse 18, which declares that "the Lord is close to the broken-hearted", This text illustrates that God is near during life's most painful moments. Throughout Psalm 34, multiple aspects of God's nature are revealed: God as deliverer, provider, protector, teacher and parent. However, it was noted that trauma and suffering often distort one's perception of God. In contrast, this Psalm portrays a comforting image of God who remains loving, good and intimately close to those who are hurting and broken.

8.8 Chapter 7: Pragmatic interpretation of eating disorders among sexually abused individuals

Chapter 7 addressed the final question of Osmer's (2008) tasks of practical theological interpretation, namely, "How do we respond?" The primary aim of this chapter was to identify pragmatic guidelines that are essential in developing a pastoral counselling model for youth with eating disorders (EDs) resulting from sexual abuse. The chapter began with a discussion of pastoral guidelines that counsellors should uphold in practice. The key guidelines identified include multi-disciplinary collaboration,

maintaining ethical standards, the use of spiritual disciplines such as prayer and scripture within the counselling process, utilising a client-centred approach, displaying priestly listening and providing family support.

This was followed by a discussion of a pastoral strategy for counselling youth who struggle with eating disorders because of sexual abuse. As part of this discussion, a proposed pastoral framework was explored. The visual framework consists of three layers. The first layer reflects on God's original design for sexuality and identity while also considering the effects of sin and brokenness on the individual and recognising that true restoration is found in Christ. The second layer focuses on spiritual and identity formation, with the aim of helping individuals develop a renewed understanding of God and themselves. The third layer examines emotional and physical formation, emphasising the importance of restoring emotional awareness, cultivating emotional regulation, and developing healthy lifestyle practices. Alongside this visual representation, a practical pastoral framework was proposed to illustrate how these pillars - spiritual formation, identity formation, emotional formation, and physical formation - can be applied within a counselling context. This was further expanded through examples of what pastoral counselling sessions could look like when guided by these pillars. In conclusion, the chapter closed with the author's personal reflections on her own journey toward freedom and recovery.

8.9. Recommendations

For future research, the author recommends conducting studies that focus explicitly on how South African youth are directly impacted by eating disorders (EDs) because of sexual abuse. One of the limitations identified in this study is the limited integration of the South African context, which may have rendered the discussion somewhat generalised. Therefore, further research that explores the lived experiences of South African youth who have developed EDs following exposure to traumatic life events such as sexual abuse is strongly encouraged.

In addition, the author highlights the need for more research focusing on eating disorders among males, an area that remains under-explored, both locally and globally. Such research would benefit from multi-disciplinary collaboration to gain a

more comprehensive understanding of the phenomenon and its unique manifestations.

Finally, it is recommended that the pastoral counselling model proposed in this study be practically implemented and evaluated within both pastoral and multidisciplinary therapeutic contexts to assess its efficacy. Through such applied research, it may be possible to determine the model's practical relevance and contribution toward successful treatment outcomes. The author ultimately hopes to produce a follow-up study that evaluates the effectiveness of this model in facilitating holistic healing and recovery among survivors of sexual abuse who struggle with EDs.

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Appendix 1: Typical disordered eating laboratory/investigations and interpretation of results https://www.cpdconnect.nhs.scot/media/231 7/eating-disorders-appendices-t19.pdf Date of access: 1 November 2024.

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