UNIVERSITÉ DU QUÉBEC À TROIS-RIVIÈRES

LA RELATION ENTRE LES SYMPTÔMES DE TROUBLES ALIMENTAIRES, L'AFFIRMATION SEXUELLE ET LES MOTIVATIONS SEXUELLES

ESSAI DE 3e CYCLE PRÉSENTÉ
COMME EXIGENCE PARTIELLE DU

DOCTORAT CONTINUUM D'ÉTUDES EN PSYCHOLOGIE
(PROFIL INTERVENTION)

PAR
CAMILLE BERGERON

OCTOBRE 2025

Université du Québec à Trois-Rivières

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DOCTORAT CONTINUUM D'ÉTUDES EN PSYCHOLOGIE
(PROFIL INTERVENTION) (D.Ps.)

Direction de recherche :

Marie-Pierre Gagnon-Girouard, Ph. D. Université du Québec à Trois-Rivières	directrice de recherche
Geneviève Martin, Ph. D. Université Laval	codirectrice de recherche

Jury d'évaluation :

Marie-Pierre Gagnon-Girouard, Ph. D. Université du Québec à Trois-Rivières	directrice de recherche
Noémie Carbonneau, Ph. D. Université du Québec à Trois-Rivières	évaluatrice interne
Fanny-Alexandra Guimond, Ph. D. Université d'Ottawa	évaluatrice externe

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Résumé substantiel en français

Introduction

Les troubles des conduites alimentaires (TCA) sont des troubles mentaux complexes qui perturbent les habitudes alimentaires des individus atteints. Les TCA peuvent occasionner diverses difficultés sur les plans physiques (p. ex., problèmes cardiaques, aménorrhée, problèmes dentaires) et psychologiques (p. ex., des symptômes de dépression, un risque suicidaire plus grand ou une image corporelle négative) (American Psychiatric Association, 2013).

Contexte théorique

Les personnes qui présentent des symptômes d'un TCA peuvent aussi éprouver des difficultés dans différentes sphères de leur vie. Du point de vue des relations interpersonnelles, ces personnes montreraient une plus faible capacité à s'affirmer (Arcelus et al., 2013). Cette difficulté se traduit notamment dans la sphère de la sexualité car ces personnes présenteraient davantage de motivations sexuelles liées au désir de prouver leur valeur, de faire plaisir ou d'apaiser leur partenaire (Spivak-Lavi & Gewirtz-Meydan, 2023), ainsi qu'une plus grande tendance à l'insatisfaction sexuelle (Castellini et al., 2012; Gonidakis et al., 2015; Spivak-Lavi & Gewirtz-Meydan, 2022). L'affirmation de soi générale et l'insatisfaction sexuelle étant des enjeux chez les personnes ayant un TCA, ces troubles pourraient possiblement être liés à une faible capacité d'affirmation sexuelle. La présente étude a pour but d'examiner les relations entre les symptômes de restriction et de désinhibition alimentaire, l'affirmation sexuelle, les motivations sexuelles

et l'évitement de la sexualité. Nous supposons que les symptômes de restriction ainsi que les symptômes de désinhibition alimentaire seront associés à une faible affirmation sexuelle. Cependant, cette dernière se traduira différemment selon les symptômes. En effet, les symptômes restrictifs seront associés à plus forte tendance à éviter les contacts sexuels, et à s'engager dans ce type de contacts pour plaire à son.sa partenaire. À l'inverse, les symptômes de désinhibition seront associés à moins d'évitement de la sexualité, et les activités sexuelles seront davantage motivées par le désir de se sentir digne d'être aimée.

Méthode

Pour tester ces hypothèses, nous avons recruté 159 femmes âgées entre 18 et 66 ans (M = 34,42; $É.T.$ = 10,66) présentant des symptômes de TCA liés à la restriction ou à la désinhibition, par le biais de publications sur les réseaux sociaux et des organismes venant en aide aux personnes vivant avec des TCA. Cette étude s'inscrit dans une étude plus large. Pour le présent projet, les participantes ont répondu à un questionnaire en ligne évaluant les caractéristiques sociodémographiques, les symptômes de TCA, l'affirmation sexuelle et les motivations sexuelles.

Résultats

Les résultats montrent que les symptômes de restriction alimentaire (r = -0,169, p = 0,033) ainsi que les symptômes de désinhibition alimentaire (r = -0,175, p = 0,026) étaient négativement liés à l'affirmation sexuelle. Ainsi, plus les participantes présentaient des symptômes de TCA, moins elles étaient enclines à s'affirmer dans la sphère de la

sexualité. La restriction alimentaire était aussi liée de manière significative à l'évitement de la sexualité (r = 0,222, p = 0,006), alors que cela n'était pas le cas de la désinhibition alimentaire (r = 0,092, p = 0,258).

Pour ce qui est des motivations sexuelles, les symptômes de restriction alimentaire étaient surtout associés à des items traduisant un désir de plaire à l'autre, tels que « Compenser les défauts de mon corps en étant une bonne partenaire sexuelle » (r = 0,300, p < 0,001) ou « Plaire à mon/ma partenaire » (r = 0,262, p < 0,001). Les symptômes de désinhibition alimentaire étaient liés à des items qui référaient au besoin de se sentir appréciée par son ou sa partenaire, comme « Avoir de l'affection » (r = 0,169, p = 0,049) ou « Me sentir aimée » (r = 0,234, p = 0,004).

Discussion

Les résultats de la présente étude suggèrent donc que les symptômes de TCA seraient associés à une plus faible affirmation sexuelle, et celle-ci se traduirait différemment selon les types de symptômes de TCA. En effet, les participantes présentant des symptômes de restriction alimentaire auraient tendance à moins s'affirmer dans leur sexualité et à éviter les contacts sexuels, alors que celles vivant avec des symptômes de désinhibition alimentaire se détourneraient moins de tels contacts. Les motivations sexuelles varieraient aussi selon le type de symptômes de TCA; la restriction alimentaire étant davantage associée à des motivations liées au désir de plaire à l'autre, et la désinhibition alimentaire à des motivations liées au désir d'amour et d'affection. Ces résultats doivent être

considérés à la lumière de certaines limites de l'étude. D'abord, la nature autorapportée et hétérogène des symptômes de TCA, l'absence de contrôle des conditions de passation en ligne et un biais de rappel possible chez les participantes, pouvant ainsi limiter la validité interne et la généralisation des résultats. Ensuite, l'étude étant exploratoire, elle met en évidence des associations sans toutefois permettre l'établissement de relations causales.

Conclusion

Davantage de recherches sont nécessaires pour orienter l'intégration de l'affirmation et des motivations sexuelles et de l'évitement de la sexualité comme cibles dans le traitement des TCA. Cette intégration pourrait favoriser le travail sur l'image corporelle, mais aussi sur les diverses difficultés interpersonnelles que les personnes avec un TCA ont tendance à rencontrer.

Table des matières

Résumé substantiel en français iv

Liste des tableaux ix

Remerciements x

Article scientifique − The Relationship Between Eating Disorder Symptoms, Sexual Assertiveness, and Sexual Motivations 1

Abstract 3

Introduction 4

The Present Study 8

Method 9

Participants and Procedure 9

Measures 11

Sociodemographic and Sexorelational Questionnaire 11

Sexual Assertiveness 12

Sexual Avoidance 12

Sexual Motivation 13

Eating Disorder Symptoms 13

Statistical Analyses 14

Results 14

Discussion 18

Strengths and Limitations 21

Conclusion 22

References 24

Références générales 29

Liste des tableaux

Tableau

1 Demographics.....10

2 Correlations Between Sexual Assertiveness and ED Symptoms, Sexual Assertiveness and Sexual Avoidance.....15

3 Correlations Between Sexual Motivations, Sexual Assertiveness and ED Symptoms.....16

Remerciements

Je tiens à exprimer ma gratitude à toutes les personnes ayant contribué de près ou de loin à la réalisation de cet essai.

Je remercie tout d'abord ma directrice d'essai, Marie-Pierre Gagnon-Girouard, et ma co-directrice d'essai, Geneviève Martin, pour leur accompagnement rigoureux, leur disponibilité et surtout leur bienveillance tout au long de mon parcours doctoral. Elles ont su me guider et me conseiller avec douceur et m'offrir un encadrement propice à l'épanouissement de ma réflexion comme future clinicienne. Je vous remercie sincèrement pour toutes les opportunités de recherche que vous m'avez offertes, expériences m'ayant grandement aidée à développer mon identité professionnelle.

Je souhaite également souligner le soutien de mes collègues dans mes laboratoires de recherche, et tout particulièrement Judith Kotiuga, pour leur entraide et les échanges stimulants qu'ils m'ont tous offert.

Enfin, je remercie aussi mes collègues au doctorat en psychologie, qui ont su me soutenir durant ce parcours. Leur présence et les plaisirs partagés avec eux ont rendu mon cheminement infiniment plus léger.

Article scientifique

The Relationship Between Eating Disorder Symptoms, Sexual Assertiveness, and Sexual Motivations

The Relationship Between Eating Disorder Symptoms, Sexual Assertiveness, and Sexual Motivations

Camille Bergeron[1]

Marie-Pierre Gagnon-Girouard[1]

and

Geneviève M. Martin[2]

[1] Department of Psychology, Pavillon Michel-Sarrazin, Université du Québec à Trois-Rivières, Trois-Rivières, 3351, bld. des Forges, Trois-Rivières (Québec), G8Z 4M3, Canada

[2] Department of Psychiatry and Neurosciences, Faculty of Medicine, Université Laval, Pavillon Ferdinand-Vandry, 1050 avenue de la Médecine, local 4889, Québec (Québec), G1V 0A6, Canada

Correspondence concerning this article should be addressed to Camille Bergeron, Department of Psychology, Pavillon Michel-Sarrazin, Université du Québec à Trois-Rivières, Trois-Rivières, 3351, bld. des Forges, Trois-Rivières (Québec), G8Z 4M3, Canada.

E-mail adress: Camille.Bergeron3@uqtr.ca

Abstract

The presence of eating disorders has been linked to poor assertiveness skills in relationships and to external sexual motivations. However, it remains unclear how eating disorder symptomatology is associated with sexual assertiveness and motivations. The objective of the study is to examine the relationship between restrictive and binge eating symptoms, sexual assertiveness, sexual motivations and sexual avoidance. Participants were 159 women reporting restrictive, compensatory, binge eating or a combination of these symptoms, recruited through ads in social media and community centers specialized in eating disorder treatment. They completed an online questionnaire assessing eating disorder symptoms, sexual motivations and sexual assertiveness. Results show that both restrictive (r = -.169, p = .033) and binge eating symptoms (r = -.175, p = .026) were weakly and negatively related to sexual assertiveness. While restrictive symptoms were mostly linked to people pleasing sexual motivations, binge eating symptoms were associated with sexual motivations related to the need for feeling loved. Findings suggest that sexual assertiveness might be a relevant clinical factor for work on sexual satisfaction among individuals with eating disorders. Future research is needed to develop a better understanding of the relationship between these variables.

Keywords: eating disorders, sexual assertiveness, sexual motivations, restrictive eating, binge eating

Introduction

Although studies have shown that people living with eating disorder (ED) symptoms tend to have more difficulty asserting themselves in their relationships (Arcelus et al., 2013; Hartmann et al., 2010; Raykos et al., 2014; Ung et al., 2017), the extent to which this impairment applies to sexual assertiveness, defined as the ability to communicate one's sexual needs and desires to a partner (Loshek & Terrell, 2014), remains unclear. Moreover, no study has investigated the relationship between sexual motivations and different ED symptoms Exploring these associations may clarify how sexual motivations and assertiveness are linked to ED symptomatology, and thereby, lead to a better understanding of the interaction between interpersonal, sexual, and eating-related difficulties, domains that have often been studied separately.

EDs are serious mental disorders that can have dramatic impacts on individuals' lives (American Psychiatric Association [APA], 2022). The lifetime prevalence of an ED diagnosis is estimated at 8.4% for women and 2.2% for men, which consists in a fourfold increase in the risk of developing an ED among the first, compared to the latter (Galmiche et al., 2019). EDs are characterized by disturbances in eating behaviors, which can have significant negative physical (e.g., amenorrhea, cardiac problems) and psychological consequences (e.g., depressive symptoms, increased suicidal risk) (APA, 2022). Restrictive ED behaviors, or the limitation of food and calorie intake relative to the body's requirements (e.g., skipping meals, reducing portions), are mainly associated with anorexia nervosa, but can also be present in other EDs, such as bulimia nervosa. In

contrast, binge eating behaviors, or eating a large quantity of food in a short amount of time without being able to stop (e.g., that is, in less than 2 hours, until one feels sick) have strong associations with bulimia nervosa and binge eating disorder (APA, 2022).

EDs are complex mental disorders with multiple etiological factors (Rikani et al., 2013). Treatment is mostly long and often leads to poor outcome (e.g., high dropout rates, partial recovery) (Dalle Grave et al., 2021; Treasure et al., 2020). Given that EDs affect multiple spheres of functioning, treatment must incorporate diverse targets, such as physical health, psychological struggles, as well as interpersonal and sexual difficulties.

Interpersonal difficulties are well documented among individuals with ED symptoms. They notably face challenges related to the communication of their feelings to others and conflict resolution in relationships (APA, 2013; Arcelus et al., 2013; Cardi et al., 2018). This may be partly attributable to their poor assertiveness skills, which can lead them to adopt a passive or submissive stance in interpersonal relationships, or to refrain from expressing their emotional needs (Arcelus et al., 2013; Brugnera et al., 2018). A systematic review by Arcelus and colleagues (2013) highlights the propensity of individuals with restrictive or binge eating symptoms to display submissive behaviors in relationships. For example, they tend to prioritize others' feelings and thoughts over their own and avoid expressing their point of view during conflicts (Arcelus et al., 2013; Hartmann et al., 2010).

Studies examining the relationship between assertiveness and ED symptoms have produced contradictory findings. A study with 159 individuals with bulimia, binge eating disorder or an ED not otherwise specified signals a non-assertive, exploitable and over-nurturing interpersonal profile (Ung et al., 2017). No differences were found between ED diagnoses regarding the interpersonal profile. Hartmann and colleagues (2010) also identified a non-assertive and submissive interpersonal style among 208 individuals with anorexia or bulimia. Again, no differences were found between ED subtypes. However, Raykos and colleagues (2014) signal lower assertiveness skills among restrictive eaters ($n = 155$), compared to individuals with binge eating behaviors ($n = 232$). The use of different measures of self-assertiveness could potentially explain the observed differences. It appears, from the few studies that have explored assertiveness, that the presence of ED symptoms is tied to self-assertion difficulties, and that this association could be stronger for subtypes of symptoms.

It is unknown whether difficulties with assertiveness that are associated with ED symptoms extend to sexuality. The few available studies concerning the sexuality of individuals with an ED signal the presence of sexual difficulties (Castellini et al., 2016) and dissatisfaction (Castellini et al., 2012; Gonidakis et al., 2015; Martin et al., 2023; Spivak-Lavi & Gewirtz-Meydan, 2022), but they did not examine sexual assertiveness. Sexual difficulties seem to manifest themselves differently depending on the type of ED symptoms. Indeed, restrictive symptoms have been linked to a more limited sexual functioning, such as lower arousal, orgasm, and satisfaction, and greater genital pain.

Individuals with restrictive eating behaviors also report a lower number of sexual partners and fewer sexual contacts (Castellini et al., 2012, 2016; Dunkley et al., 2020; Eddy et al., 2004). For their part, binge eating symptoms seem to be associated with greater sexual drive and disinhibition (Castellini et al., 2016; Martin et al., 2023; Morgan et al., 1999) and emotional dysregulation, the latter being related to a more impulsive sexual profile marked by promiscuity and participation in unsafe sexual practices (Castellini et al., 2016; Eddy et al., 2004). Both restrictive and binge eating symptomatology are related to intimacy avoidance (Dakanalis et al., 2014; Jewell et al., 2023), which may manifest differently in the sphere of sexuality depending on the specific ED symptoms present.

Sexual assertiveness involves the open and clear expression of sexual needs and desires to partners, such as refusing to engage in unwanted sexual contacts or communicating about sexual satisfaction (Loshek & Terrell, 2014). According to Morokoff and colleagues (1977), sexual assertiveness also includes the tendency to act autonomously and independently regarding one's sexuality (Wongsomboon et al., 2022). One therefore has the right to be autonomous in the acceptance, refusal, and initiation of sexual contacts. Among individuals from the general population, sexual assertiveness has been shown to positively influence sexual self-esteem, functioning, and satisfaction (Chesli et al., 2024; López Alvarado et al., 2020; May & Johnston, 2022; Ménard & Offman, 2009).

To date, no study has examined sexual self-assertiveness in association with ED symptomatology. In the context of sexual assertiveness, sexual motivations can sometimes hint to the reasons why certain people tend to not assert themselves in their sexuality. Sexual motivations refer to the reasons why people engage in sexual contacts and the various goals and needs that are fulfilled by these contacts (Cooper et al., 1998). Spivak-Lavi and Gewirtz-Meydan (2023) studied the relationship between disordered eating and sexual motivations among 341 Israeli women from the general population. Results show that disordered eating was related to greater engagement in sexual behaviors for self-validation reasons, coping with negative feelings, experiencing intimacy with the partner and gaining approval by the partner (e.g., partner could get angry if we do not have sex). Interestingly, few women with disordered eating reported being motived by the experience of sexual pleasure. The various ways in which individuals with EDs navigate sexual contacts to obtain self-validation and appease their partner, and whether those leave room for the assertion of their sexual needs, desires and limits, remain unclear. As yet, it remains to be determined if sexual motivations vary according to ED symptomatology. The present study explores these questions.

The Present Study

The objective of the study is to examine the associations between ED symptoms and the following variables: self-perception of sexual assertiveness, motivations and avoidance. It is hypothesized that both restrictive and binge eating symptoms will be negatively linked to sexual assertiveness. They will however show varying associations

with sexual motivations and avoidance: (a) restrictive eating will be tied to the motivation to please the partner and the tendency to avoid sexual contacts, and (b) binge eating behaviors will be linked to the motivation to feel worthy and loved by the partner and to no sexual avoidance.

Method

Participants and Procedure

The study is part of a larger research project including women reporting symptoms of EDs and a control group. The sample of the current study is comprised of 159 participants identifying as females, aged between 18 and 66 years old (M = 34.42; SD = 10.66), who reported restrictive and/or binge eating symptoms. No formal ED diagnosis was made. Most participants indicated having Canadian or American origins (82.4%), followed by European (17.6%), North American Indigenous (3.1%), Central or South American (2.5%) and Asian (2.5%) origins. Table 1 presents participants' socioeconomic and sexorelational profile.

Participants were recruited through social media posts (Instagram/Facebook) and e-mail newsletters from the research team and eight non-profit organizations and five community clinics all offering specialized ED or body image treatment in the province of Quebec. The social media ads invited adult females with or without ED symptoms to participate in a study on sexuality via a link to the Qualtrics platform.

Table 1

Demographics

	N	%
Salary		
< $10 000	9	7.4
Between 10 000 – $19 999	14	11.6
Between 20 000 – $29 999	8	6.6
Between 30 000 – $39 999	14	11.6
Between 40 000 – $49 999	21	17.4
Between 50 000 – $59 999	13	10.7
Between 60 000 – $69 999	8	6.6
Between 70 000 – $79 999	12	9.9
Between 80 000 – $89 999	7	5.8
Between 90 000 – $99 999	9	7.4
≥ $100 000	6	5.0
Sexual Orientation		
Only attracted to men	71	44.7
Mostly attracted to men	48	30.2
Attracted equally to men and women	12	7.5
Mostly attracted to women	2	1.3
Only attracted to women	3	1.9
Attracted towards the person, no matter whether they are a man or a woman	21	13.2
Not attracted by anyone	1	0.6
Questioning/does not know	1	0.6
Relationship Status		
Single	42	26.4
In a relationship without cohabitation	33	20.8
In a relationship with cohabitation/common-law union	58	36.5
Married	21	13.2
Separated/Divorced	3	1.9
Other (long distance, widowed)	2	1.3

The link, which directed participants to the consent form, was active between November 2022 and May 2024 for the present study. After completing the consent form, participants were automatically redirected to the self-reported questionnaire. A screening question regarding the presence or absence of ED symptoms was included in the questionnaire, which asked participants to indicate the problematic eating behaviors they had experienced in the past five years. The possible answers were: (a) loss of control over food intake followed by a feeling of guilt (behaviors similar to binge eating disorder), (b) loss of control over eating followed by compensatory behaviors similar to bulimia (e.g., self-induced vomiting, use of laxatives, diuretics, excessive exercise, etc.), (c) food restriction (behaviors similar to anorexia), and (d) none of these types of eating behaviors. Participants were allowed to select multiple responses, and those who did not report any ED symptoms were excluded from the current study. The present analysis focuses exclusively on participants reporting ED symptoms, to study the relationship between ED symptoms and our different variables.

The study was approved by the Ethics Board for Research Involving Humans at the University of Québec in Trois-Rivières (CERPPE-22-13-07.07).

Measures

Sociodemographic and Sexorelational Questionnaire

A sociodemographic questionnaire was developed to evaluate age, ethnicity, sexual orientation, and relationship status. Participants were also asked to indicate if they

presented the following mental health symptoms: (a) anxiety, (b) depression, and (c) attention deficit and hyperactivity.

Sexual Assertiveness

The *Sexual Assertiveness Scale* of the *Multidimensional Sexual Self-Concept Questionnaire* (MSSCQ; Snell, 2003) was used to assess participants' self-perception of sexual assertiveness. It includes five items, such as "I'm very assertive about the sexual aspects of my life", rated on a 5-point Likert-type scale ranging from *Not at all characteristics of me* (1) to *Very characteristic of me* (5). Higher scores were associated with the perception of higher sexual assertiveness. The total score represents the mean of all five items. The Cronbach's alpha was $\alpha = 0.87$ for this sample, indicating good internal consistency.

Sexual Avoidance

Six items were elaborated to evaluate sexual avoidance (Martin et al., 2023), for example "I avoid all situations that provoke sexual desire in me" and "I try to avoid sexual contacts with my partner." The items are rated on a 5-point Likert-type scale ranging from *Strongly disagree* (1) to *Strongly agree* (5). The mean of the six items is calculated to produce a total score. A higher score indicates greater sexual avoidance. The Cronbach's alpha of this scale for the current sample was 0.84, which shows a good internal consistency.

Sexual Motivation

Sexual motivation was assessed using a questionnaire developed by "Anorexie et Boulimie Québec", that was adapted by the authors for the present study. The 37 items target motivations for engaging in sexual contacts (e.g., "To feel like I have value" or "To express my love to my partner"). Items are rated on a Likert-type scale ranging from *Strongly disagree* (1) to *Strongly agree* (5). The internal consistency was excellent ($\alpha = 0.91$) in this sample.

Eating Disorder Symptoms

Restrictive symptoms were measured using the Restraint scale of the EDE-Q (Fairburn et al., 1993). It comprises six items, scored on a 7-point Likert-type scale, ranging from *Not present* (0) to *Present every day* (6). Sample items include: "Over the past four weeks have you gone for periods of eight or more waking hours without eating anything?" and "Over the past four weeks have you wanted your stomach to be empty?" The mean of the six items is calculated to create a total score. Higher scores indicate a higher severity of ED symptoms. The internal consistency of the scale with the study sample was good ($\alpha = 0.83$).

The Binge Eating Disorder Screener-7 (BEDS-7; Herman et al., 2016) was used to assess binge eating symptoms, since the BEDS-7 is the only diagnostic instrument for BED that is used clinically. Multiple studies have used it with adult participants (Abdulla et al., 2023; Badrasawi & Zidan, 2019; Farello et al., 2023). The questionnaire contains

two yes/no screening questions to verify the presence of BED symptoms. If participants provided a positive answer to both questions, they were asked to complete the remaining five items, which evaluate the severity of BED symptoms, on a Likert-type scale that ranges from *Never or rarely* (1) to *Always* (4). The five items were used to calculate a mean score representing the severity of symptoms of binge eating. A score of 5 refers to the absence of such symptoms and a score of 20 the presence of severe binge eating symptoms. The internal consistency of the BEDS-7 for the current study was acceptable ($\alpha = 0.75$).

Statistical Analyses

Pearson's bivariate correlations were used to analyze the relationships between ED symptoms and: sexual assertiveness sexual motivations, and sexual avoidance. Analyses were conducted using SPSS version 29.0.

Results

As displayed in Table 2, the correlations between ED symptomatology and sexual assertiveness were significant, that is both restrictive ($r = -.169$, $p = .033$) and binge ($r = -.175$, $p = .026$) eating behaviors were weakly and negatively related to sexual assertiveness. While a weak but significant positive relationship was found between restrictive symptoms and sexual avoidance ($r = .222$, $p = .006$), that was not the case for binge eating symptoms ($r = .092$, $p = .258$).

Table 2

Correlations Between Sexual Assertiveness and ED Symptoms, Sexual Assertiveness and Sexual Avoidance

	Restrictive Symptoms	Binge Eating Symptoms	Sexual Assertiveness	Sexual Avoidance
Restrictive Symptoms	–	–	–	–
Binge Eating Symptoms	**.389****	–	–	–
Sexual Assertiveness	**-.169***	**-.175***	–	–
Sexual Avoidance	**.222****	.092	**-.566****	–

Note. **Bold** text indicates statistically significant results.
*$p < .05$. **$p < .01$.

Table 3 highlights the correlations between ED symptomatology and sexual motivations. Various sexual motivations were significantly related to restrictive symptoms, with small to medium correlations, namely "To make up for my physical imperfections by being a good partner" ($r = .300$, $p < .001$) and "To please my partner" ($r = .262$, $p < .001$). Binge eating symptoms had significant but weak relationships with sexual motivations pertaining to intimacy and love, such as "To get affection" ($r = .160$, $p = .049$) and "To feel loved" ($r = .234$, $p = .004$). However, not all items evaluating the need for intimacy or to feel love (e.g., "To express my love to my partner", "To connect with the other in a profound way") showed a significant relationship to binge eating symptoms. The item "To feel sexual pleasure" was also negatively and significantly related to binge eating behaviors ($r = -.173$, $p = .032$), but the magnitude of the relation was small.

Table 3

Correlations Between Sexual Motivations, Sexual Assertiveness and ED Symptoms

Sexual Motivation Scale Items	Sexual Assertiveness	Restrictive Symptoms	Binge Eating Symptoms
(1) To feel desired	.129	.002	.058
(2) To feel like I have value	-.067	.046	.080
(3) I feel like I owe something to my partner	**-.353****	**.225****	.139
(4) I didn't know how to say "no"	**-.412****	**.294****	.135
(5) Because it's my duty	**-.400****	**.264****	**.163***
(6) To stop being bothered by my partner's sexual demands	**-.330****	**.201***	.138
(7) To discourage my partner from seeing other people	**-.332****	**-.160***	.091
(8) To experience sexual pleasure	**.347****	-.128	**-.173***
(9) To feel connected to my body	**.323****	-.149	-.129
(10) To feel alive	**.223****	-.129	-.039
(11) To try new experiences	**.175***	-.005	.051
(12) To clear your mind	.098	-.086	-.006
(13) To feel like a woman	.087	-.400	.027
(14) To confirm my power of seduction	.100	.055	-.006
(15) To have fun	**.415****	-.144	-.096
(16) To reassure myself	-.025	-.027	-.017
(17) To explore someone else's body	**.172***	.010	.078
(18) To feel close to someone	**.326****	-.003	.014
(19) To improve my sexual skills	.112	-.068	.039
(20) To know myself better	**.182***	-.116	-.030
(21) To feel empowered	.052	-.081	-.036
(22) To feel I'm like other people	**-.449****	**.267****	**.255****
(23) To release stress or tension	**.367****	-.147	-.024
(24) To gain attention	.070	-.069	.006
(25) To get affection	.071	.096	**.160***
(26) To satisfy my sexual desires	**.322****	-.145	-.080

Table 3

Correlations Between Sexual Motivations, Sexual Assertiveness and ED Symptoms (continued)

Sexual Motivation Scale Items	Sexual Assertiveness	Restrictive Symptoms	Binge Eating Symptoms
(27) To feel in control	.093	-.155	-.058
(28) To please my partner	-.078	**.262****	**.196***
(29) To feel loved	-.096	.124	**.234****
(30) To express love to my partner	.021	.090	.120
(31) To get a break from my routine or out of boredom	**.227****	-.111	-.147
(32) To get away	.066	-.024	-.058
(33) It's good exercise	.151	-.015	.019
(34) To make up for my physical imperfections by being a good sexual partner	**-.232****	**.300****	.106
(35) To feel like my partner and I share something in common	.028	.082	-.049
(36) To connect with my partner in a profound way	**.308****	-.045	-.030
(37) To buy peace from my partner	**-.323****	**.209****	.107

Note. **Bold** text indicates statistically significant results.
*$p < .05$. **$p < .01$.

This suggests that the experience of sexual pleasure may not be an important driving force behind the involvement in sexual contacts among women with BE symptoms. Interestingly, the item "To feel like I'm like other people" was significantly and positively correlated with both restrictive ($r = .267$, $p < .001$) and binge eating symptoms ($r = .255$, $p = .002$) and negatively related to sexual assertiveness ($r = -.449$, $p < .001$). Most of the items of the sexual motivation scale that were positively correlated with ED symptoms

showed negative and significant relationships with sexual assertiveness. This suggests difficulties in sexual assertiveness, among participants.

Discussion

The objective of the current study was to examine the associations between ED symptoms and self-perception of sexual assertiveness, sexual motivations and sexual avoidance. To our knowledge, this is the first study to examine the relationship between ED symptoms and the self-perception of sexual assertiveness. As predicted, results showed that both restrictive and binge eating symptoms were negatively related to sexual assertiveness. That is, the more ED symptoms were present - whether restrictive, binge eating or both - the lower was the evaluation of one's ability to assert sexual needs, desires, and limits. In addition, restrictive eating, but not binge eating, was associated with sexual avoidance, which confirms our hypothesis. The lack of a significant relationship between sexual avoidance and binge eating symptoms could possibly be explained by the tendency toward sexual disinhibition observed among individuals with binge eating symptoms (Castellini et al., 2016; Morgan et al., 1999). These results suggest hypotheses to why, as individuals exhibit more ED symptoms, they may demonstrate lower sexual assertiveness. However, the strength of these associations was weak so caution should be exercised when interpreting the results. It is worth considering that women with restrictive eating reported avoiding sexual contacts, it may thus have been more challenging for them to answer questions about sexual assertiveness. Also, they may avoid such contacts to refrain from

having to assert their needs or limits. As for women with binge eating, the findings suggest that sexuality may provide a platform for the experience of love.

ED symptoms were also associated with various sexual motivations. The presence of restrictive symptoms was tied to a greater tendency to engage in sexual contacts to please the partner, whereas binge eating symptoms were linked to the need for intimacy and love. In the present study, both restrictive and binge eating symptomatology was associated with the motivation "To please my partner." Thus, both restrictive and disinhibited symptoms could be associated to a certain desire to please the partner. However, motivations such as "To make up for my physical imperfections by being a good partner" or "I feel like I owe something to my partner" were only associated with restrictive symptoms and not binge eating symptoms. These motivations seem to reflect a need to compensate for certain flaws or to be dutiful for people exhibiting restrictive symptoms, while the sexual motivations related to binge eating symptoms seem to point to a need to feel connected to the other.

These findings echo those reported by Spivak-Laki and Gewirtz-Meydan (2023). Their study found that the desire for intimacy and closeness with the partner was associated with ED symptoms, which is aligned with the love motive expressed by women with binge eating symptoms in the present research project. However, binge eating symptoms were not found to be linked to all the sexual motivation that fall under the need for intimacy. Further studies are needed to determine if women with binge eating

symptoms are driven to engage in sexual contacts to experience love, intimacy, or both. Restrictive symptoms in this study did not correlate with sexual motivations related to intimacy or feeling loved. While Spivak-Laki and Gewirtz-Meydan's study (2023) showed associations between general disordered eating and sexual motivations, the current study highlights distinct differences in how restrictive and binge eating symptoms relate to sexual motivations.

Beyond our initial hypotheses, results also indicated that restrictive symptoms seemed to be tied to sexual motivations concerning the avoidance of asserting themselves with their partner (e.g. "To stop being bothered by my partner's sexual demands", I didn't know how to say "no" or "To buy peace from my partner"). Given that restrictive symptoms were also associated with sexual avoidance, it is possible that individuals with restrictive ED symptoms experience such challenges with sexual assertiveness that, when they do engage in sexual contacts, their motivation may partly reflect a tendency to avoid self-assertion or interpersonal conflict.

When compared to studies on general assertiveness skills and ED symptoms, our findings are consistent with those from Ung and collaborators (2017) and Hartmann and colleagues (2010), that showed that people exhibiting ED symptoms tend to have lower assertiveness skills. It would be interesting for future research to compare controls to people with ED symptoms concerning sexual assertiveness skills.

Strengths and Limitations

Certain limitations must be considered when interpreting the results of the study. First, symptoms of ED were self-reported rather than derived from a formal diagnosis, as the study was conducted entirely online. Thus, the results of the study refer to the presence of ED symptoms and cannot be generalized to specific ED diagnoses. It is also worth noting that the sample exhibited considerable heterogeneity in terms of severity of ED symptoms and clinical conditions. This may have introduced more variability in the sample and influenced the results of the study. Nevertheless, the sample was representative of the population (e.g., varying degrees of ED symptom severity, attendance in treatment or not, etc.), which enhances the generalizability of the findings. Second, it was not possible to control the conditions in which participants completed the questionnaires as they were administered online. This may have introduced statistical noise in the data collected. Third, the sexual motivation scale was not validated, which reduces the reliability of this measure and limits the confidence with which associations involving sexual motivations can be interpreted. Fourth, those participants who were not currently involved with a romantic or sexual partner had to rely on memory in completing the questionnaire, which could have biased some of their responses. Fifth, given its exploratory nature, this study reveals associations between variables, but causal relations cannot be established.

The study presents strengths that are worth mentioning. Sexuality has received little empirical attention in relation to ED, the study thus sheds light on sexual assertiveness

and avoidance in relation to ED symptomatology. It also adds to the limited literature on sexual motivations among individuals with ED symptoms. Furthermore, the study highlights important avenues for future research on why people with EDs do or do not engage in sexual contacts, and how this relates to sexual assertiveness in this clinical population. It raises several pertinent questions, including whether interventions targeting sexual assertiveness, motivations and functioning could be beneficial for individuals with an ED, and, if so, what therapeutic interventions may be most effective considering this clinical population. Exploring these questions could help in the development of interventions aimed at enhancing assertiveness skills for people exhibiting ED symptoms. This research project reveals the need for future research on the promotion of assertiveness skills in people with EDs.

Conclusion

Findings from this study suggest that low sexual assertiveness skills are negatively related to both restrictive and binge eating symptoms, while sexual avoidance was only positively related to restrictive symptoms. Sexual motivations seem to be quite different according to restrictive or binge eating symptoms, as restrictive eaters tend to be motivated by people-pleasing, while binge eaters tend to be motivated by their need for feeling loved. Assertiveness skills and involvement in sexuality seem to be interesting avenues for research and intervention, as it is closely related to sexual consent – the voluntary agreement to engage in sexual activity (Criminal Code, 1985). The capacity to refuse to engage in a sexual activity constitutes a key component of sexual assertiveness (Chesli et

al., 2024; López Alvarado et al., 2020; Ménard & Offman, 2009). Research has shown that greater sexual assertiveness skills are associated with a reduced risk of sexual victimization (Greene & Navarro, 1998; Livingston et al., 2007; Walker et al., 2011). Given the documented associations between EDs and the experience of sexual victimization (Gomez et al., 2021; Madowitz et al., 2015), there could be a potential link between sexual assertiveness, sexual victimization and ED symptoms. While further investigation is needed to clarify the nature of these relationships, the promotion of assertiveness skills in this clinical population could represent a promising avenue for both the prevention of sexual victimization and the support of mental health in people living with EDs.

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