

1995

Sexual abuse experienced in childhood: A predisposing factor for the development of eating disorders in females

Lois O. Fink
University of Northern Iowa

Let us know how access to this document benefits you

Copyright ©1995 Lois O. Fink

Follow this and additional works at: <https://scholarworks.uni.edu/grp>



Part of the [Education Commons](#)

Recommended Citation

Fink, Lois O., "Sexual abuse experienced in childhood: A predisposing factor for the development of eating disorders in females" (1995). *Graduate Research Papers*. 2310.

<https://scholarworks.uni.edu/grp/2310>

This Open Access Graduate Research Paper is brought to you for free and open access by the Student Work at UNI ScholarWorks. It has been accepted for inclusion in Graduate Research Papers by an authorized administrator of UNI ScholarWorks. For more information, please contact scholarworks@uni.edu.

Sexual abuse experienced in childhood: A predisposing factor for the development of eating disorders in females

Abstract

"An unacknowledged trauma is like a wound that never heals over and may start to bleed again at any time" (Miller, 1984, as cited in Kearney-Cooke & Striegel-Moore, 1994, p. 305). Previous research has suggested a strong relationship between child sexual abuse and the development of a wide range of maladaptive responses among females (Browne & Finkelhor, 1986; Sloan & Leichner, 1986). These maladaptive responses may include the development of behavioral, physical, and psychological problems. One of the more recent manifestations of psychosomatic symptoms being investigated is the possible linkage between child sexual abuse (CSA) and eating disorders, specifically anorexia nervosa and bulimia nervosa (Beitchman et al., 1992; Browne & Finkelhor, 1986; Calam & Slade, 1988; Gelinis, 1983; Goldfarb, 1987; Miller & McCluskey-Fawcett, 1993; Rorty, Yager, & Rossotto, 1994). Despite numerous studies to date, research has been unable to identify clear-cut cause of anorexia or bulimia. However, several correlations between child sexual abuse and eating disorders appears to be indicated.

SEXUAL ABUSE EXPERIENCED IN CHILDHOOD:
A PREDISPOSING FACTOR FOR THE DEVELOPMENT OF
EATING DISORDERS IN FEMALES

A Research Paper
Presented to
The Department of Educational Administration
and Counseling
University of Northern Iowa

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Lois O. Fink
December 1995

This research paper by: Lois O. Fink

Entitled: SEXUAL ABUSE EXPERIENCED IN CHILDHOOD:
A PREDISPOSING FACTOR FOR THE DEVELOPMENT OF
EATING DISORDERS IN FEMALES

has been approved as meeting the research paper
requirements for the Degree of Master of Arts.

Audrey L. Smith

Oct. 26 1995
Date Approved

Adviser/Director of Research Paper

Terry Kottman

10-26-95
Date Approved

Second Reader of Research Paper

Michael D. Waggoner

10.31.95
Date Received

Head, Department of Educational
Administration and Counseling

"An unacknowledged trauma is like a wound that never heals over and may start to bleed again at any time" (Miller, 1984, as cited in Kearney-Cooke & Striegel-Moore, 1994, p. 305). Previous research has suggested a strong relationship between child sexual abuse and the development of a wide range of maladaptive responses among females (Browne & Finkelhor, 1986; Sloan & Leichner, 1986). These maladaptive responses may include the development of behavioral, physical, and psychological problems. One of the more recent manifestations of psychosomatic symptoms being investigated is the possible linkage between child sexual abuse (CSA) and eating disorders, specifically anorexia nervosa and bulimia nervosa (Beitchman et al., 1992; Browne & Finkelhor, 1986; Calam & Slade, 1988; Gelinias, 1983; Goldfarb, 1987; Miller & McCluskey-Fawcett, 1993; Rorty, Yager, & Rossotto, 1994). Despite numerous studies to date, research has been unable to identify clear-cut cause of anorexia or bulimia. However, several correlations between child sexual abuse and eating disorders appears to be indicated.

Psychological effects of CSA have been well-documented in the clinical literature (Beitchman et al., 1992; Browne & Finkelhor, 1986), leading to the

conclusion that sexual abuse has both immediate and long-term effects on "body image, identity, self-regulation, interpersonal functioning, and feelings of ineffectiveness: (Kearney-Cooke & Striegel-Moore, 1994, p. 306). Others have found that women who present with eating disorders frequently report similar problems (Browne & Finkelhor, 1986; Hall, Tice, Beresford, Wooley, & Hall, 1989; Young, 1992). According to Oppenheimer, Howells, Palmer, and Chaloner (1985), sexual abuse may cause self-disgust with femininity and sexuality, which ultimately manifests concern with body image, sometimes leading to an eating disorder.

Leading authorities agree that child sexual abuse is widespread. It has been estimated that 20% of the general population of the United States has experienced sexual abuse (Browne & Finkelhor, 1986; Goldfarb, 1987; Hall et al., 1989). Other statistics suggest that one in three females as compared to one in eight males will be sexually abused before she reaches the age of 18 (Bass & Davis, 1993). Russell (1983, as cited in Calam & Slade, 1989) suggested the even higher prevalence of 31% of all females experiencing sexual abuse before age 18 when all forms of sexual abuse are included.

Research indicates that eating disorders are common among at least 1% of our population (Foreyt &

McGavin, 1989; Kaplan & Sadock, 1990; Miller & McCluske-Fawcett, 1991). Anorexia affects approximately 1% of the population as a whole, while bulimia affects between 1% and 5% of the population, with a female-to-male ration of 1:9-10 (Foreyt & McGavin, 1989). There appears to be an even higher prevalence of bulimia among high school and college-age women, affecting between 4% and 15% of this age group (Foreyt & McGavin, 1989; Kaplan & Sadock, 1990; Miller & McCluske-Fawcett, 1991).

Since these eating disorders are primarily addressed as emotional disorders, they are a major focus in psychological practice and research. Anorexia and/or bulimia frequently are a presenting problem with female patients; these disorders have serious side effects and physical complications, which can be both dangerous and life-threatening (Kerr, 1991; Zerbe, 1991).

Given the prevalence of sexual abuse and of eating disorders among the population in the United States, it would seem important to establish the extent to which these are related. The finding of a causal link between child sexual abuse and eating disorders could present important implications for the prevention and/or treatment of anorexia nervosa or bulimia

nervosa. The purpose of this paper was to review the literature which address the question of a significant link between child sexual abuse and the subsequent development of the eating disorders anorexia and bulimia in females.

Definitions/Diagnostic Features

Eating Disorders

Anorexia nervosa and bulimia nervosa are developmental disorders typically beginning during adolescence and are characterized by physically and/or psychologically harmful eating patterns (Foreyt & McGavin, 1989; Kerr, 1991; Zerbe, 1993). Individuals who present with anorexia or bulimia share an obsession with weight and food and an intense fear of becoming fat (Zerbe, 1993).

Anorexia typically begins between the ages of 14 and 18 (Zerbe, 1993). This disorder is characterized by a refusal to maintain body weight at or above a minimally normal weight for age and height. Individuals with anorexia do not allow themselves to eat, often alternating between dieting, fasting, and exercising to excess (restricting type) or may engage in binge eating or purging behavior (American Psychiatric Association, 1994).

Bulimia typically begins between 11 and 19 years of age (Zerbe, 1993). Literally meaning "ox hunger" (Foreyt & McGavin, 1989), bulimia is characterized by recurrent, excessive, and uncontrolled consumption of large amounts of often high caloric foods within a short time frame. This is followed by purging after each binge, through self-induced vomiting (purging type). According to the DSM-IV (1994), use of laxatives, diuretics, enemas, fasting, and excessive exercise are also common behaviors used to prevent weight gain (nonpurging type) (American Psychiatric Association, 1994).

Child Sexual Abuse

"Child sexual abuse is an act imposed on a child who lacks emotional, maturational, and cognitive development by a person in a position of authority and power over the child (Josephson & Fong-Beyette, 1987, p. 475). Trepper and Barrett (1989) have further defined sexual abuse as "any sexual contact that is intended to stimulate the child sexually, or to stimulate sexually the offending adult through use of the child" (p. xvi). This includes touching, kissing, fondling, and overt sexual contact.

Historical Background and Etiological Speculations

Anorexia and bulimia, often considered to be disorders of the 20th century, date back as far as Biblical and ancient times (Foreyt & McGavin, 1989). According to the research of Foreyt & McGavin, fasting was a common form of religious discipline across religious groups. Moral strength and capacity for sacrifice were demonstrated by self-starvation; abstinence was seen as a sign of spiritual power and saintly self-denial.

Although anorexic behavior is not likely today to be linked to a form of religious discipline, the guilt, perfectionism, and preoccupation with self-control associated with the behavior remain similar (Foreyt & McGavin, 1989). Typically, individuals who present with anorexia do not think anything is wrong with their gaunt appearance or eating habits and may take pride in their "self-control" (Zerbe, 1993).

Accounts of bulimic behavior are noted in early Roman times with descriptions of public places, vomitoria, where people could go to vomit (Foreyt & McGavin, 1989). However, according to Foreyt & McGavin, the public nature of vomiting is not consistent with the secretiveness of the bingeing or purging of today's bulimic.

Individuals who present with bulimia frequently report being ashamed as they see their cycle of eating as out of control and they fear discovery (Kerr, 1991; Zerbe, 1993). Binges are not triggered by physical hunger, but typically by emotional upset (Kerr, 1991). In times of stress, food becomes a source of comfort and a means to deal with powerful negative feelings. Feelings of guilt, anxiety, and depression are prevalent (Zerbe, 1993).

Early analytical literature hypothesized a linkage of anorexia to a variety of sexual and psychosexual factors (Covert, Kinder, & Thompson, 1989). Covert et al.'s (1989) review of medical literature cited Laseque's (1873) premise, which correlated heterosexual relationship stressors with the precipitation of "l'anorexia hysterique." Other hypotheses included that of Freud (1902, as cited in Covert et al., 1989; Sloan & Leichner, 1986), who speculated that anorexia exists as a variant of melancholia brought about by underdeveloped sexuality. Janet (1929, as cited in Covert et al., 1989) viewed anorexia as a hysterical reaction because of sexual frustration. According to Covert et al. (1989), these views of Freud and Janet precipitated those of Waller, Kaufman, and Deutsch (1940), who theorized that anorexia was a form of

conversion hysteria. Later literature regarding psychosexual aspects of anorexia and bulimia included failure to resolve conflicts related to sexual feelings and behaviors (Daily & Sargant, 1966, as cited in Coover et al., 1989), rejection of sexual maturity (Muller & Beck, 1973, as cited in Coover et al., 1989), and inability to adjust to menarche (Bruch, 1978, as cited in Coover et al., 1989) as causal factors. According to these views, it would appear that refusal to eat could be a total rejection of sexuality.

Review of the Literature

Despite speculations regarding the etiology of anorexia and bulimia in early literature, it was not until the mid-1970s that systematic investigations of psychosexual aspects of the disorders were conducted (Foreyt & McGavin, 1989). Subsequent investigations of females presenting with eating disorders recorded lower level of interest in sex, decreased ability to enjoy sexual relations, and negative feelings toward sexuality among those females who had histories of sexual abuse when compared to females who had not experienced sexual abuse (Browne & Finkelhor, 1986; Sloan & Leichner, 1986). According to Sloan and Leichner, the significance of sexual conflicts in many

patients presenting with eating disorders has been well-documented since the mid-1970s.

An abundance of research evidence describes all sexual abuse as damaging and holds that the trauma does not end when the abuse stops (Beitchman, et al., 1992; Gelinas, 1983; Goldfarb, 1987; Miller & McCluskey-Fawcett, 1993; Waller, 1991; Young, 1992). Browne and Finkelhor (1986) reported that empirical studies have suggested childhood sexual abuse plays a role in the development of problems ranging from "anorexia nervosa to prostitution" (p. 66). Many cases of sexual molestation may go unreported, and victims reach adulthood without acknowledging or revealing the abuse and victimization. Continued emotional problems follow these victims into adulthood. While some victims seek counseling, it is frequently under the guise of another problem (Gelinas, 1983; Joy, 1987); they may remain unaware that a link exists between earlier sexual abuse and the current problem. Duration and frequency of the abuse, age at onset, force and aggression, type of sexual act, and relationship of the perpetrator to the victim are variables which can influence the depth of the traumatization (Young, 1992).

Young (1992) has identified a range of psychological distressors and impairments which he

found to be associated with sexual abuse. Among these are disassociation, drug and alcohol abuse, self-mutilation, suicidal ideation and suicide, sexual dysfunctions, depression, anxiety, rage, poor self-esteem, and guilt. Young also cited eating disorders among these impairments.

Young (1992) reported that disassociation may occur during sexual assault and that the victim then identifies with the mind. The body is viewed by the victim as a "foreign container of bad sexual feelings and sensations" (p. 97). Through starvation, the victim believes these feelings will disappear.

For other victims, the body is seen as having betrayed them and it is hated; to survive, the body must be destroyed. Cleansing or ridding the body of "bad" is analogous to the act of vomiting. Because the body is the site of the original trauma, disturbances in body image can result from sexual abuse. Kearney-Cooke and Striegel-Moore (1993) suggested that guilt, shame, and sense of dirtiness remain; the need to rid the body may be a defensive way to handle those adverse feelings.

Research studies have begun to examine the extent and nature of sexual abuse among women who have presented for treatment of eating disorders (Hall et

al., 1989). Several findings have emerged from these studies. Results of a case study by Sloan and Leichner (1986) of 6 women in inpatient treatment for eating disorders suggested that symptoms of eating disorders may serve as a means "to avoid painful memories and negative feelings associated with sexuality or avoid sexuality in all its manifestations such as sexual activity, menstruation, or adult characteristics" (p. 659).

Lowered self-esteem is cited as one of the most common complaints and most damaging effects of sexual abuse (Browne & Finkelhor, 1986). Victims report feelings of inferiority, guilt, shame, and low self-worth (Browne & Finkelhor, 1986; Kearney-Cooke & Striegel-Moore, 1994). In a community sample of 31 females by Courtois (1979), 87% of the respondents reported that their sense of self had been moderately to severely affected by intrafamilial sexual abuse. Finkelhor's (1979, as cited in Browne & Finkelhor, 1986) study of college students found that victims of child sexual abuse reported significantly lower levels of sexual self-esteem than did those who had not been abused.

Abnormally low self-esteem has been observed in clients presenting with both anorexia and bulimia

(Kerr, 1991; Zerbe, 1993). Low self-esteem has been reported to be a critical, pervasive problem in both group and individual therapy experience as reported by Baird and Sights (1986). Hall et al. (1989) reported in their study of 158 females with eating disorders that patients often suffered from low self-esteem. Food, for the subjects in this study, was not the central problem.

Garfinkel and Garner (1982) further stated that evidence suggests an interaction of psychological, physiological, developmental, and cultural forces may be subsequently set into motion by a triggering event such as a direct threat to one's self-esteem. Injured or lowered self-esteem may be a critical bridge, or perhaps one of many, that link child sexual abuse with subsequent development of appetite disorders (Palmer, Oppenheimer, Dignon, Chaloner, & Howells, 1990).

Goldfarb (1987) believed that eating disorders develop in conjunction with ongoing sexual abuse and may give victims a false sense of control. Victims may overeat or undereat in an attempt to gain control over their own bodies; when there is sexual abuse, this control is missing for them. Beckman and Burns (1990) agreed with Goldfarb that control may be a mediating factor between the abuse and eating disorders. The

less control a victim feels as a result of the abuse, the more she may seek to gain control through eating behavior.

According to research by Calam and Slade (1990), the self-starvation behavior of an individual with anorexia may serve as a means of punishment toward the parent who failed to protect her. Calam and Slade contended that victims of intrafamilial abuse may seek to gain even greater control as compared to victims of extrafamilial abuse because the abuse occurred in an environment which was perceived to be safe. The extrafamilial experience of victimization may be perceived as a chance happening, thus allowing victims to retain a higher sense of control over their lives.

Despite the fact that several of the studies reported identified a significant relationship between sexual abuse and appetite disorders, numerous conflicting reports dispute such a relationship (Coover et al., 1989; Finn, Hartman, Leon, & Lawson, 1989; Kinzel, Traweger, Guenther, & Biebl, 1994; Pope & Hudson, 1992; Pope, Mangweth, Negrao, Hudson, & Cordas, 1994; Smolak, Levine, & Sullins, 1990; Welch & Fairburn, 1994).

Welch and Fairburn (1994) suggested that there are shortcomings in the research directed toward finding an

association between sexual abuse and eating disorders. Specifically, Pope and Hudson (1992), in their studies of child sexual abuse as a risk factor for bulimia, have identified methodological limitations and suggested a need to address those problems in future research. Among those methodological problems cited are the absence of appropriate control groups, the lack of a satisfactory definition of sexual abuse, and the use of poor evaluation techniques, such as questionnaires. Kearney-Cooke and Striegel-Moore (1994) agreed that there is no uniformly accepted definition of what constitutes sexual abuse and also stated that researchers have not been able to agree upon a specific methodological approach to elicit information about sexual abuse. Welch and Fairburn (1993) cautioned against potential bias in the use of clinically detected samples. They pointed out that this shortcoming arises because individuals with a history of sexual abuse might be expected to be overrepresented.

Finn et al. (1989) conducted a study consisting of 87 females receiving psychotherapy in three different settings (women's treatment center for sexual abuse, women's therapy collective, and groups held by private-practice clinicians) in which participants were

assessed for abnormal eating patterns and for the presence of sexual abuse histories. The investigation failed to provide support for the hypothesis of an increased prevalence of sexual abuse histories among women with eating disorders. However, in this study eating disorders were not clinically diagnosed and were self-reported. Finn et al. (1989) concluded that the setting studied may have resulted in the selection of subjects more likely to report abusive experiences whether or not they had eating problems.

Beckman and Burns (1990), in their study of 340 eating disordered college women, were unable to find any one-to-one correlation between child sexual abuse and eating disorders. They concluded that the role of sexual abuse in eating disorders is a complex one and cited no measurable differences between victims and nonvictims of sexual abuse.

Welch and Fairburn (1990), in their study, found no significant difference between community and clinic subjects having bulimia nervosa with respect to their histories of sexual abuse. Fifty community-based subjects with bulimia were compared with 100 community-based comparison subjects without an eating disorder, 50 community-based comparison subjects with other psychiatric disorders, and 50 patients with bulimia in

a matched-case control design. Welch and Fairburn (1994) concluded that sexual abuse appears to be a risk factor for psychiatric disorders in general among young females; it is not specific to bulimia.

Pope et al. (1994), in a comparison study of 91 American, Austrian, and Brazilian college-age females with current or past histories of bulimia, failed to find higher rates of CSA than of the rate for the general public. These researchers suggested that CSA is not a risk factor for the development of bulimia.

Researchers who believe there is a relationship between eating disorders and sexual abuse are unsure which effects to directly attribute to sexual abuse (Covert et al., 1989; Hastings & Kern, 1994; Miller & McCluskey-Fawcett, 1993; Waller, 1993). Covert et al. (1989) stated "there is not sufficient empirical data in the literature to unequivocally support any specific claims" (p. 176). Not all individuals with histories of sexual abuse develop eating disorders, nor do all persons presenting with appetite disorders have a history of sexual traumatization (Sloan & Leichner, 1986). Yet, there remains a striking association between those two factors.

Reports by those involved in treatment of persons with appetite disorders disagree with those who dispute

the association (Browne & Finkelhor, 1986); Goldfarb, 1987; Hastings & Kern, 1994; Miller & McCluskey-Fawcett, 1993; Palmer et al., 1990). Individuals involved in therapy for their eating disorders may not always initially disclose the sexual abuse (Finn et al., 1989; Kearney-Cooke & Striegel-Moore, 1994; Sloan & Leichner, 1986). When studies were conducted with these individuals, they may not have yet reached a stage in their therapy at which they have recognized an abuse history.

Hall et al. (1989) reported that 40% to 50% of females with eating disorders gave histories of some unwanted sexual experience in their childhoods. According to Sloan and Leichner (1986), adverse sexual experiences were reported by 5 of 6 patients in an anorexia treatment program. Further investigation by Sloan and Leichner found that 9 of 23 subsequent new patients also reported histories of child sexual abuse.

In a comparison study of 144 college-age females identified with bulimia and a matched control group without bulimic symptoms, Miller and McCluskey-Fawcett (1993) concluded that a history of sexual abuse may be more common in females who present with bulimia than in nonbulimic females. Striking similarities were found in both family and psychological profiles for

adolescent females who presented with bulimia and with sexual abuse survivors. Among similarities presented between the two groups in the study were negative attitudes toward body image and toward parental control and authority. Negative attitudes were typically directed toward those body parts which are more commonly associated with sexuality, such as breasts, buttocks, and stomach (Miller & McCluskey-Fawcett, 1993).

In the same study of 144 college-age females reported by Miller and McCluskey-Fawcett (1993), females who presented with bulimia frequently described mealtimes as stressful events. Food was utilized as a treat when someone was upset. Parental control was often displayed and the subjects reported being relieved when their fathers were not present. Contrary to the researcher's expectations, more incidents of sexual abuse after age 12 than before age 12 were found. Several explanations for this outcome were suggested, including the fact that recall may have been more difficult because events prior to age 12 are further in the past. Also, strong coping mechanisms may repress the memory. Findings of Miller and McCluskey-Fawcett (1993), nonetheless, indicated that bulimic women in their study reported significantly

more incidents of sexual abuse than did nonbulimic women.

In a study of 67 bulimic and anorexic women who were receiving treatment, Waller (1991) concluded that bulimic women are substantially more likely to report a history of unwanted sexual abuse than are anorexic women. Physical force and age of victimization appeared to be less influential factors than did the incestuous nature of the abuse and lack of satisfactory disclosure. Waller (1981) claimed that family interaction may be a possible mediating factor between sexual abuse and the development of eating disorders.

Researchers have investigated several other potential mediating factors between child sexual abuse and anorexic or bulimic symptomology. Among those investigated were personality traits or disorders (Waller, 1993, 1994), family environment (Browne & Finkelhor, 1986; Hastings & Kern, 1994; Kinzl et al., 1994), and childhood abuse other than sexual (Rorty, Yager, & Rossotto, 1994).

In his study of 115 female referrals to an eating disorder clinic in England, Waller (1993) investigated a three-way interaction of eating disorders, sexual abuse, and borderline personality disorder. A significantly higher presence of borderline personality

disorder was identified among those females who reported sexual abuse than among those females who did not report abuse. More than half of the women in his study disclosed some unwanted sexual experience. However, despite finding an association between sexual abuse and borderline personality disorders and one between eating disorders and borderline personality disorders, findings were inconclusive. The researcher was unable to infer any causal direction because causality is likely to be complex and multifactorial.

While some degree of unwanted sexual experience in childhood or adulthood was reported by the subjects, in this study it differed across types of eating disorders. (Waller, 1993). A significant association was found only in anorexic subjects having a bulimic component (females who maintained low weight and binged and/or purged). Waller stated his findings are "compatible with a model in which sexual abuse influences personality such as affective instability, anger, and impulsiveness which are common to borderline personality disorder and where personality style influences the behaviors used in eating disorders" (p. 262).

A relationship among child sexual abuse, family environment, and bulimia has also been suggested by

researchers (Hastings & Kern, 1994). Individuals with bulimia and victims of sexual abuse often report dysfunctional family backgrounds (Hastings & Kern, 1994; Kinzl et al., 1994). In contrast, supportive and reliable family factors are thought to moderate the child sexual abuse-bulimia association because they minimize the negative effects of child sexual abuse (Browne & Finkelhor, 1986; Hastings & Kern, 1994).

According to Hastings and Kern (1994), chaotic familial characteristics associated with bulimia included low levels of cohesiveness, independence, and expressiveness and high levels of conflict and control. Similar characteristics have also been reported in families of victims of child sexual abuse (Hastings & Kern, 1994; Kinzl, et al., 1994). Hastings and Kern investigated family environment and eating behavior among 786 college-age females. Forty-three percent of the females reported child sexual abuse, while 73% of those females who presented with bulimia reported child sexual abuse and/or relatively chaotic family environments. In addition, a strong correlation between the severity of the abuse and severity of the bulimic disturbance was evidenced. Hastings & Kern's (1994) findings suggest that child sexual abuse and

family environment appear to combine in an additive manner to increase the risk of bulimia.

Kinzl et al. (1994), in their study of family background and sexual abuse among 350 female university students, were unable to correlate child sexual abuse with the subsequent development of eating disorders. However, significantly higher rates of bulimia and anorexia were reported among those females with dysfunctional familial backgrounds. According to Kinzl et al., it becomes difficult to differentiate effects of child sexual abuse from other consequences of dysfunctions which coexist. Numerous psychopathologies contribute to dysfunction; child sexual abuse may or may not be one of these pathologies. They suggest that the risk of intrafamilial and extrafamilial child sexual abuse increases with an adverse familial background (Kinzl et al., 1994).

Rorty et al. (1994) studied recovered bulimic women, bulimic women in treatment, and nonbulimic women to investigate the relationship between bulimia and childhood abuse, particularly child sexual abuse. Only when combined forms of abuse were involved was a higher evidence of significance found. Rates of sexual abuse experienced in childhood were not significantly different between the two groups. Bulimic women

experienced higher levels of childhood trauma, specifically parental and psychological abuse, when compared with females without a history of eating disorders. Rorty et al. (1994) concluded that while not to be viewed as a linear risk factor, multiple forms of child abuse may indeed be mediating factors in the development of bulimia.

Treatment Implications

Although not to be an issue to be ignored in the therapy of bulimic females, Pope and Hudson (1992) have cautioned against clinicians making the assumption that CSA is the cause of the eating disorder and that treatment of the abuse will "necessarily alleviate the symptoms" (p. 462). It is their opinion that research and treatment may be better served through research of other potential causes of bulimia as well as better understanding of the high levels of childhood sexual abuse in our society as a whole.

In contrast to this view, Palmer et al. (1990) emphasized that issues of adverse sexual experiences be addressed and incorporated into the assessment and therapy of individuals who present with eating disorders. Finn et al. (1986) agreed and suggested that clinicians carefully inquire about sexual abuse experiences at intake and again later in treatment when

more trust has been established with a client. A history of sexual abuse may alter the course of and the treatment of the eating disorder. Miller and McCluskey-Fawcett (1993) stated that an awareness that bulimia may be a sequelae of abuse also becomes an important part of evaluation and treatment of victims of sexual abuse in terms of prevention of the onset of an eating disorder.

Waller (1991) has further suggested that incorporation of protective factors would be beneficial in planning responses to sexual abuse and in preventing subsequent development of eating disorders. For example, protective factors such as increasing self-esteem (Browne & Finkelhor, 1986; Garfinkel & Gardner, 1992; Kearney-Cooke & Striegel-Moore, 1994) and locus of control (Beckman & Burns, 1990; Goldfarb, 1987) would function to reduce the likelihood of any disorder developing.

Goldfarb (1987) indicated a need for therapists who may be treating a sexual abuse victim for an eating disorder to develop a sensitivity to this "potential antecedent" so that they may utilize appropriate intervention strategies. According to Goldfarb, sexual abuse victims may need "specific interventions and pose special challenges" (p. 679) in therapy. This critical

information may be used as a stepping stone to future research and be of vital importance to those involved in the transformation of victims into survivors.

Conclusion

The apparent sequelae of sexual abuse includes a broad range of psychological impairment and distress, yet researchers are not able to unequivocally agree on a link between sexual abuse and eating disorder symptomatology. From this review of the literature, it appears many of the researchers speculate that sexual abuse may be a predisposing factor in the development of anorexia nervosa and bulimia nervosa and have made attempts to find supporting data while clarifying existing data. Many have concluded there is no such link while others have reported significantly higher correlations between sexual abuse and the eating disorders.

Prior sexual abuse may indeed be common among individuals who present with eating disorders and may be an explanation for some of the observed symptomatology of eating disorders in many patients. However, factors which mediate between symptomatology of anorexia and bulimia and a history of child sexual abuse are still poorly understood. Causal links remain complex and multifactorial.

Coovert et al. (1989) put research speculations in perspective when they said that although the general idea that a connection between sexual abuse and eating disorders has a "certain intuitive appeal, the place in scientific literature is justifiable only on the basis of clear empirical support" (p. 169). While studies conducted to date have posed some "interesting questions and offered some interesting clues" (p. 178), there is yet a need for more research and more clearly formulated questions. This poses a challenge for subsequent investigators.

References

- American Psychiatric Association. (1994). Diagnostic statistical manual of mental disorders: DSM-IV (4th ed.). Washington, DC: Author.
- Baird, P., & Sights, J. (1986). Low self-esteem as a treatment issue in psychotherapy of anorexia and bulimia. Journal of Counseling and Development, 64, 449-451.
- Bass, E., & Davis, L. (1988). The courage to heal. New York: Harper & Row.
- Beckman, K., & Burns, G. (1990). Relation of sexual abuse and bulimia in college women. International Journal of Eating Disorders, 9, 487-492.
- Beitchman, H., Hood, H., Zucker, K., Hood, J., DaCosta, A., Arkman, D., & Cassavia, E. A review of the effects of child sexual abuse. Child Abuse and Neglect, 16, 101-117.
- Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99, 66-77.
- Calam, R., & Slade, P. (1988). Sexual experience and eating problems in female undergraduates. Journal of Clinical Psychology, 67, 276-278.

- Coovert, D., Kinder, B., & Thompson, K. (1989). The psychosexual aspects of anorexia nervosa and bulimia: A review of the literature. Clinical Psychology Review, 9, 169-180.
- Courtois, C. (1979). The incest experience and its aftermath. Victimology: An International Journal, 4, 337-347.
- Finn, E., Hartman, M., Leon, G., & Lawson, L. (1986). Eating disorders and sexual abuse: Lack of confirmation for a clinical hypothesis. International Journal of Eating Disorders, 5, 1051-1060.
- Foreyt, J., & McGavin, K. (1989). Anorexia nervosa and bulimia nervosa. In E. J. Mask & R. A. Barkley (Eds.), Treatment of childhood disorders. New York: Guilford Press.
- Garfinkel, P. E., & Gardner, D. M. (1982). Anorexia nervosa: A multidimensional perspective. New York: Brunner/Mazel.
- Gelinas, D. (1983). The persisting negative effects of incest. Psychiatry, 46, 312-332.
- Goldfarb, L. (1987). Sexual abuse antecedent to anorexia nervosa, bulimia, and compulsive overeating: Three case reports. International Journal of Eating Disorders, 6, 676-679.

- Hall, C. W., Tice, L., Beresford, T., Wooley, B., & Hall, A. (1989). Sexual abuse in patients with anorexia nervosa and bulimia. Psychosomatics, 30, 73-79.
- Hastings, T., & Kern, J. (1994). Relationships between bulimia, childhood sexual abuse, and family environment. International Journal of Eating Disorders, 15, 103-111.
- Josephson, G., & Fong-Beyette, M. (1987). Factors assisting female clients' disclosure of incest during counseling. Journal of Counseling and Development, 65, 475-478.
- Joy, S. (1987). Retrospective presentation of incest: Treatment strategies for use with adult women. Journal of Counseling and Development, 65, 479-481.
- Kaplan, J., & Sadock, B. (Eds.). (1990). Pocket handbook of clinical psychiatry. Baltimore: Williams & Wilkens.
- Kearney-Cooke, A., & Striegel-Moore, R. (1994). Treatment of childhood sexual abuse in anorexia nervosa and bulimia nervosa: A feminist psychodynamic approach. International Journal of Eating Disorders, 4, 305-319.

- Kerr, J. (1991). Characteristics common to females who exhibit anorexia or bulimic behavior: A review of current literature. Journal of Clinical Psychology, 47, 846-853.
- Kinzl, F., Traweger, C., Guenther, V., & Biebl, W. (1994). Family background and sexual abuse associated with eating disorders. American Journal of Psychiatry, 151, 1127-1131.
- Miller, A. F., & McCluskey-Fawcett, K. (1993). The relationship between childhood sexual abuse and subsequent onset of bulimia nervosa. Child Abuse and Neglect, 17, 305-314.
- Oppenheimer, R., Howells, K., Palmer, R., & Chaloner, D. (1985). Adverse experiences in childhood and clinical eating disorders: A preliminary description. Journal of Psychiatric Research, 144, 357-361.
- Palmer, R., Oppenheimer, D., Chaloner, D., & Howells, K. (1990). Childhood sexual experiences with adults reported by women with eating disorders: An extended series. British Journal of Psychiatry, 156, 699-703.
- Pope, H., & Hudson, J. (1992). Is childhood sexual abuse a risk factor for bulimia nervosa? American Journal of Psychiatry, 149, 455-463.

- Pope, H., Mangweth, B., Negrao, A., Hudson, J., & Cordas, T. (1994). Childhood sexual abuse and bulimia nervosa: A comparison of American, Austrian, and Brazilian women. American Journal of Psychiatry, 151, 732-737.
- Rorty, M., Yager, J., & Rossotto, E. (1994). Childhood sexual, physical, and psychological abuse in bulimia nervosa. American Journal of Psychiatry, 151, 1122-1126.
- Smolak, L., Levine, M., & Sullins, E. (1990). Are child sexual experiences related to eating-disordered attitudes and behaviors in a college sample? International Journal of Eating Disorders, 9, 167-178.
- Sloan, G., & Leichner, P. (1986). Is there a relationship between sexual abuse or incest and eating disorders? Canadian Journal of Psychiatry, 31, 656-660.
- Trepper, T., & Barrett, M. (1989). Systemic treatment of incest: A therapeutic handbook. New York: Brunner/Mazel.
- Waller, G. (1991). Sexual abuse as a factor in eating disorders. British Journal of Psychiatry, 159, 664-671.

- Waller, G. (1993). Association of sexual abuse and borderline personality disorder in eating disordered women. International Journal of Eating Disorders, 13, 259-263.
- Waller, G. (1994). Childhood sexual abuse and borderline personality disorder in the eating disorders. Child Abuse and Neglect, 18, 97-101.
- Welch, S., & Fairburn, C. (1994). Sexual abuse and bulimia nervosa: Three integrated case control comparisons. American Journal of Psychiatry, 151, 402-407.
- Young, L. (1992). Sexual abuse and the problem of embodiment. Child Abuse and Neglect, 16, 89-98.
- Zerbe, K. (1993). The body betrayed: Women, eating disorders, and treatment. Washington, DC: American Psychiatric Press.