Pergamon

Child Abuse & Neglect 29 (2005) 375–382

Child Abuse & Neglect

Brief Communication

# Reported childhood sexual abuse and eating-disordered cognitions and behaviors

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Received 25 October 2003; received in revised form 25 August 2004; accepted 14 November 2004

*Keywords:* Eating disorders; Sexual abuse; Cognitions

## Introduction

Links have been proposed between childhood sexual abuse and the development of eating disorders (e.g., Fallon & Wonderlich, 1997; Root & Fallon, 1989). However, the reported prevalence of such trauma in the eating-disordered population varies widely across studies, due to differences in definitions, methodologies and tools used (Welch & Fairburn, 1994). Given the similar prevalences of reported sexual abuse in eating-disordered patients, female psychiatric controls, and non-psychiatric controls, some researchers have concluded that there is no specific relationship between sexual abuse and the eating disorders (Pope & Hudson, 1992; Welch & Fairburn, 1994). However, while there appears to be no straightforward causal link between childhood sexual abuse and the simple presence of an eating disorder, there does appear to be evidence for more complex relationships between abuse and specific bulimic behaviors and eating attitudes. For example, when one compares diagnostic subgroups of eating-disordered patients, the prevalence of childhood sexual abuse is unusually low among restrictive anorexics, but high among women with disorders involving bulimic behaviors (e.g., Steiger & Zanko, 1990; Waller, Halek, & Crisp, 1993). Bingeing and purging behaviors appear to regulate disturbing cognitions and emotions, which can arise from an abuse history (e.g., Root and Fallon, 1989). Similar links appear to be found with other behaviors that can be characterized as assisting in the blocking of intolerable emotional

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0145-2134/$ – see front matter 
doi:10.1016/j.chiabu.2004.11.002

states, such as self-harm (Romans, Martin, Anderson, Herbison, & Mullen, 1995). In addition to the abuse-eating behavior link, there is also a link to negative body image (Byram, Wagner, & Waller, 1995; Waller, Hamilton, Rose, Sumra, & Baldwin, 1993), possibly due to the development of body shame and deprecation following the abuse.

To summarize, there is evidence of a link between childhood sexual abuse and specific aspects of the eating disorders (bingeing, vomiting, and body image disturbance). However, it is not clear whether there is a link between childhood sexual abuse and other behaviors or more specific eating-related cognitions. The first aim of this study of a large clinical sample was to replicate and extend the link between reported sexual abuse and different eating disorder diagnoses. In keeping with previous findings, it was hypothesized that sexual abuse would be less commonly reported among groups with no purging behaviors (restrictive anorexics and binge eating disorder). However, there are moves towards considering the core elements of the eating disorders rather than focusing on diagnostic differences (Fairburn, Cooper, & Shafran, 2003; Waller, 1993). Therefore, it is important that such an investigation should use a measure of eating-related pathology that is relevant to the broad spectrum of the eating disorders. Thus, the second aim was to determine the dimensional association of reported sexual abuse with a broad range of eating characteristics (both cognitions and behaviors). Again, in keeping with research to date, it was hypothesized that such a trauma history would be associated with bulimic behaviors and with negative attitudes relating to body shape and size.

## Method

### *Design*

This study used a cross-sectional design, with a population of eating-disordered women. Associations were examined between retrospective reports of childhood sexual abuse and current self-reports of eating attitudes and behaviors.

### *Participants*

The participants were 299 women who met DSM-IV criteria for an eating disorder (American Psychiatric Association, 1994). They were a case series of patients, recruited from a specialist eating disorders clinic over a period of 2 years (July 2000–June 2002, inclusive). The only patients excluded from this sample were the relatively small number of males referred over that time period, any patients with a comorbid learning disability or psychotic state, and any who had been referred in error (i.e., those who did not have an eating disorder). All were diagnosed at assessment by clinicians trained in the differential diagnosis of the eating disorders, using a structured interview based on DSM-IV criteria. Weight and height were measured objectively to provide body mass index (BMI = weight [kg]/height $[m]^2$). A normal BMI is in the range 20–25, while a BMI of 30+ indicates obesity and a BMI of less than 17.5 indicates the level of underweight associated with anorexia nervosa.

Of the sample, 62 patients met criteria for anorexia nervosa, restricting subtype; 61 met criteria for anorexia nervosa, binge/purge subtype; 92 met criteria for bulimia nervosa; 27 met criteria for eating disorder not otherwise specified (EDNOS)-binge eating disorder; 29 met criteria for EDNOS-atypical anorexia nervosa (i.e., missing one criterion for a diagnosis of anorexia nervosa); 10 met criteria for